UNITED STATES DISTRICT COURT
DISTRICT OF OREGON

STATE OF WASHINGTON, et al.,

Plaintiffs,

v.

UNITED STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Case No. 6:25-cv-01748-AA

DECLARATION OF LUCY WOLF

I, Lucy Wolf, declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

2. I am an Assistant Attorney General with the Washington State Office of the Attorney General and one of the attorneys representing Plaintiff State of Washington in the above-captioned matter.

3. Attached hereto as Exhibit 1 is a true and correct copy of a Congress.gov report titled "Teen Births in the United States: Overview and Recent Trends" published on April 17, 2025.

4. Attached hereto as Exhibit 2 is a true and correct copy of the Congressional Research Service's (CRS) report titled, "Teenage Pregnancy Prevention: Statistics and Programs" published on January 15, 2016.

5. Attached hereto as Exhibit 3 is a true and correct copy of the U.S. Department of Health and Human Services (HHS) webpage on Sexually Transmitted Infections (STI's).

6. Attached hereto as Exhibit 4 is a true and correct copy of HHS' STI National Strategies Plan for the United States for 2021-2025.

7. Attached hereto as Exhibit 5 is a true and correct copy of the Center for Disease Control's webpage titled, "Sexually Transmitted Infections Prevalence, Incidence, and Cost Estimates in the United States" published on April 3, 2024.

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8. Attached hereto as Exhibit 6 is a true and correct copy of a CRS report titled, "Teen Pregnancy Prevention: Background and Proposals in the 111th Congress" updated on April 25, 2011.

9. Attached hereto as Exhibit 7 is a true and correct copy of the ACF.gov webpage State Personal Responsibility Education Program (PREP) youth population targets.

10. Attached hereto as Exhibit 8 is a true and correct copy of Washington State's December 27, 2024, Notice of Award for Award #2501WAPREP.

11. Attached hereto as Exhibit 9 is a true and correct copy of the Standing Notice of Funding Opportunity for Title V State Sexual Risk Avoidance Education (SRAE) HHS-2024-ACF-ACYF-SRAE-0044.

12. Attached hereto as Exhibit 10 is a true and correct copy of the PREP Studies of Performance Measures and Adulthood Preparation Subjects (PMAPS) Fact Sheet published February 2023.

13. Attached hereto as Exhibit 11 is a true and correct copy of the ACF PREP Performance Measures Final report: 2013-2017 published in March 2021.

14. Attached hereto as Exhibit 12 is a true and correct copy of the Washington State Health Education Learning Standards.

15. Attached hereto as Exhibit 13 is a true and correct copy of Washington State's August 6, 2025, Notice of Award for Award #2501WAPREP.

16. Attached hereto as Exhibit 14 is a true and correct copy of Minnesota's August 6, 2025, Notice of Award for Award #2501MNSRAE.

17. Attached hereto as Exhibit 15 is a true and correct copy of the Fiscal Year 2025 State PREP Supplemental Terms and Conditions.

18. Attached hereto as Exhibit 16 is a true and correct copy of the Fiscal Year 2025 State SRAE Supplemental Terms and Conditions.

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19. Attached hereto as Exhibit 17 is a true and correct copy of an August 21, 2025, letter from the Administration for Children and Families (ACF) to California regarding State PREP Grants for Fiscal Years 2023, 2024 and 2025.

20. Attached hereto as Exhibit 18 is a true and correct copy of an August 19, 2025, letter from California to ACF regarding State PREP Grants for Fiscal Years 2023, 2024 and 2025.

21. Attached hereto as Exhibit 19 is a true and correct copy of a June 20, 2025, letter from ACF to California regarding State PREP Grants for Fiscal Years 2023, 2024 and 2025.

22. Attached hereto as Exhibit 20 is a true and correct copy of all August 26, 2025, letters from ACF to states regarding State PREP Grants for Fiscal Years 2023, 2024 and 2025.

23. Attached hereto as Exhibit 21 is a true and correct copy of the August 26, 2025, letter from ACF to Washington State regarding State PREP Grants for Fiscal Years 2023, 2024 and 2025.

24. Attached hereto as Exhibit 22 is a true and correct copy of an HHS Press Release titled, "Trump Administration Puts 46 States and Territories on Notice to Remove Gender Ideology Content from Sex Ed Materials" published August 26, 2025.

25. Attached hereto as Exhibit 23 is a true and correct copy of the PREP Evaluation Snapshot titled "Inputs and Outcomes: PREP Programs Serving Runaway and Homeless Youth" published April 2018.

26. Attached hereto as Exhibit 24 is a true and correct copy of the PREP Evaluation Performance Indicators titled "Youth Participants' Characteristics and Outcomes" published April 2018.

I declare under penalty of perjury under the laws of the State of Washington and the United States of America that the foregoing is true and correct.

DATED and SIGNED this 26th day of September 2025, at Seattle, Washington.

s/ Lucy Wolf
LUCY WOLF, WSBA #59208
Assistant Attorney General

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Exhibit 1

CONGRESS.GOV

Teen Births in the United States: Overview and Recent Trends

CRS Product Type: Reports
CRS Product Number: R45184
Topics: Social Welfare
Publication Date: 04/17/2025
Authors: Mickler, Alexandria K.; Tollestrup, Jessica

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Summary

Adolescent childbearing is associated with significant social, health, and financial risks for teens, their families, and society more broadly. Data from the National Center for Health Statistics (NCHS), within the Centers for Disease Control and Prevention (CDC), indicate that the teen birth rate has decreased steadily over time. However, the United States continues to have one of the highest rates of teen births among other industrialized countries.

This report focuses on teen birth rates—and the marked decline in recent years. The teen birth rate is defined as the number of live births per 1,000 females aged 15 to 19 each year. The earliest NCHS estimate of the teen birth rate (in 1940) was 54.1, which later peaked in 1957 at 96.3. It then decreased in most years from the 1960s through the 1980s, with a low of 50.2 in 1986. The birth rate increased over the next few years, to 61.8 in 1991. From 1992 onward, the teen birth rate declined except in two years, 2006 and

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2007. From 2007 to 2023, the rate declined by approximately 68%, to a historical low in 2023 of 13.1.

The teen birth rate has decreased across all racial and ethnic groups in recent years; however, the rates declined more for certain groups than others. From 2016 to 2023, birth rates fell by 54% for non-Hispanic Asian teens, 41% for non-Hispanic White teens, 40% for non-Hispanic American Indian or Alaska Native teens, 35% for Hispanic teens, 34% for non-Hispanic Black teens, and 26% for non-Hispanic Native Hawaiian or Other Pacific Islander teens. In 2023, the teen birth rates for non-Hispanic American Indian or Alaska Native teens (20.9 per 1,000 females aged 15 to 19), Hispanic teens (20.8), non-Hispanic Native Hawaiian or Other Pacific Islander teens (21.2), and non-Hispanic Black teens (19.3) were each more than double the rate for non-Hispanic White teens (8.4), and more than 10 times the rate for non-Hispanic Asian teens (1.8).

Teen birth rates have varied considerably by state and territory, which may be due to a variety of factors, such as population composition. (An analysis of these factors by state is beyond the scope of this report.) In 2023, the state with the lowest teen birth rate was New Hampshire (4.6); the state with the highest teen birth rate was Mississippi (24.9).

Fifteen states had rates of less than 10 births per 1,000 teens aged 15 to 19 in 2023: New Hampshire, Vermont, Massachusetts, Connecticut, Maine, New Jersey, Rhode Island, Minnesota, New York, Utah, California, Oregon, Washington, Pennsylvania, and Wisconsin (ordered from lowest to highest). Seven states had teen birth rates of 20 births per 1,000 teens or higher: Mississippi, Arkansas, Louisiana, Kentucky, Oklahoma, Tennessee, and Alabama (ordered from highest to lowest). The rates for the territories ranged from 11.6 in the U.S. Virgin Islands to 23.5 in Guam.

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Teen birth rates have declined in rural areas over time but continue to remain relatively higher than teen birth rates in urban areas. The number of second (and additional) births to teen parents has also declined over time, with an 80% total decline from a recent high of 8.1 in 2007 to a historical low of 1.8 in 2023.

Research suggests that multiple factors have led to lower teen birth rates in the United States. From the 1990s through 2019, the risk of teen pregnancy decreased primarily because of improved contraceptive use, including an increase in the use of more

effective contraceptive methods (e.g., long-acting and reversible methods) and an increase in the use of multiple methods of contraception. During this period, some of the risk of pregnancy among younger teens declined because of decreased sexual activity; however, general trends in adolescent sexual activity have remained relatively stable. Broad economic and social variables may also influence teen behaviors, such as expanded educational or labor opportunities.

Teen pregnancy has high costs for teen parents, their children, and society more generally. Teenage mothers and fathers tend to have less education and are more likely to have lower incomes than their peers who are not parents. Moreover, lower levels of education reduce teen parents' potential for economic self-sufficiency. Children of adolescent parents are also more likely to face certain adverse health and social outcomes, such as preterm birth and other child morbidities.

This report accompanies CRS Report R45183, Adolescent Pregnancy: Federal Prevention Programs, which discusses federal support for programs that seek to prevent pregnancy among adolescents, and CRS In Focus IF10877, Federal Adolescent Pregnancy Prevention Programs, which includes summary information about the programs.

Introduction

This report provides context for Congress about trends in the U.S. teen birth rate—defined as the number of live births per 1,000 females aged 15 to 19—with a focus on recent trends.[1] Since the 1960s, the U.S. teen birth rate has generally been in decline, with the rate reaching a record low in 2023 (the year for which the most recent data are available). Multiple factors have likely contributed to the decrease, though the influence of any single factor is not fully understood and may vary over time. These may include proximate factors, such as contraceptive use, and distal factors, such as broader social and economic factors.[2]

Teen births are a significant public health concern because of the range of health, social, and economic effects adolescent childbearing can have on adolescents, their children, and broader society.[3] Despite substantial declines over time, the teen birth rate in the United States has remained higher than that of comparable high-income countries.[4] Furthermore, there are persistent racial, ethnic, and geographic disparities.[5]

This report provides a description of teen birth rate trends and a brief discussion on (1) factors that may contribute to the ongoing decline in teen birth rates and (2) the adverse outcomes related to teen births. This report accompanies CRS Report R45183, *Adolescent Pregnancy: Federal Prevention Programs*, which discusses Congress's current approach of supporting programs that

seek to prevent pregnancy among adolescents, and CRS In Focus IF10877, *Federal Adolescent Pregnancy Prevention Programs*, which includes summary information about the programs.

Teen Births in the United States

Official data on births to adolescent females are provided by the National Center for Health Statistics (NCHS), an agency of the Centers for Disease Control and Prevention (CDC).[6] The NCHS, in collaboration with states and other jurisdictions, compiles and publishes official national data for all *vital events* (i.e., births, deaths, marriages, divorces, and fetal death) in the National Vital Statistics System (NVSS).[7] In particular, birth data in the NVSS draw upon information included in all registered birth certificates and account for nearly every birth in the United States.[8]

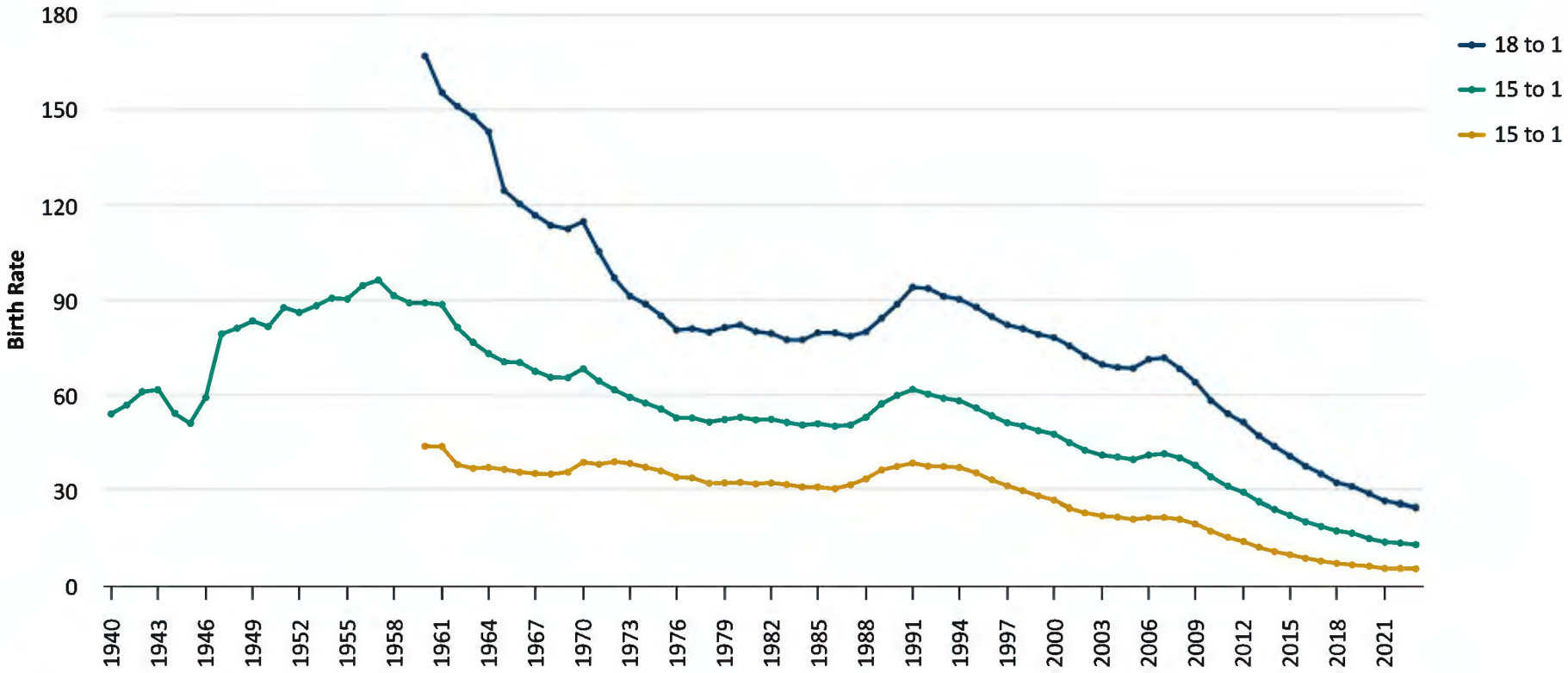
Data on births are distinct from data on pregnancies. Whereas the number of births—and related characteristics such as maternal age—are derived directly from vital records, information on pregnancies relies on estimates from several data sources. In addition to data on births, such figures also incorporate calculations of pregnancy losses (e.g. miscarriage, stillbirth) from the National Survey of Family Growth and estimates of induced abortion from both the CDC's Abortion Surveillance System and the Guttmacher Institute's Abortion Provider Census.[9] Various statistical approaches have been implemented over time to account for strengths and shortfalls of the aforementioned sources, as well as the inherent complexities in measuring pregnancy loss. As this report exclusively focuses on teen birth data, an evaluation of the nuances and challenges with pregnancy data are beyond the scope of this report.

Teen Birth Rate Trends

Since 1940, NCHS has published birth rate data that allow for longitudinal comparison by the age of the birth mother. The earliest estimate of the teen birth rate (in 1940) was 54.1 births per 1,000 females aged 15 to 19.[10] Twenty years later, in 1960, NCHS began publishing teen birth rate data further disaggregated by subgroups; that is, the birth rate among teens aged 15 to 17 as well as among teens aged 18 to 19. Figure 1 shows the national U.S. teen birth rate from 1940 through 2023 (the rate excludes the territories).[11] Broadly, the teen birth rate (for ages 15-19) hovered around an average 56.9 throughout the early to mid-1940s, and then ticked up in the baby boom era of the 1950s, peaking in 1957 at 96.3. It then decreased in most years from the 1960s through the 1980s, with a low of 50.2 in 1986.[12] The birth rate increased over the next few years to 61.8 in 1991. From 1992 onward, the teen birth rate declined except in two years, 2006 and 2007. Since 2009, the teen birth rate has fallen to a new record low each year, with the most recent data reflecting a historical low of 13.1 in 2023—a 2% decrease from 2022 and a 68% decrease from the most recent peak observed in 2007.[13]

Figure 1. Teen Birth Rate, 1940-2023

Figure is interactive in HTML report version.



Source: Figure created by CRS using data from the following: 1950-1959 data are from Stephanie J. Ventura et al., "Births to Teenagers in the United States, 1940–2000," National Vital Statistics Report, vol. 49, no. 10, September 2001, https://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_10.pdf; 1960-2009 data are from Stephanie J. Ventura et al., "National and State Patterns of Teen Births in the United States, 1940–2013," National Vital Statistics Report, vol. 63, no. 4, August 2014, https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_04.pdf; 2010-2023 data are from "Births: Final Data for 2023," HHS, CDC, NCHS, National Vital Statistics Report, vol. 74, no. 1, March 2025, https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-1.pdf (hereinafter, Michelle J.K. Osterman et al., "Births: Final Data for 2023.")

Notes: Birth rate = number of live births per 1,000 females aged 15 to 19. Subgroup data for teens aged 15-17 and 18-19 did not become available until 1960.

Recent Trends

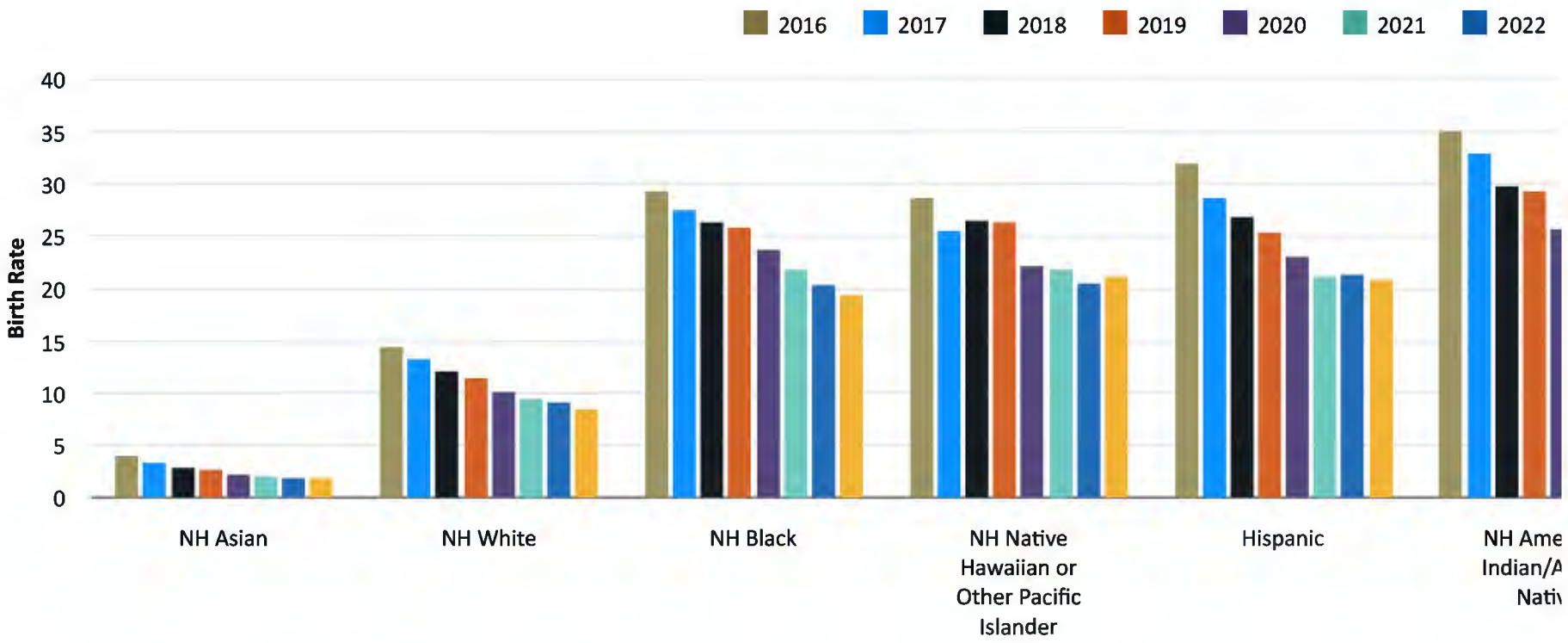
In 2023, there were approximately 3.6 million births in the United States.[14] About 141,000 of these births (3.9%) were to teenagers aged 15 to 19. This reflects a teen birth rate of 13.1 births per 1,000 females aged 15-19 in 2023—the lowest rate on record, and a 2% decline from 2022.[15] The 2023 birth rates for 15- to 17-year-olds (5.5 per 1,000) and 18- to 19-year-olds (24.6 per 1,000) were also the lowest on record, though the birth rate among older teens remains consistently higher than the birth rate among younger teens.[16]

The 2023 rate reflects an overall decline of 68% since the most recent high in 2007 and a 79% decline from the second most recent high in 1991. Despite a decline in the overall teen birth rate, disparities exist among certain racial or ethnic groups. Teen birth rates in 2023 varied based on race and ethnicity, with four groups—non-Hispanic American Indian and Alaska Native (20.9 per 1,000), Hispanic (20.8), non-Hispanic Native Hawaiian or Other Pacific Islander (21.2), and non-Hispanic Black (19.3) teens—having more than double the teen birth rate for non-Hispanic White (8.4) teens, and more than 10 times the rate for non-Hispanic Asian (1.8) teens.[17]

Figure 2 shows the teen birth rate by race and Hispanic origin between 2016 and 2023. From 2016 to 2023, the teen birth rate generally decreased across all racial and ethnic groups; however, the rates declined more for certain groups compared with others and some groups experienced periodic increases.[18] From 2016 to 2023, birth rates fell by 54% for non-Hispanic Asian teens, 41% for non-Hispanic White teens, 40% for non-Hispanic American Indian and Alaska Native teens, 35% for Hispanic teens, 34% for non-Hispanic Black teens, and 26% among non-Hispanic Native Hawaiian or Other Pacific Islander teens.

Figure 2. Teen Birth Rate, by Race and Hispanic Origin, 2016-2023

Figure is interactive in HTML report version.



Source: Figure created by CRS using data from Michelle J.K. Osterman et al., "Births: Final Data for 2023."

Notes: Birth rate = number of live births per 1,000 females aged 15 to 19. NH = Non-Hispanic.

Teen birth rates have varied considerably by state and territory, which may be due to a variety of factors, such as population composition as well as individual, family, and broader societal factors that may vary by state and geographic region (among other characteristics). An analysis of these factors by state are beyond the scope of this report. **Figure 3** displays a map of the five-year teen birth rate averages across each state from 1990 to 2023.[19] For these maps, the teen birth rate generally is divided into eight categories to show variations across each of the 50 states and the District of Columbia.

Annual teen birth rates for each state and territory (where available) are presented in **Table B-1**, **Table B-2**, and **Table B-2** in **Appendix B**. **Figure B-1** in **Appendix B** compares individual state teen birth rates against the national teen birth rate for each year from 1940 through 2023.

In 2023, the state with the lowest teen birth rate was New Hampshire (4.6 per 1,000); the state with the highest rate was Mississippi (24.9). Fifteen states had rates of less than 10 births per 1,000 teens aged 15 to 19 in 2023: New Hampshire, Vermont, Massachusetts, Connecticut, Maine, New Jersey, Rhode Island, Minnesota, New York, Utah, California, Oregon,

Washington, Pennsylvania, and Wisconsin (ordered from lowest to highest). Seven states had teen birth rates of 20 per 1,000 teens or higher: Mississippi, Arkansas, Louisiana, Kentucky, Oklahoma, Tennessee, and Alabama (ordered from highest to lowest). The rates for the territories ranged from 11.6 in the U.S. Virgin Islands to 23.5 in Guam. From 2007 (when the birth rate last increased) to 2023, the teen birth rate decreased in each state or territory by between 51.9% and 78.5%.[20]

Teen birth rates have also declined in rural areas over time but remain relatively higher than rates in urban areas.[21]

Figure 3. Five-Year Average Teen Birth Rates, by State

Figure is interactive in HTML report version.

Source: Figure created by CRS using data from Michelle J.K. Osterman et al., "Births: Final Data for 2023."

Notes: Birth rate = number of live births per 1,000 females aged 15 to 19. Due to the degree of missing longitudinal data, teen birth rates for U.S. territories are not included in the figure. All available individual-year data for each territory are included in Table B-1, Table B-2, and Table B-3 in Appendix B.

Although the majority of teen births are first births, some teens have additional children while still in their adolescent years. These births, sometimes referred to as *repeat births*, affect the overall teen birth rate and are associated with further risks to teen parents and their children.[22] The total teen birth rate can also be understood as a combination of the "first child" teen birth rate and the "second child and over" teen birth rate, also referred to as "second and higher-order" births. Over the past two decades, teenagers have experienced greater declines in the number, rate, and percentage of "second child and over" births than for first births.[23] Figure 4 displays trends in the total teen birth rate alongside the rate of "first child" and "second child and over" births.

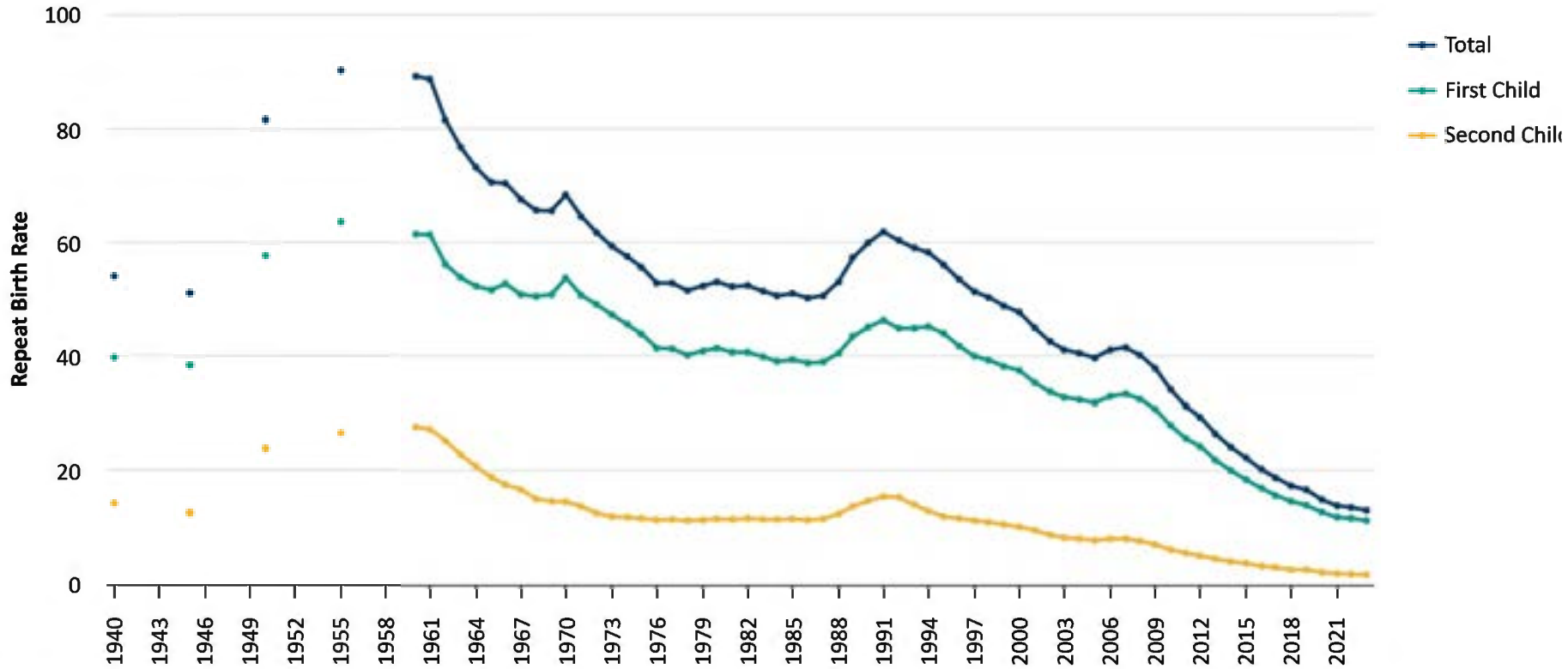
Based on available data, the highest "first child" teen birth rate (63.7) occurred in 1955, whereas the highest "second child and over" teen birth rate (27.7) occurred in 1960 (Figure 4).[24] As with the total teen birth rate, the "first child" and "second child and over" rates declined in most years from the 1960s to the 1980s; however, the "first child" teen birth rate increased slightly in 1966 and 1970, while the "second child and over" rate continued to decline. Both rates generally declined from 1971 to 1986, reaching a record low (at the time) "first child" teen birth rate of 38.8 and a record low (at the time) "second child and over" teen birth rate of 11.4, both of which occurred in 1986.[25] Over the next few years, both rates began ticking upwards again, with the "first child" teen birth rate reaching 46.3 and the "second child and over" teen birth rate reaching 15.5 in 1991.

As with the total teen birth rate, both rates declined from 1992 onwards, aside from increases in both rates in 2006 and a subsequent increase in "first child" teen birth rates in 2007. The 2023 "first child" teen birth rate of 11.3 reflects a historical low and

a 65.8% decrease from the most recent high in 2007; the "second child and over" teen birth rate of 1.8 also reflects a historical low and a 77.8% decrease from the most recent high of 8.1 (observed in both 2006 and 2007).

Figure 4. Repeat Teen Birth Rates (TBR), 1940-2023

Figure is interactive in HTML report version.



Source: Figure created by CRS using NVSS data provided by NCHS in November 2024.

Notes: Birth rate = number of live births per 1,000 females aged 15 to 19. Individual year data from 1940 through 1959 are unavailable because these population rates were not revised with more accurate populations provided by the Census Bureau. However, the rates for 1940, 1945, 1950, and 1955 include the revised populations and are presented above.

Factors Linked to Declines in Teen Births

Researchers suggest that multiple factors have contributed to the near continuous decline in U.S. teen birth rates; these factors include a variety of individual, family, and broader societal factors, each of which may influence teen births to varying degrees.[26]

Over time, individual behaviors among teens have contributed to the declining teen birth rate in various manners. For instance, data from 1995 to 2002 indicate that an older age at first sexual experience accounted for 23% of the decline in teen pregnancy among younger teens (i.e., teens aged 15 to 17).[27]

More recent data indicate that trends in adolescent sexual activity have not changed significantly, but rather that decreases in the teen birth rate are attributed to an increased use of contraception. From 2006 through 2019, teens reported an increase in the use of contraception and more consistent use of highly effective methods.[28] Teens more frequently report the use of long-acting reversible contraceptives (LARCs; e.g., intrauterine devices, or IUDs, and birth control implants), though data concerning the use of condoms remains mixed.[29] Further, the choice to use certain contraceptive methods in conjunction with or instead of other methods may be influenced by a variety of factors, including clinical guidelines and related updates, physical and financial access, and individual preferences (a discussion of these influences among adolescents are beyond the scope of this report).[30] Differences observed in some trends in adolescent sexual behavior and contraceptive use may also depend on the sampling approach used by particular surveys.[31]

Broad economic and social variables may influence teen behaviors, such as whether they will abstain from sex or use contraceptives.[32] Behavioral changes may have been driven by a confluence of factors, such as expanded educational and labor market opportunities for women and improvements in contraceptive technology.[33] Some observers theorize that the long-term downward trend in teen birth rates is attributable to the recession that began in 2007. They contend that during economic downturns the decrease in teen births—like the decrease in overall births—is partly due to teenagers being more careful as they witness the economic difficulties faced by their families.[34] Despite this rationale, the teen birth rate continued to diminish after the recession (as well as during periods of economic expansion in the 1990s).[35] Some researchers have aimed to quantify how media exposure may affect teen birth rates and related attitudes about contraceptive use and adolescent childbearing. The extent of this influence is not well understood.[36]

Some observers contend that teen pregnancy prevention programs, such as those supported with federal funding, could potentially play a role in the declining birth rate for teenagers.[37] The extent to which these programs have contributed to a decline in the teen birth rate is not fully known.[38] Some researchers have found that the proportion of teens who receive formal sex education has changed little in recent years, and that teens are less likely to be instructed on topics such as how to access contraception, how to refuse sex, and/or how to prevent sexually transmitted infections (STIs).[39] Additionally, the receipt of this information can vary by teens' sociodemographic characteristics.[40]

While the U.S. teen birth rate has decreased over time, it has been higher than that of most other industrialized countries.[41] For instance, the 2021 U.S. teen birth rate of 13.9 per 1,000 was higher than the rate of the United Kingdom (8.2), France (5.1),

Canada (4.9), and Sweden (2.5) (based on the most recent international data available that include the teen birth rate).[42] The reasons for the high teen birth rate in the United States relative to other industrialized countries have not been fully explored. Economic conditions and income inequality within and between countries, as well as societal differences, such as rates of alcohol consumption, may play a role.[43] Further, the research literature, which is somewhat limited, indicates that use of contraceptives among teens appears to be greater in other developed countries compared with the United States.[44]

Financial and Social Costs of Teen Births

Adolescent childbearing has high costs for the families of teen parents and society more generally.[45] Teenage mothers and fathers tend to have less education and are more likely to have lower income than their peers who are not teen parents. For example, approximately 90% of women who do not give birth during adolescence graduate from high school, whereas about 50% of teen mothers receive a high school diploma by 22 years of age.[46] In addition, according to the HHS Office of Population Affairs,[47] adolescents who have children before turning 20 (compared with older parents) are

- more likely to need public assistance;
- more likely to have low income as adults; and
- more likely to have children who face challenges such as poorer educational, behavioral, and health outcomes.[48]

These adverse outcomes may be explained in part by the accompanying stressors and risk factors linked to having a child as a teen. They are also partly explained by underlying differences between those who give birth as teens and those who delay childbearing. Lower levels of education reduce teen parents' potential for economic self-sufficiency. At the same time, having lower income and less education can also increase the likelihood of teens becoming pregnant in the first place.[49] Compared with their counterparts who have children at a later age, teen mothers often come from more disadvantaged backgrounds (e.g., family more likely to receive public welfare benefits, parents have lower levels of education) or, as discussed below, may be the children of teen parents themselves.[50] In addition, teen sexual activity, even among those who do not become pregnant, can increase the risk of sexually transmitted infections (STIs), which can lead to long-term health issues. Some STIs are disproportionately common among adolescents and young adults.[51]

Adolescent childbearing can also affect the children of teen parents. Children of teenage mothers have poorer outcomes than children of mothers who give birth in their early 20s or later. They are generally more likely to (1) have chronic medical conditions, (2) use public health care, (3) have lower school readiness scores, (4) do poorly in school, (5) give birth during their teen years (females), and (6) be incarcerated (males).[52] Relatedly, NVSS data examining linked infant and maternal health records indicated

that infants born to teen mothers are more likely to face higher rates of neonatal and infant mortality and morbidity, including preterm birth or low birth weight, while teen mothers also face heightened risk of maternal health complications.[53]

In addition to the consequences for teens and their families, teen childbearing has societal impacts. One study examined these societal impacts, specifically estimating the cost savings to public programs that were associated with avoiding unintended pregnancies during the teen years. The Power to Decide[54] did a simulation analysis to estimate the number of births to teenagers that had been averted due to the decrease in teen fertility rates from 1991 to 2015. The analysis then estimated total savings of $4.4 billion for this period, taking into consideration the cost savings to Medicaid that would have been associated with labor and delivery, postpartum care for the mother, and infant care, and receipt of Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits. Additional research of decreased or delayed teenage pregnancy and childbearing could help to inform the impacts for teen parents, their children, and society more generally.[55]

Appendix A. Teen Birth Rate, 1940-2023

Table A-1. Teen Birth Rate, 1940-2023

Birth rate is per 1,000 females aged 15 to 19

Year	Birth Rate	Year	Birth Rate	Year	Birth Rate
1940	54.1	1968	65.6	1996	53.5
1941	56.9	1969	65.5	1997	51.3
1942	61.1	1970	68.3	1998	50.3
1943	61.7	1971	64.5	1999	48.8
1944	54.3	1972	61.7	2000	47.7
1945	51.1	1973	59.3	2001	45.0
1946	59.3	1974	57.5	2002	42.6
1947	79.3	1975	55.6	2003	41.1
1948	81.1	1976	52.8	2004	40.5
1949	83.4	1977	52.8	2005	39.7

1950	81.6	1978	51.5	2006	41.1
1951	87.6	1979	52.3	2007	41.5
1952	86.1	1980	53.0	2008	40.2
1953	88.2	1981	52.2	2009	37.9
1954	90.6	1982	52.4	2010	34.2
1955	90.3	1983	51.4	2011	31.3
1956	94.6	1984	50.6	2012	29.4
1957	96.3	1985	51.0	2013	26.5
1958	91.4	1986	50.2	2014	24.2
1959	89.1	1987	50.6	2015	22.3
1960	89.1	1988	53.0	2016	20.3
1961	88.6	1989	57.3	2017	18.8
1962	81.4	1990	59.9	2018	17.4
1963	76.7	1991	61.8	2019	16.7
1964	73.1	1992	60.3	2020	15.0
1965	70.5	1993	59.0	2021	13.9
1966	70.3	1994	58.2	2022	13.6
1967	67.5	1995	56.0	2023	13.1

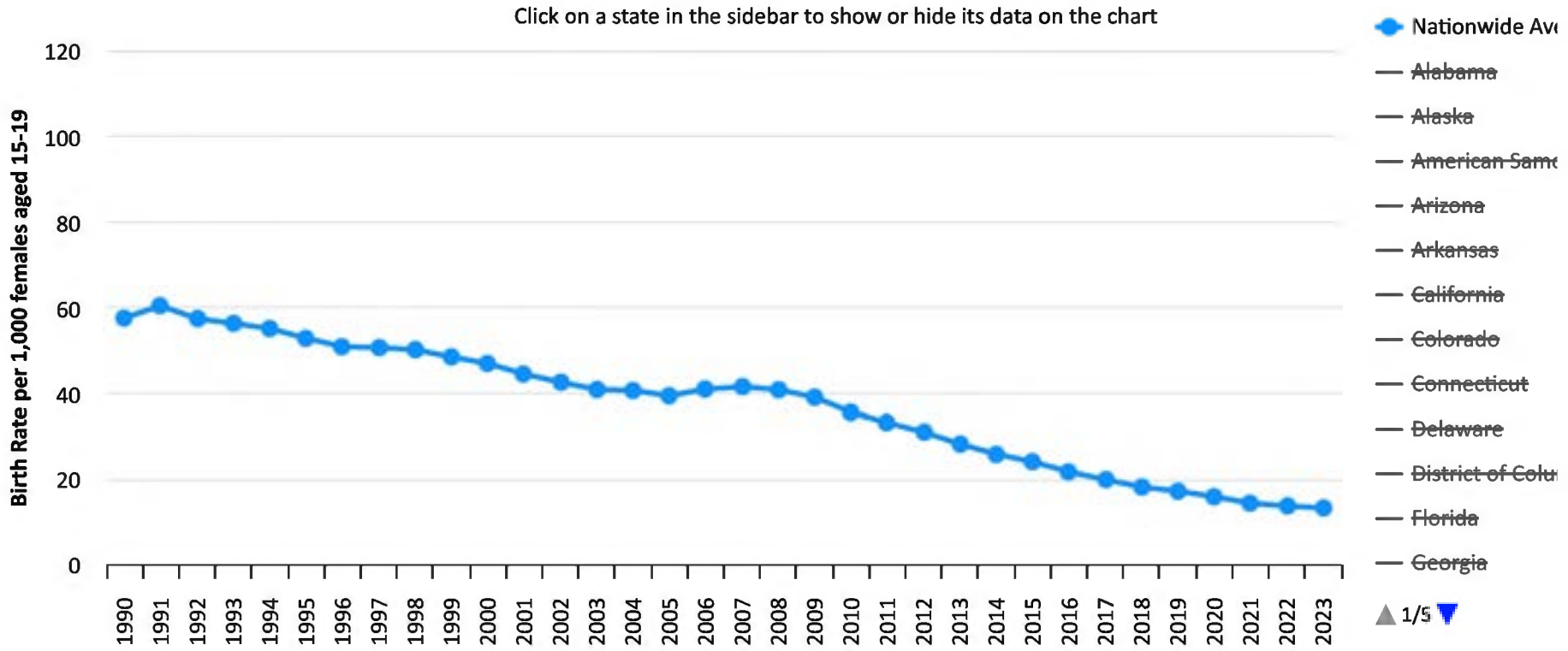
Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: These data are presented in **Figure 1**, which is interactive in the HTML version of this report. National teen birth rates do not include data from the U.S. territories.

Appendix B. Teen Birth Rates

Figure B-1. Teen Birth Rates, by State and Territory

Number of live births per 1,000 females aged 15 to 19. Figure is interactive in the HTML report version.



Source: Figure prepared by the Congressional Research Service based on data from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: These data were used to calculate five-year state averages in Figure 3. Some data are unavailable for certain territories in certain years. See Table B-1, Table B-2, and Table B-3 in Appendix B for more information.

Table B-1. Teen Birth Rates, by State and Territory, 1990-2000

State/Territory	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Alabama	71.0	73.6	72.0	69.2	70.6	68.5	67.1	64.5	63.9	60.9	60.7

Alaska	65.3	66.0	65.2	59.7	59.5	54.5	50.8	49.3	47.5	47.7	49.0
Arizona	75.5	79.7	80.2	78.1	76.8	73.5	71.5	68.7	68.8	68.0	67.9
Arkansas	80.1	79.5	74.8	72.8	74.8	71.9	73.5	70.8	68.7	66.1	66.2
California	70.6	73.8	72.8	71.8	70.2	66.8	61.0	55.7	52.0	49.1	47.0
Colorado	54.5	58.3	58.4	55.8	55.2	52.3	50.7	49.3	50.2	50.0	51.3
Connecticut	38.8	40.1	39.0	38.8	39.7	38.6	36.6	35.1	34.9	32.7	31.1
District of Columbia	54.5	60.4	58.7	58.0	57.8	54.6	53.8	52.3	50.6	50.7	48.0
Delaware	93.1	109.6	106.7	112.8	97.0	85.2	79.2	67.1	62.0	56.0	53.2
Florida	69.1	67.9	65.2	63.7	63.0	60.2	57.2	55.8	53.9	51.7	51.1
Georgia	75.5	76.0	74.2	72.0	70.6	69.8	66.8	65.6	64.0	63.5	62.8
Hawaii	61.2	59.2	54.2	53.7	54.4	48.8	48.9	44.4	47.0	45.0	46.1
Idaho	50.6	53.9	51.5	50.3	46.1	48.7	46.9	43.0	44.6	43.5	42.9
Illinois	62.9	64.5	63.0	62.0	61.5	58.4	55.3	52.7	51.8	49.7	48.0
Indiana	58.6	60.4	58.5	57.9	57.0	56.6	55.1	52.8	52.2	50.5	49.1
Iowa	40.5	42.5	40.5	40.7	39.3	38.3	37.4	35.3	34.9	35.4	34.2
Kansas	56.1	55.4	55.6	55.5	53.3	52.0	49.4	48.4	47.5	48.1	46.1
Kentucky	67.6	68.8	64.8	63.7	64.2	62.3	61.2	59.0	57.2	56.4	55.1
Louisiana	74.2	76.0	76.1	75.9	74.5	69.9	66.8	65.9	65.6	63.0	62.1
Maine	43.0	43.5	40.0	37.1	35.6	33.9	31.7	32.3	30.7	30.2	29.2
Maryland	53.2	54.1	50.6	49.7	49.3	47.2	45.7	43.1	42.6	42.2	41.3
Massachusetts	35.1	37.5	37.5	37.2	36.4	33.3	31.1	30.4	29.5	27.4	25.9
Michigan	59.0	58.9	56.6	53.1	52.0	49.1	46.4	44.3	43.5	41.4	40.2
Minnesota	36.3	37.3	35.9	35.0	34.4	32.5	32.3	32.1	30.9	30.3	30.1

Mississippi	81.0	85.3	83.6	82.2	81.7	79.2	74.0	71.8	71.4	70.9	70.1
Missouri	62.8	64.4	63.1	59.4	58.6	55.1	53.2	51.1	51.0	49.4	48.7
Montana	48.4	46.8	46.0	46.1	41.6	42.4	39.3	38.2	38.0	36.0	36.7
Nebraska	42.3	42.4	41.1	40.5	42.9	37.8	38.9	37.4	37.5	37.5	37.7
Nevada	73.3	74.5	70.6	73.2	73.4	73.4	69.5	67.4	65.6	63.9	63.0
New Hampshire	33.0	33.1	31.3	30.5	29.9	30.3	28.2	28.2	26.8	23.8	23.3
New Jersey	40.5	41.3	38.9	37.9	39.0	37.7	35.2	34.8	34.7	32.8	31.8
New Mexico	78.2	79.5	79.7	80.6	77.0	74.0	70.5	67.8	68.7	66.8	65.6
New York	43.6	45.5	44.5	44.6	44.3	42.2	39.9	36.7	36.4	34.7	33.2
North Carolina	67.6	70.0	69.2	66.1	65.3	63.0	62.3	59.9	59.8	58.0	58.6
North Dakota	35.4	35.5	36.9	36.3	33.9	32.9	31.6	29.2	29.7	27.0	27.3
Ohio	57.9	60.5	58.0	56.7	54.9	53.4	50.4	49.8	48.5	46.5	46.0
Oklahoma	66.8	72.1	69.8	68.3	65.6	63.7	63.1	63.7	61.4	60.1	59.7
Oregon	54.6	54.8	53.0	50.8	50.2	50.1	50.5	46.2	47.1	46.1	42.8
Pennsylvania	44.9	46.7	44.8	43.7	42.9	40.9	38.4	36.1	35.9	35.1	34.0
Rhode Island	43.9	44.7	46.2	47.6	45.0	39.8	38.9	38.3	36.5	33.5	33.6
South Carolina	71.3	72.5	69.7	64.7	64.7	62.8	60.2	58.8	58.3	58.5	58.0
South Dakota	46.8	47.6	48.3	44.4	43.0	40.9	40.1	40.6	39.8	38.5	38.1
Tennessee	72.3	74.8	70.9	69.2	69.7	66.6	64.5	62.4	62.5	60.8	59.5
Texas	75.3	78.4	78.2	77.7	77.2	75.6	73.1	71.2	70.5	69.6	68.9
Utah	48.5	48.0	45.7	43.4	41.4	40.9	41.2	41.0	39.6	38.8	38.3
Vermont	34.0	39.2	35.6	34.8	32.4	28.1	29.5	26.3	23.8	25.0	23.4
Virginia	52.9	53.4	51.7	49.6	50.5	48.4	45.4	44.0	43.4	42.6	40.9

Washington	53.1	53.7	51.0	50.5	48.6	48.0	45.6	43.0	42.4	41.0	39.2
West Virginia	57.3	58.0	56.3	55.6	54.3	52.7	50.5	49.1	49.6	48.5	46.5
Wisconsin	42.6	43.7	42.0	41.0	38.8	37.9	36.9	35.8	35.2	36.3	35.2
Wyoming	56.3	54.3	49.8	49.9	48.7	47.9	44.7	43.9	48.9	41.4	41.7
Total—United States	59.9	61.8	60.3	59.0	58.2	56.0	53.5	51.3	50.3	48.8	47.7
American Samoa	n/a	n/a	n/a	n/a	n/a	n/a	n/a	43.9	43.9	46.4	38.1
Guam	n/a	95.7	n/a	n/a	n/a	n/a	n/a	106.3	104.8	96.6	69.5
Northern Marianas	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	65.5	62.0	61.1
Puerto Rico	n/a	72.4	n/a	n/a	n/a	n/a	n/a	77.8	n/a	n/a	n/a
U.S. Virgin Islands	n/a	77.9	n/a	n/a	n/a	n/a	n/a	66	62	55.2	46.8

Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: These data were used to calculate the five-year state averages presented in Figure 3. "N/A" indicates data that were unavailable for certain territories in certain years. *Total – United States* teen birth rates do not include data from the U.S. territories.

Table B-2. Teen Birth Rates, by State and Territory, 2001-2011

State/Territory	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Alabama	55.7	53.6	51.4	51.0	48.1	51.8	52.1	50.5	48.3	43.6	40.5
Alaska	42.9	42.4	41.2	41.7	39.9	41.8	42.9	44.2	43.2	38.3	36.2
Arizona	65.3	62.6	61.9	60.8	58.7	61.2	59.6	54.5	48.6	41.9	38.5
Arkansas	62.7	60.4	59.3	60.3	58.6	60.8	60.1	59.8	57.8	52.5	50.7
California	44.5	41.6	40.1	39.5	38.7	39.9	39.6	37.9	34.9	31.5	28.7
Colorado	47.0	46.9	43.1	43.3	41.8	41.9	41.6	40.5	37.7	33.4	28.9

Connecticut	28.1	25.7	24.6	24.4	23.3	23.5	23.0	22.6	21.2	18.7	16.4
District of Columbia	45.0	42.6	41.6	40.0	40.1	40.6	39.2	38.3	33.5	30.5	29.3
Delaware	50.1	47.3	42.3	43.5	42.1	48.1	50.4	51.1	48.5	45.4	42.8
Florida	48.1	45.1	43.0	42.7	42.3	43.1	43.0	40.0	36.6	32.0	29.5
Georgia	59.8	55.6	53.1	52.7	52.0	53.7	53.4	50.0	47.0	41.4	38.2
Hawaii	43.1	39.7	38.3	36.4	36.5	39.0	38.7	38.9	37.0	32.5	30.0
Idaho	40.1	38.0	38.3	37.5	36.4	38.1	39.9	39.6	35.9	33.0	25.7
Illinois	45.7	42.2	40.2	40.1	38.5	39.8	40.2	38.5	35.9	33.0	29.5
Indiana	45.8	43.7	42.6	42.6	42.1	41.8	43.0	41.2	40.8	37.3	34.8
Iowa	32.2	31.1	30.6	30.1	31.1	32.6	32.8	33.4	32.1	28.6	25.3
Kansas	43.4	42.1	40.3	39.7	40.1	40.9	42.5	44.1	42.7	39.3	35.4
Kentucky	51.5	50.3	49.2	48.7	48.1	52.3	52.6	52.5	49.7	46.2	43.5
Louisiana	58.2	57.2	54.8	54.6	47.3	53.6	55.2	54.0	51.7	47.7	45.1
Maine	27.2	25.2	24.9	24.3	24.4	24.9	26.0	25.0	24.0	21.4	20.8
Maryland	38.0	35.9	33.7	32.7	32.1	33.7	34.3	32.6	30.7	27.3	24.7
Massachusetts	23.8	21.7	21.3	20.5	20.0	20.6	21.4	19.8	19.5	17.2	15.4
Michigan	38.2	34.6	34.2	33.9	32.2	33.2	33.5	32.3	31.9	30.1	27.8
Minnesota	28.0	27.2	26.2	26.3	25.5	27.3	27.9	26.5	24.1	22.5	19.3
Mississippi	65.6	63.5	61.2	60.1	58.3	67.2	70.1	64.0	62.2	55.0	50.2
Missouri	46.0	43.7	42.8	42.9	41.7	44.1	44.0	43.5	40.6	37.1	34.5
Montana	35.6	36.4	34.8	35.4	34.5	37.6	35.3	38.9	38.4	35.0	29.2
Nebraska	35.8	35.9	34.9	34.8	33.1	32.8	35.5	35.8	34.8	31.1	27.2
Nevada	58.4	56.7	54.9	52.9	51.6	53.4	51.7	49.1	44.0	38.6	36.1

New Hampshire	20.7	19.5	18.0	18.1	18.0	18.1	19.3	19.1	16.4	15.7	13.7
New Jersey	29.7	27.8	26.5	25.0	24.2	24.8	24.9	24.0	22.0	20.1	18.7
New Mexico	63.7	63.1	62.8	60.6	61.2	62.7	63.9	61.4	60.3	53.0	48.8
New York	31.8	28.9	27.3	26.1	25.7	26.0	26.0	25.5	24.2	22.7	21.2
North Carolina	53.7	50.5	47.2	47.3	47.0	48.1	48.0	47.3	43.7	38.3	34.9
North Dakota	25.3	25.0	24.7	24.7	27.0	26.1	29.2	28.3	28.7	28.8	28.2
Ohio	42.8	39.6	39.2	38.2	38.3	38.9	39.9	39.5	37.9	34.1	31.5
Oklahoma	57.8	57.7	55.3	54.4	52.8	56.6	58.5	57.8	57.4	50.4	47.8
Oregon	40.4	36.8	34.2	33.1	32.7	34.5	34.5	35.6	32.5	28.2	25.8
Pennsylvania	32.3	30.5	30.1	29.4	29.2	30.4	30.7	30.4	28.7	27.0	24.9
Rhode Island	33.0	31.3	27.8	29.0	27.8	27.5	29.2	27.6	25.8	22.3	21.3
South Carolina	54.8	50.8	49.5	49.8	48.7	52.0	51.9	51.2	47.0	42.6	39.1
South Dakota	37.5	37.6	34.3	37.8	36.8	38.7	41.3	39.1	38.7	34.9	34.3
Tennessee	56.7	53.9	52.7	51.1	53.3	52.1	53.4	52.2	48.4	43.2	40.8
Texas	66.0	64.6	62.6	62.1	60.9	61.6	61.8	60.7	57.9	52.2	46.9
Utah	36.1	33.8	31.8	30.9	30.5	33.3	35.4	34.6	30.7	27.9	23.1
Vermont	22.6	22.5	17.8	19.5	17.4	19.8	21.0	20.3	17.3	17.9	16.8
Virginia	39.1	36.5	35.2	34.2	33.6	34.2	34.2	32.5	30.4	27.4	24.5
Washington	35.9	33.5	31.8	31.4	31.1	32.2	33.3	32.8	30.4	26.7	25.4
West Virginia	45.3	45.1	44.2	42.9	42.2	44.2	45.8	46.9	48.2	44.8	43.5
Wisconsin	33.4	31.7	30.8	29.7	29.7	29.9	31.1	30.3	29.4	26.2	23.2
Wyoming	39.5	41.0	41.6	42.8	42.7	46.0	49.9	47.5	43.4	39.0	35.2
Total—United States	45.0	42.6	41.1	40.5	39.7	41.1	41.5	40.2	37.9	34.2	31.3

American Samoa	38.9	46.2	40.4	45.8	34.2	37.1	28.9	37.1	38.4	34.1	38.4
Guam	70.5	64.7	64.3	62.6	59.2	58.7	60.0	55.0	57.1	60.1	62.1
Northern Marianas	56.8	42.3	42.3	39.3	30.4	31.6	35.1	42.3	46.6	53.4	47.2
Puerto Rico	68.0	62.2	59.5	61.7	61.2	60.0	57.1	54.9	54.7	51.4	51.7
U.S. Virgin Islands	51.5	56.8	50.9	52.7	50.0	49.6	51.5	51.1	57.4	50.5	59.3

Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: These data were used to calculate the five-year state averages presented in Figure 3. "N/A" indicates data that were unavailable for certain territories in certain years. *Total – United States* teen birth rates do not include data from the U.S. territories.

Table B-3. Teen Birth Rates, by State and Territory, 2012-2023

State/Territory	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Alabama	39.2	34.3	32.0	30.1	28.4	27.0	25.2	25.6	24.8	22.9	20.9	20.1
Alaska	34.5	30.3	27.8	29.3	25.8	22.0	19.3	18.3	17.7	17.5	16.9	16.0
Arizona	37.4	33.1	29.9	26.3	23.6	22.0	20.1	18.5	16.6	15.1	15.1	14.3
Arkansas	45.7	43.5	39.5	38.0	34.6	32.8	30.4	30.0	27.8	26.5	24.6	23.8
California	26.5	23.6	21.1	19.0	17.0	15.1	13.6	12.4	11.0	9.9	9.8	9.1
Colorado	25.4	23.4	20.3	19.3	17.8	16.1	14.3	13.9	12.5	11.4	11.1	10.9
Connecticut	15.1	12.9	11.5	10.1	9.4	8.8	8.3	7.7	7.6	7.1	6.4	6.8
District of Columbia	25.0	24.7	20.7	18.1	19.5	18.5	16.7	14.9	15.6	13.5	12.5	13.5
Delaware	38.6	32.1	28.4	25.6	24.0	21.0	19.3	16.8	14.6	13.9	14.7	12.3
Florida	28.0	24.6	22.5	20.8	19.3	18.2	16.7	16.2	15.2	13.5	13.1	12.7
Georgia	33.8	30.5	28.4	25.6	23.6	21.9	20.6	19.7	18.2	16.6	16.6	16.5

Hawaii	28.1	25.1	23.1	20.6	19.2	19.1	17.2	15.7	13.0	12.3	11.7	11.3
Idaho	27.7	28.3	23.2	22.5	20.1	18.6	16.0	14.9	14.6	12.0	10.9	10.5
Illinois	27.9	24.6	22.8	21.1	18.7	17.4	15.8	14.6	13.6	11.1	11.3	10.7
Indiana	33.0	30.3	28.0	26.0.	23.6	22.8	21.8	20.8	18.7	17.0	16.7	15.7
Iowa	24.1	22.1	19.8	18.6	17.2	16.0	15.3	14.1	13.3	12.7	12.4	11.8
Kansas	34.1	29.6	27.6	25.5	21.9	21.3	20.0	19.2	18.1	16.3	16.2	15.1
Kentucky	41.5	39.5	35.3	32.4	30.9	29.0	27.3	24.9	23.8	22.3	21.8	20.7
Louisiana	43.1	39.2	35.8	34.1	30.6	29.1	27.5	27.8	25.7	24.5	23.7	23.1
Maine	19.4	17.4	16.5	15.4	14.7	13.1	11.1	9.1	10.6	7.8	8.4	7.2
Maryland	22.1	19.4	17.8	17.0	15.9	14.2	14.1	13.9	13.1	11.3	10.9	10.8
Massachusetts	14.1	12.1	10.6	9.4	8.5	8.1	7.2	6.9	6.1	5.7	5.8	5.8
Michigan	26.3	23.6	21.1	19.4	17.7	16.4	15.8	15.1	13.5	12.2	11.6	10.9
Minnesota	18.5	16.8	15.5	13.7	12.6	12.1	10.2	10.1	9.1	8.5	8.2	7.8
Mississippi	46.1	42.6	38.0	34.8	32.6	31.0	27.8	29.1	27.9	25.6	26.4	24.9
Missouri	32.2	30.0	27.2	25.0	23.4	22.5	21.6	20.3	18.8	17.1	16.9	15.9
Montana	28.8	27.9	26.4	25.3	23.7	21.2	17.2	16.3	13.2	13.6	12.2	11.8
Nebraska	26.8	24.9	22.2	22.0	19.1	18.1	16.7	15.3	15.1	14.0	14.1	13.1
Nevada	33.4	30.3	28.5	27.6	24.2	21.9	20.5	18.9	16.8	15.1	14.0	13.1
New Hampshire	13.8	12.6	11.0	10.9	9.3	8.4	8.0	6.6	6.6	5.4	4.6	4.6
New Jersey	16.7	14.8	13.1	12.1	11.0	10.3	10.3	10.0	9.2	7.9	8.2	7.5
New Mexico	47.5	43.3	37.8	34.6	29.8	27.9	25.3	24.4	21.9	19.0	19.7	17.9
New York	19.7	17.7	16.1	14.6	13.2	12.5	11.7	11.4	10.0	9.1	8.6	8.5
North Carolina	31.8	28.4	25.9	23.6	21.8	20.6	18.7	18.2	17.3	16.0	15.0	14.8

North Dakota	26.5	24.1	23.9	22.2	20.3	16.2	16.4	15.6	13.7	12.9	11.7	11.2
Ohio	29.8	27.2	25.1	23.2	21.8	20.8	18.9	18.8	17.6	15.5	15.4	14.6
Oklahoma	47.3	42.9	38.5	34.8	33.4	29.7	27.2	27.4	25.0	24.1	21.2	20.6
Oregon	23.8	21.6	20.0	19.0	16.6	15.0	13.3	12.1	10.1	9.5	10.1	9.4
Pennsylvania	23.7	20.9	19.3	17.7	15.8	14.8	14.1	13.3	12.6	11.5	10.6	9.8
Rhode Island	19.9	17.7	15.8	14.3	12.9	11.4	11.5	10.0	9.4	7.8	8.3	7.5
South Carolina	36.6	31.6	28.5	26.2	23.7	21.7	22.0	21.6	19.3	18.3	17.3	17.1
South Dakota	33.3	29.1	26.2	26.4	25.1	22.6	20.4	19.2	18.7	17.0	17.4	16.6
Tennessee	38.5	34.7	33.0	30.5	28.0	26.6	25.3	23.7	23.3	21.5	21.0	20.4
Texas	44.4	41.0	37.8	34.6	31.0	27.6	25.3	24.0	22.4	20.3	20.4	19.4
Utah	23.3	20.6	19.4	17.6	15.6	15.2	13.1	12.0	10.8	9.7	9.0	8.7
Vermont	16.3	14.5	14.2	11.6	10.3	10.1	8.8	7.6	7.0	6.4	5.8	5.7
Virginia	22.9	20.1	18.4	17.1	15.5	15.0	14.3	13.6	13.1	11.7	11.2	10.9
Washington	23.4	20.5	19.1	17.6	16.6	14.8	12.7	12.7	11.3	10.1	9.6	9.7
West Virginia	44.1	40.1	36.6	31.9	29.3	27.1	25.4	25.2	22.5	20.9	19.8	18.5
Wisconsin	21.9	19.6	18.0	16.2	15.0	13.8	13.0	12.5	11.5	10.1	9.8	9.9
Wyoming	34.7	29.6	30.1	29.2	26.1	24.6	20.8	19.4	18.1	16.0	16.0	12.6
Total—United States	29.4	26.5	24.2	22.3	20.3	18.8	17.4	16.7	15.0	13.9	13.6	13.1
American Samoa	39.7	42.9	46.8	46.9	40.8	38.4	n/a	n/a	n/a	n/a	n/a	n/a
Guam	54.7	54.1	48.4	38.3	38.0	40.1	34.4	33.3	33.0	23.8	19.8	23.5
Northern Marianas	37.9	44.3	38.6	36.9	27.4	16.1	28.3	20.7	17.9	14	9.4	16.9
Puerto Rico	48.8	44.6	40.4	33.9	29.6	24.3	19.3	19.1	15.5	13.2	12.6	12.3
U.S. Virgin Islands	42.8	n/a	n/a	39.1	25.4	n/a	n/a	n/a	15.1	18.5	15.0	11.6

Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Notes: These data were used to calculate the five-year state averages presented in Figure 3. "N/A" indicates data that were unavailable for certain territories in certain years. *Total – United States* teen birth rates do not include data from the U.S. territories.

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Footnotes

1. This report uses the terms *teenagers*, *teens*, and *adolescents* interchangeably. This report also uses *adolescent females* and *women* to be consistent with the terms used by the Department of Health and Human Services (HHS), including official teen birth statistics from the National Center for Health Statistics (NCHS). The teen birth rate age range reflects the standard definition used by the Centers for Disease Control and Prevention (CDC) and other federal agencies. The CDC also disaggregates birth rates by other age ranges, including ages 10 to 14; however, this age group is not included in calculations of the national teen birth rate and has remained unchanged since 2021 at 0.2 births per 1,000 females. See Michelle J.K. Osterman et al., "Births: Final Data for 2023," HHS, CDC, NCHS, *National Vital Statistics Report,* vol. 74, no. 1, March 2025, https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-1.pdf (Hereinafter, Michelle J.K. Osterman et al., "Births: Final Data for 2023.")
2. John Bongaarts, "A Framework for Analyzing the Proximate Determinants of Fertility," *Population and Development Review*, vol. 4, no. 1 (March 1978). Laura Lindberg et al., "Understanding the Decline in Adolescent Fertility in the United States, 2007-2012," *Journal of Adolescent Health*, vol. 59 (2016), p. 578.
3. Urban Institute, Kids Having Kids: Costs and Social Consequences of Teen Pregnancy, edited by Saul D. Hoffman and Rebecca A. Maynard, 2nd ed., 2008. (Hereinafter, Urban Institute, Kids Having Kids: Costs and Social Consequences of Teen Pregnancy.) See also, HHS, Centers for Disease Control and Prevention (CDC), Winnable Battles Final Report 2010-2015, https://stacks.cdc.gov/view/cdc/43072; Stefanie Mollborn, "Teenage Mothers Today: What we Know and How it Matters," Child Development Perspectives, vol. 11, no. 1 (March 2017).
4. CDC, *About Teen Pregnancy*, May 15, 2024, https://www.cdc.gov/reproductive-health/teen-pregnancy/index.html.

5. Michelle J.K. Osterman et al., "Births: Final Data for 2023."

6. On March 27, 2025, HHS issued a press release and fact sheet announcing the restructuring of HHS. The fact sheet indicated that this restructuring would decrease the CDC's workforce and "return [the CDC] to its core mission of preparing for and responding to epidemics and outbreaks." At the time of this report's publication, the potential effect of this restructuring on NCHS activities is unknown. U.S. Department of Health and Human Services, "Fact Sheet: HHS' Transformation to Make America Healthy Again," press release, March 27, 2025, https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html.

7. NCHS, *About the National Vital Statistics System*, https://www.cdc.gov/nchs/nvss/about_nvss.htm.

8. NCHS estimates that more than 99% of all births occurring in the United States were registered and included in the National Vital Statistics System (NVSS). See National Center for Health Statistics, *User Guide to the 2022 Natality Public Use File*, https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/natality/UserGuide2022.pdf.

9. Lauren M. Rossen et al., *Updated Methodology to Estimate Overall and Unintended Pregnancy Rates in the United States*, National Center for Health Statistics, Vital and Health Statistics: Series 2, Number 201, April 2023, pp. 1-4, https://stacks.cdc.gov/view/cdc/124395.

10. Stephanie J. Ventura et al., "Births to Teenagers in the United States, 1940–2000," *National Vital Statistics Report*, vol. 49, no. 10, September 2001, https://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_10.pdf.

11. The CDC began publishing birth rates inclusive of Alaska and Hawaii in 1959 and 1960, respectively. Data from these individuals were categorized as "Other Races," which represented a subset of the broader "Nonwhite" category historically used in earlier NVSS reports. According to the CDC, birth data from both Hawaii and Alaska affected their tabulations of birth rates by race/ethnicity in 1960, but they did not further analyze the statistical effect of this changing demographic composition among teen births, specifically. However, summary tabulations of the teen birth rate among the overarching category of Nonwhite mothers indicate a decrease in births among teens aged 10-14 and 15-19 from 1957 to 1960. This may suggest that the changing demographic composition of the United States did not significantly affect the downward trend in teen births; however, this also was not tested for statistical significance. See U.S. Department of Health, Education, and Welfare, *Vital Statistics of the United States*, Volume I - Natality, 1960, Table 1-E, https://www.cdc.gov/nchs/data/vsus/nat60_1.pdf.

12. The baby boom era refers to individuals born in the U.S. between mid-1946 and mid-1964. Sandra L. Colby and Jennifer M. Ortman, "The Baby Boom Cohort in the United States: 2012 to 2016, Population Estimates and Projections," *Current Population Reports,* CDC, May 2014.

13. Michelle J.K. Osterman et al., "Births: Final Data for 2023."

14. Table A-1 includes birth rates for teens since 1950. Michelle J.K. Osterman et al., "Births: Final Data for 2023."

15. Michelle J.K. Osterman et al., "Births: Final Data for 2023."

16. The CDC also tracks births for youth aged 10 to 14. Their birth rate has been much lower than the rate of births for older teens and is therefore not included in this analysis. The birth rate was 0.2 births per 1,000 youth aged 10 to 14 in 2023, which has remained steady since 2015.

17. Michelle J.K. Osterman et al., "Births: Final Data for 2023," Table 2.

18. From 2017 to 2018, an increase of 3.8% was observed among non-Hispanic Native Hawaiian or Other Pacific Islander teens; an increase of 3.3% was also observed among this group from 2022 to 2023. From 2022 to 2023, a 0.9% increase in teen births was observed among Hispanic females. See Michelle J.K. Osterman et al., "Births: Final Data for 2023," Table 2.

19. U.S. territories are not included in the five-year averages due to missing data. However, all available individual-year data are presented in Appendix B.

20. This is based on a CRS analysis comparing data from 2007 to 2023. All available state and territory data used to calculate percent changes are presented in **Appendix B**.

21. Brady E. Hamilton et al., "Teen Birth Rates for Urban and Rural Areas in the United States, 2007-2015," HHS, CDC, NCHS, *NCHS Data Brief*, no. 264, November 2016; and April Sutton, Daniel T. Lichter, and Sharon Sassler, "Rural–Urban Disparities in Pregnancy Intentions, Births, and Abortions Among US Adolescent and Young Women, 1995–2017," *American Journal of Public Health*, 109(12), December 2019, pp. 1762-1769. See also Sylvester O. Orimaye, "Adolescent Birth Rates and Rural–Urban Differences by Levels of Deprivation and Health Professional Shortage Areas in the United States, 2017–2018," *American Journal of Public Health*, vol. 11, no. 1 (2021).

22. Anne K. Driscoll et al., "Changes in First and Second Births to US Teenagers from 2000 to 2022," HHS, CDC, NCHS, *National Vital Statistics Report*, vol. 73, no. 6, July 2024, https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-06.pdf. (Hereinafter Anne K. Driscoll et al., "Changes in First and Second Births to US Teenagers from 2000 to 2022.")

23. Anne K. Driscoll et al., "Changes in First and Second Births to US Teenagers from 2000 to 2022."

24. Data for each individual year from 1940 through 1959 are not available due to inaccurate population rate estimates. The teen birth rates for 1940, 1945, 1950, and 1955 include the revised (and more accurate) population estimates as reported by the Census Bureau. These available data are presented in Figure 4. Email with data through 2023 provided by CDC, NCHS, November 15, 2024.

25. These figures reflect the record lows across all available data from 1940-1986. They are not the all-time record lows (both of which were observed in 2023).

26. HHS, Office of the Assistant Secretary for Health, Office of Population Affairs, "Trends in Teen Pregnancy and Childbearing," https://opa.hhs.gov/adolescent-health/reproductive-health-and-teen-pregnancy/trends-teen-pregnancy-and-childbearing.

27. Heather D. Boonstra, "What is Behind the Declines in Teen Pregnancy Rates?" *Guttmacher Policy Review*, vol. 17, issue 3, September 3, 2014, https://www.guttmacher.org/gpr/2014/09/what-behind-declines-teen-pregnancy-rates. (Hereinafter, Heather D. Boonstra, "What Is Behind the Declines in Teen Pregnancy Rates?)

28. Laura D. Lindberg et al., "Trends in U.S. adolescent sexual behavior and contraceptive use, 2006-2019," *Contraception X*, vol. 3 (2021).

29. Laura D. Lindberg et al., "Trends in U.S. adolescent sexual behavior and contraceptive use, 2006-2019," *Contraception X*, vol. 3 (2021). See also, Leigh E. Szucs et al., "Condom and Contraceptive Use Among Sexually Active High School Students—Youth Risk Behavior Survey, United States, 2019," HHS, CDC, *Morbidity and Mortality Weekly Report Supplements*, vol. 69, no. 1 (August 2020), pp. 11-18.

30. The CDC, as well as various independent professional membership organizations, publishes clinical guidance about the use of contraceptive methods by certain population subgroups. CDC's U.S. Medical Eligibility for Contraceptive Use (also known as the MEC) is adapted from global guidance developed by the World Health Organization. It describes who can safely use various methods of contraception based on specific health conditions and other characteristics. A companion document, known as the Selected Practice Recommendations (SPR), addresses more timely challenges regarding the initiation and/or use of certain contraceptive methods. In 2013, the SPR clarified the safety and efficacy of the use of LARC methods among adolescents, updating concerns that were previously outlined in the 2010 U.S. MEC. The 2016 update to the U.S. MEC affirmed the safety of LARC use among adolescents and women who had not previously given birth. National survey data (see footnote 29 above) indicate that adolescents used LARCs prior to these updates; however, the prevalence of LARC use has increased over time. See CDC, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2016*, Morbidity and Mortality Weekly Report, July 29, 2016, pp. 4-5, https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf.

31. Laura D. Lindberg et al., "Comparability of estimates and trends in adolescent sexual and contraceptive behaviors from two national surveys: National Survey of Family Growth and the Youth Risk Behavior Survey," *PLoS One*, vol. 16, no. 7 (2021). See also, Elizabeth Wildsmith et al., *The 30-Year Decline in Teen Birth Rates Has Accelerated Since 2010*, Child Trends,

December 23, 2022, https://www.childtrends.org/publications/the-30-year-decline-in-teen-birth-rates-has-accelerated-since-2010.

32. Heather D. Boonstra, "What Is Behind the Declines in Teen Pregnancy Rates?," and Melissa S. Kearney and Phillip B. Levine, "Investigating Recent Trends in the U.S. Teen Birth Rate," *Journal of Health Economics,* vol., 41, 2015. See also, Sarah Kliff, "The Mystery of the Falling Teen Birth Rate," *Vox*, January 21, 2015. (Hereinafter, Sarah Kliff, "The Mystery of the Falling Teen Birth Rate.")

33. Melissa S. Kearney and Phillip B. Levine, "Investigating Recent Trends in the U.S. Teen Birth Rate," *Journal of Health Economics,* vol. 41, 2015. S.M. Goodreau, "Declines in Pregnancies among U.S. Adolescents from 2007 to 2017: Behavioral Contributors to the Trend," *Journal of Pediatric and Adolescent Gynecology*, vol. 36, no. 6 (December 2022).

34. Sarah Kliff, "The Mystery of the Falling Teen Birth Rate."

35. Melissa S. Kearney, Phillip B. Levine, and Luke Pardue, "The Puzzle of Falling U.S. Birth Rates since the Great Recession," *Journal of Economic Perspectives*, vol. 36, no. 1 (Winter 2022), pp. 151-176, and Paul Taylor et al., *In a Down Economy, Fewer Births*, Pew Research Center, Social and Demographic Trends, October 10, https://www.pewresearch.org/social-trends/2011/10/12/in-a-down-economy-fewer-births/.

36. Melissa S. Kearney and Phillip B. Levine, *Media Influences on Social Outcomes: The Impact of MTV's 16 and Pregnant on Teen Childbearing*, National Bureau of Economic Research, Working Paper 19795, Cambridge, MA, August 2015, https://www.nber.org/papers/w19795; David A. Jaeger et al., "A Cautionary Tale of Evaluating Identifying Assumptions: Did Reality TV Really Cause a Decline in Teenage Childbearing?," *Journal of Business & Economic Statistics*, 38(2) (2018), pp. 317-326, https://doi.org/10.1080/07350015.2018.1497510.

37. See CRS Report R45183, *Adolescent Pregnancy: Federal Prevention Programs*, for further information about current programs that are federally funded.

38. Sarah Kliff, "The Mystery of the Falling Teen Birth Rate," and Heather D. Boonstra, "What Is Behind the Declines in Teen Pregnancy Rates?"

39. Laura D. Lindberg and Leslie M. Kantor, "Adolescents' Receipt of Sex Education in a Nationally Representative Sample, 2011-2019," *Journal of Adolescent Health*, vol. 70 (2022), pp. 294-296. (Hereinafter Laura D. Lindberg and Leslie M. Kantor, "Adolescents' Receipt of Sex Education in a Nationally Representative Sample, 2011-2019.")

40. Laura D. Lindberg and Leslie M. Kantor, "Adolescents' Receipt of Sex Education in a Nationally Representative Sample, 2011-2019."

41. Gilda Sedgh et al., "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends," *Journal of Adolescent Health*, vol. 56 (2015). See also Table 10 in United Nations, *Demographic Yearbook*, 71st Ed., 2020. (Hereinafter, Gilda Sedgh et al., "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Trends.")

42. United Nations, Statistics Division, "Demographic Yearbook 2022," https://unstats.un.org/unsd/demographic-social/products/dyb/dyb_2022/. (See Table 10, "Live births by age of mother and sex of child, general and age-specific fertility rates: latest available year, 2013–2022.") See also, Gilda Sedgh et al., "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Trends."

43. John S. Santelli et al., "Inequality, National Wealth, Economic Development and Global Trends in Teenage Birth Rates, 1990-2010," *Journal of Adolescent Health*, vol. 52, no. 1 (February 2013); and Melissa S. Kearney and Phillip B. Levine, "Why Is the Teen Birth Rate in the United States So High and Why Does It Matter?," *Journal of Economic Perspectives,* Spring: 26(2), 2012, pp. 141-166. (Hereinafter, Melissa S. Kearney and Phillip B. Levine, "Why Is the Teen Birth Rate in the United States So High and Why Does It Matter?"); John S. Santelli et al., "Global Trends in Adolescent Fertility, 1990–2012, in Relation to National Wealth, Income Inequalities, and Educational Expenditures," *Journal of Adolescent Health*, vol. 60, no. 2 (February 2017), pp. 161-168; and Torleif Halkjelsvik and Vegard Fykse Skirbekk, "Concurrent Decline in Teenage Fertility Rate and Binge Drinking? An Observational Study Across 45 Nations," *Drug and Alcohol Review*, 2024.

44. Melissa S. Kearney and Phillip B. Levine, "Why Is the Teen Birth Rate in the United States So High and Why Does It Matter?" See also, Gilda Sedgh et al., "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Trends"; Rachel H. Scott et al., "Adolescent Sexual Activity, Contraceptive Use, and Pregnancy in Britain and the U.S.: A Multidecade Comparison," *Journal of Adolescent Health*, vol. 66, no. 5 (May 2020), pp. 582-588.

45. HHS, CDC, *Winnable Battles Final Report*.

46. HHS, CDC, "About Teen Pregnancy," May 15, 2024, https://www.cdc.gov/reproductive-health/teen-pregnancy/index.html.

47. On March 27, 2025, HHS issued a press release and fact sheet announcing the restructuring of HHS. At the time of this report's publication, the potential effect of this restructuring on activities within the Office of Population Affairs is unknown. U.S. Department of Health and Human Services, "Fact Sheet: HHS' Transformation to Make America Healthy Again," press release, March 27, 2025, https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html.

48. HHS, OPA, OASH, "About Teen Pregnancy and Childbearing," https://opa.hhs.gov/adolescent-health/reproductive-health-and-teen-pregnancy/about-teen-pregnancy-and-childbearing.

49. Urban Institute, *Kids Having Kids: Costs and Social Consequences of Teen Pregnancy*.

50. Melissa S. Kearney and Phillip B. Levine, "Why Is the Teen Birth Rate in the United States So High and Why Does It Matter?"; and Urban Institute, *Kids Having Kids: Costs and Social Consequences of Teen Pregnancy*.

51. HHS, CDC, *National Overview of STIs, 2022*, January 2024.

52. Emily Holcombe et al., *Ten Reasons to Still Keep the Focus on Teen Childbearing*, Child Trends, March 2009; Urban Institute, *Kids Having Kids: Costs and Social Consequences of Teen Pregnancy*; and Stefanie Mollborn, "Teenage Mothers Today: What we Know and How it Matters," *Child Development Perspectives*, vol. 11, no. 1 (March 2017), pp. 63-69. See also Anna Aizer et al., "Grandparents, Moms, or Dads? Why children of teen mothers do worse in life," *Journal of Human Resources* (November 2020), pp. 1019-1052.

53. Ashley M. Woodall and Anne K. Driscoll, *Racial and Ethnic Differences in Mortality Rate of Infants Born to Teen Mothers: United States, 2017–2018*, National Center for Health Statistics, Data Brief, No. 371, June 2020, https://www.cdc.gov/nchs/data/databriefs/db371-h.pdf.

54. The Power to Decide is a Washington, DC-based organization that promotes that all young people have access to the sexual health information, reproductive health services, and sense of possibility that they need—to decide if, when, and under what circumstances to get pregnant and have a child. The Power to Decide*, Progress Pays Off Savings Fact Sheet*, https://powertodecide.org/sites/default/files/media/savings-fact-sheet-national.pdf.

55. Kelleen Kaye and Alison Ng, *Estimating the State and National Savings Associated with Declines in Teen Childbearing*, Power to Decide, January 2018. The decrease in teen births is based on the additional number of teen births estimated to have occurred in 2015 if the teen birth rate remained the same as in 1991.

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Exhibit 2

Congressional Research Service
Informing the legislative debate since 1914

Teenage Pregnancy Prevention: Statistics and Programs

Carmen Solomon-Fears
Specialist in Social Policy

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CRS REPORT
Prepared for Members and
Committees of Congress

Summary

In 2014, U.S. teen births accounted for 6.3% of all births and 13.9% of all nonmarital births. The birth rate for U.S. teenagers (ages 15 through 19) increased in 2006 and 2007 after a steady decline since 1991. However, in each of 2008 through 2014, the teen birth rate dropped below the 2006 teen birth rate, reversing the two-year upward trend. Although the birth rate for U.S. teens has dropped in 22 of the past 24 years, it remains higher than the teen birth rate of most industrialized nations. Preventing teen pregnancy is generally considered a priority among policymakers and the public because of its high economic, social, and health costs for teen parents and their families.

The Adolescent Family Life (AFL) program, created in 1981 (Title XX of the Public Health Service Act), was the first federal program to focus on pregnancy among adolescents. It was created to support demonstration projects that provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families. From 1998 to 2009, federal teen pregnancy prevention efforts in the AFL program and in general relied heavily on using abstinence-only education as their primary tool. The appropriation for the AFL program was $16.7 million in FY2010 and $12.4 million for FY2011. The AFL program has not received any funding since FY2011.

P.L. 111-117 (Consolidated Appropriations Act, 2010) included a new discretionary Teen Pregnancy Prevention (TPP) program, funded at $110 million for FY2010, which provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. Since FY2010, funding for the TPP program has fluctuated from a high of $109 million in FY2011 to a low of $98.4 million in FY2013 (post-sequester). P.L. 113-76 (the Consolidated Appropriations Act, 2014) provided $101 million for the TPP program (and $8.5 million for program evaluation) for FY2014. P.L. 113-235 (the Consolidated and Further Continuing Appropriations Act, 2015) funded the TPP program at $101 million for FY2015 (plus $6.8 million for program evaluation). Pursuant to P.L. 114-53 (the Continuing Appropriations Act, 2016; enacted September 30, 2015), the TPP is funded for FY2016 at the FY2015 rate of $101 million (plus $6.8 million for program evaluation) minus an across-the-board rescission of 0.2108%, through December 11, 2015, or enactment of applicable appropriations legislation. Pursuant to P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015), the TPP is funded for FY2016 at $101 million (plus $6.8 million for program evaluation).

P.L. 111-148 (the Patient Protection and Affordable Care Act-ACA) established a new state formula grant program and appropriated $375 million, at $75 million per year for five years (FY2010-FY2014), to enable states to operate a new Personal Responsibility Education Program (PREP), which is a broad approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted diseases. PREP also provides youth with information on several adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills). P.L. 113-93 (the Protecting Access to Medicare Act of 2014), which was enacted on April 1, 2014, extended PREP ($75 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10 (the Medicare Access and CHIP Reauthorization Act of 2015) extended PREP ($75 million per year) through FY2017 (i.e., September 30, 2017).

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996). The Title V Abstinence Education program is a formula grant program, specifically for abstinence-only

education, funded by mandatory spending. The program's funding expired on June 30, 2009, but P.L. 111-148 reauthorized the program and restored funding at the previous annual level of $50 million for each of FY2010-FY2014. P.L. 113-93 extended the Title V Abstinence Education block grant ($50 million per year) through FY2015. P.L. 114-10 increased the Title V Abstinence Education block grant to $75 million per year for FY2016 and FY2017.

Several appropriation laws included an additional $5 million for *competitive grants* for abstinence-only education for each of FY2012, FY2013, FY2014, and FY2015 (P.L. 112-74, P.L. 113-6, P.L. 113-76, and P.L. 113-164/P.L. 113-235). P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015) included funding of $10 million for competitive grants which exclusively implement education in sexual risk avoidance (defined as refraining from nonmarital sexual activity) for FY2016.

This report briefly examines some of the data collected by the National Center for Health Statistics on teenage childbearing, offers potential reasons for high teen pregnancy and birth rates, and provides basic information on federal programs whose purpose is primarily to delay sexual activity among teenagers and to reduce teen pregnancy. The **Appendix** provides a funding history of the teen pregnancy prevention programs discussed in this report.

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Introduction

In 2010, an estimated 614,400 U.S. teenagers (ages 15-19) became pregnant, approximately 89,300 had miscarriages, and 157,500 had legal abortions (latest available data).[1] The result was that there were nearly 367,700 births to teenagers in that year. In 2014, 6.3% of all U.S. births were to teens, and 13.9% of all nonmarital births were to teens.

According to a 2010 report:

> Teen childbearing is associated with adverse health and social outcomes for teen mothers and their children, although these outcomes often reflect preexisting social deficits. Compared with women who delay childbearing until their 20s, teen mothers are more likely to drop out of school and have low educational attainment; to face unemployment, poverty, and welfare dependency; to experience more rapid repeat pregnancy; to become single mothers; and to experience divorce, if they marry. Infants of teen mothers are more likely to be premature and experience infant mortality. The children of teenage mothers do less well on indicators of health and social wellbeing than do children of older mothers.[2]

In recognition of the negative, long-term consequences associated with teenage pregnancy and births, the prevention of out-of-wedlock pregnancies[3] is a major goal of this nation. Reducing nonmarital childbearing is one of the explicit goals that were stipulated in the 1996 welfare reform law.[4] Although the birth rate for U.S. teens has dropped in 22 of the last 24 years, it remains higher than the teenage birth rate of most industrialized nations.[5]

Teenage Births in the United States

National Trends

In 1950, the number of births to U.S. females under age 20 was 438,000; by 1960, births to teens had increased nearly 36% to 593,746; and by 1970 they had increased another 11% to 656,460. Since then, the number of births to teens has generally declined, with some upward fluctuations.

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[1] Kathryn Kost and Stanley Henshaw, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*, Guttmacher Institute, May 2014, p. 10.

[2] John S. Santelli and Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," *Annual Review of Public Health 2010*, vol. 31, pp. 371-383.

[3] As noted later, 89% of births to females under age 20 were nonmarital births (i.e., births to unmarried women) in 2013. Note that although P.L. 104-193 uses pregnancies as the policy variable, in practice births have become the indicator because birth data are more current and reliable than pregnancy data.

[4] Pursuant to P.L. 104-193 (the 1996 welfare reform law), states may use Temporary Assistance for Needy Families (TANF) funds in any manner "reasonably calculated" to achieve the four goals set forth in TANF statute. These four goals are (1) provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; (2) end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and (4) encourage the formation and maintenance of two-parent families. The bulk of federal TANF funding is in a basic block grant totaling $16.5 billion for the 50 states and the District of Columbia.

[5] For further information on a comparison of U.S. teen birth rates with those of other countries, see "Fast Facts: How Does the United States Compare?" at http://www.thenationalcampaign.org/national-data/teen-pregnancy-birth-rates.aspx. Also see Gilda Sedgh, Lawrence B. Finer, Akinrinola Bankole, Michelle A. Eilers, and Susheela Singh, "Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends," *Journal of Adolescent Health*, vol. 56, issue 2, February 2015, pp. 223-230.

Births to teenagers declined nearly 62% from 1970 to 2014; 55% from 1980 to 2014; 53% from 1990 to 2014; 47% from 2000 to 2014; and 32% from 2010 to 2014. In 2014, the number of births to teens was 251,847 (of which 2,769 births were to girls under age 15).[6]

As shown in **Figure 1**, the peak birth rate for U.S. teenagers occurred in 1957, with 96.3 births per 1,000 women ages 15-19. The 2014 teenage birth rate of 24.2 per 1,000 women ages 15-19 is almost 9% lower than the 2013 teenage birth rate. Teenage birth rates increased during the late 1940s (i.e., the "baby boom" years after World War II) and 1950s, decreased during the 1960s and early 1970s, remained relatively stable between 1975 and 1988, increased sharply during the late 1980s, declined every year from 1991 through 2005, and then increased in 2006 and 2007. The 2014 teen birth rate (24.2 births per 1,000 teens ages 15-19) is currently the lowest teen birth rate recorded. Although the *number* of births to females under age 20 decreased nearly 53% from 1991 to 2014, the *birth rate* of teens ages 15 through 19 declined by nearly 61% in the same period.[7] The smaller decline in the number of births to teens compared with the teen birth rate is due to an increase in the number of teenage females in the 1990s.

In 2014, the birth rate for teenagers ages 15-17 was 10.9 per 1,000 teens ages 15-17, down 72% from 1991. For teens ages 18-19, the birth rate was 43.8 per 1,000 teens ages 18-19, down 53% from 1991.[8]

In 2014, of the 251,847 births to females under age 20, 89% (223,386 births) were to unmarried teenagers.[9] With fewer teens entering into marriage, the proportion of births to unmarried teens has increased dramatically (89% in 2014 versus 29% in 1970).

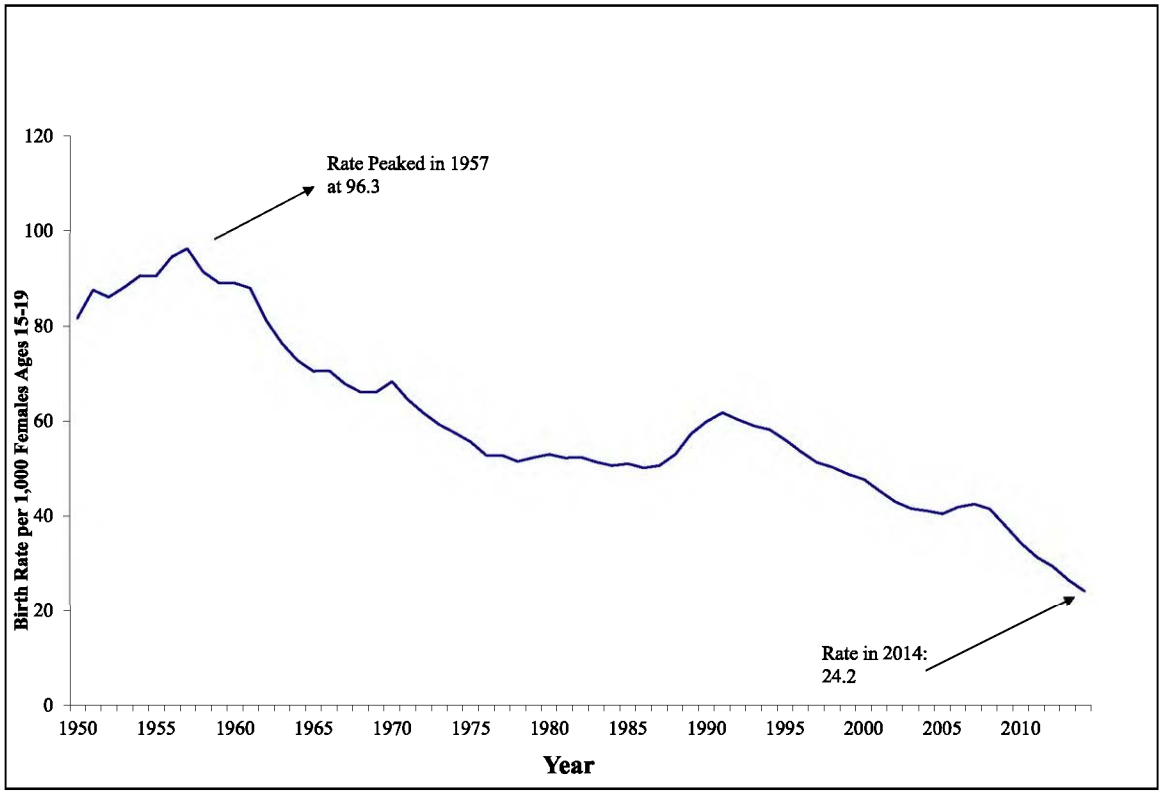
[6] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table 2.

[7] According to the Center for Disease Control and Prevention (CDC), if the 1991 birth rates had prevailed, there would have been an estimated 3.4 million additional births to teenagers from 1992 through 2010. (Source: Brady E. Hamilton and Stephanie J. Ventura, "Birth Rates for U.S. Teenagers Reach Historic Lows for All Age and Ethnic Groups," *NCHS Data Brief*, no. 89, April 2012, p. 3.)

[8] Although this report focuses on teenagers, young adults ages 20-24 also have high birth rates. In 2014, for young adults ages 20-24, the birth rate was 79.0 per 1,000 young adults ages 20-24; down 31% from 1991.

[9] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table 15.

Figure 1.Teen Birth Rates (Ages 15-19), 1950-2014



Source: Chart prepared by the Congressional Research Service (CRS), based on data from the National Center for Health Statistics, Department of Health and Human Services (HHS).

State Data/Trends

Teen birth rates vary considerably from state to state. In 2014, the state with the lowest reported rate was Massachusetts, at 10.6 births per 1,000 women (ages 15-19); the state with the highest reported rate was Arkansas, at 39.5 births per 1,000 women (ages 15-19).[10] From 2013 to 2014, the birth rate of teens (ages 15-19) decreased or did not change significantly in all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, American Samoa, and the Northern Mariana Islands.[11]

Some Demographic Features and Trends

After having declined for all racial and ethnic groups during the period from 1991 to 2005, the teen birth rate increased for white, black, and American Indian/Alaska Native women ages 15 through 19 from 2005 to 2007.[12] The teen birth rates for women ages 15 through 19 decreased for all racial and ethnic groups during the period 2007 to 2014.[13] From 2007 to 2014, teen birth rates

[10] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table 12 and p. 6.

[11] Ibid.

[12] Joyce A. Martin, Brady E. Hamilton, Stephanie J. Ventura, Michelle J.K. Osterman, and T.J. Mathews, "Births: Final Data for 2011," *National Vital Statistics Reports*, vol. 62, no. 1, June 28, 2013, Table A.

[13] Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, Sally C. Curtin, and T.J. Mathews, "Births: Final Data for 2014," *National Vital Statistics Reports*, vol. 64, no. 12, December 23, 2015, Table A.

(for women ages 15 through 19) fell 50% for Hispanic teens, 48% for Asian/Pacific Islander teens, 45% for American Indian/Alaska Native teens, 44% for black teens, and 36% for white teens. However, birth rates for Hispanic, black, and American Indian/Alaska Native teenagers continue to be much higher than that of other racial/ethnic groups. In 2014, Hispanic teens (ages 15-19) gave birth at a rate of 38.0 per 1,000 Hispanic teens. Black teens gave birth at a rate of 34.9 per 1,000 black teens. American Indian/Alaska Native teens gave birth at a rate of 27.3 per 1,000 American Indian/Alaska Native teens. In contrast, white teens gave birth at a rate of 17.3 per 1,000 white teens, and Asian/Pacific Islander teens gave birth at the lowest rate, 7.7 per 1,000 Asian/Pacific Islanders teens.[14]

Also noteworthy is the decline in subsequent births among teens. In 1951, 28% of all teen births were second or higher-order births, compared to 17% in 2014.[15]

Financial and Social Costs of Teen Births

Preventing teen pregnancy is generally considered a priority among policymakers and the public because of its high economic, social, and health costs for teen parents and their families. Teenage mothers and fathers tend to have less education and are more likely to live in poverty than their peers who are not teen parents. Children of teenage mothers are more likely than children of older mothers to have chronic medical conditions, rely heavily on provided health care, do poorly in school, give birth during their teen years (continuing the cycle of teen pregnancy), spend some time in a juvenile detention facility or jail, and be unemployed or underemployed as a young adult.[16]

Other data indicate that 30% of teen girls who have dropped out of high school cite pregnancy or parenthood as a reason, 67% of teen mothers who moved out of their own family's household live below the poverty level, 63% of teen mothers receive some type of public benefits within the first year after their children are born, less than 25% of teen mothers receive any child support payments, and children born to mothers under age 18 score significantly worse on measures of school readiness including math and reading tests.[17]

Teen childbearing in the United States cost taxpayers (federal, state, and local) about $9.4 billion in 2010, according to an analysis by The National Campaign to Prevent Teen and Unplanned Pregnancy.[18] According to the report, most of the costs of teen childbearing are associated with negative consequences for the children of teen mothers, including increased costs for health care, child welfare, incarceration, and lost tax revenue. The study looks only at the increase in these costs that is associated with having a child before age 20 versus having a child at age 20 or 21. That is, they are net costs and not gross costs.[19]

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[14] Ibid.

[15] Ibid., Table 2.

[16] Emily Holcombe, Kristen Peterson, and Jennifer Manlove, *Ten Reasons to Still Keep the Focus on Teen Childbearing*, Child Trends, March 2009. See also: Urban Institute, *Kids Having Kids: Costs and Social Consequences of Teen Pregnancy*, edited by Saul D. Hoffman and Rebecca A. Maynard, 2008 (second edition).

[17] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Why It Matters: Teen Childbearing, Education, and Economic Wellbeing*, July 2012.

[18] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Counting It Up—The Public Cost of Teen Childbearing: Key Data*, December 2013. (This analysis updates research originally conducted by Saul Hoffman, of the University of Delaware, and released by the National Campaign to Prevent Teen Pregnancy in 2006.)

[19] The costs discussed by the study include those associated with all children in a given year who had been born to a teen mother—this includes very young children as well as those who are currently adolescents or young adults.

The December 2013 study by the National Campaign to Prevent Teen Pregnancy estimated that in 2010, adolescent childbearing cost U.S. taxpayers about $9.4 billion per year: $3.1 billion in child welfare benefits; $2.1 billion in public sector health care expenses; $2.0 billion in spending on incarceration (for the sons of women who had children as adolescents); and $2.2 billion in lost tax revenue because of lower earnings of children of teen mothers over their own adult lifetimes. Research indicates that teens who give birth are less likely to complete high school and go on to college, thereby reducing their potential for economic self-sufficiency. The research also indicates that the children of teens are more likely than children of older parents to experience problems in school and drop out of high school, and as adults are more likely to repeat the cycle of teenage pregnancy and poverty. The 2013 report contends that if the teen birth rate had not declined between 1991 and 2010, the annual costs associated with teen childbearing would have been about $21 billion (instead of $9.4 billion).[20]

Reasons for High Pregnancy and Birth Rates Among Teens

In 2013, 30.0% of 9th graders reported having experienced sexual intercourse. The corresponding statistics for older teens were 41.4% for 10th graders, 54.1% for 11th graders, and 64.1% for 12th graders.[21]

The high volume of pregnancies and birth rates among teenagers is associated with earlier sexual activity among teen girls. Also, beginning in about 2004, the use of contraception (which was never as high as the use in other developed countries) started waning.[22] The academic and professional communities also maintain that teen parenthood is one of the negative consequences of growing up without a father.[23] The president of the Alan Guttmacher Institute, commenting on a study about adolescent pregnancy and childbearing in "developed" countries, stated: "In the United States, poverty and inequity clearly are behind much of our high rates of pregnancy, birth and abortion. But lack of sensitive, confidential, low-cost contraceptive services and the denial of accurate and frank information about sex, are equally to blame."[24] Other commentators argue that

> teen childbearing is so high in the United States because of underlying social and economic problems. It reflects a decision among a set of girls to "drop-out" of the economic mainstream; they choose non-marital motherhood at a young age instead of investing in their own economic progress because they feel they have little chance of advancement.[25]

[20] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Counting It Up—The Public Cost of Teen Childbearing: Key Data*, December 2013.

[21] Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance—United States, 2013," *MMWR*, vol. 63, no.4, June 13, 2014, p. 112 (Table 63).

[22] John S. Santelli and Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," *Annual Review of Public Health 2010*, vol. 31, pp. 375-376.

[23] Wendy Sigle-Rushton and Sara McLanahan, *Father Absence and Child Well-Being: A Critical Review*, Princeton University, Center for Research on Child Wellbeing (Working Paper #02-20), November 2002.

[24] Alan Guttmacher Institute, *United States and the Russian Federation Lead the Developed World in Teenage Pregnancy Rates*, News Release, February 24, 2000, p. 2.

[25] Kearney and Levine, "Why is the teen birth rate in the United States so high and why does it matter?" *Journal of Economic Perspectives,* Spring: 26(2), 2012, pp. 141-166.

Decline in Pregnancy/Birth Rates

One reason given for the historical decline (1991-2005) in teen pregnancies and births is that sexually active female teenagers had significantly increased their use of contraceptives, particularly condoms. Abstinence campaigns, aimed at younger teens, were also seen as having a positive effect on pregnancy prevention. Moreover, casual sex, which may increase the risk of sexually transmitted diseases (STDs) and may prove to be fatal given the presence of HIV/AIDS, is viewed in an increasingly negative light by many teenagers.

In 2006 and 2007, the decline in the teen birth rate was interrupted by a small increase. According to a 2008 report:

> A dearth of research examining the factors responsible for previous trends undermines our ability to understand what may be occurring at present. Hypotheses abound, including changes in the economy, attitudes, anxiety, schooling, public policy, programs and services, families, and media messages. In addition, prevention fatigue and the need for new strategies to reach teens who have not been reached by existing approaches have also been suggested.[26]

Some observers attribute the return to the long-term downward trend in teen birth rates (after the two-year increase in 2006 and 2007) to the severe recession that began in 2008. They contend that the decrease in teen births—like the decrease in overall births—is, in part, because teenagers are being more careful as they witness the economic difficulties faced by their families.[27]

According to the Center for Disease Control and Prevention (CDC):

> The impact of strong pregnancy prevention messages directed to teenagers has been credited with the birth rate declines. Recently released data from the National Survey of Family Growth, conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), have shown increased use of contraception at first initiation of sex and use of dual methods of contraception (that is, condoms and hormonal methods) among sexually active female and male teenagers. These trends may have contributed to the recent birth rate declines.[28]

According to one commentator, several factors have been discussed among researchers as reasons underlying the falling teen birth rate during the period since 2007. Some of these factors include (1) the recession that started in late 2007 and ended in the middle of 2009; (2) the slight increase in IUD use; (3) the popular MTV show that deglamorized teen pregnancy; (4) the use of the Plan B "morning after" pill; and (5) increased use of the Internet via iPhones which allow teenagers immediate access to information they may have been too embarrassed to ask parents or other adults.[29] There is not agreement among researchers regarding which of and to what extent the aforementioned factors contributed to the 36% reduction in teen births since 2007.

Other interested parties maintain that "with improved economic opportunities, reduced poverty, and improved prospects for other adult outcomes, teen pregnancy would also decline."[30] They

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[26] The National Campaign to Prevent Teen and Unplanned Pregnancy and Child Trends, *Teen Births: Examining the Recent Increase*, by Kristin Anderson Moore, October 2008, p. 1.

[27] Rob Stein, "Birthrate Among Teens Hits Record Low," *Washington Post*, December 22, 2010, A02.

[28] Brady E. Hamilton and Stephanie J. Ventura, "Birth Rates for U.S. Teenagers Reach Historic Lows for All Age and Ethnic Groups," *NCHS Data Brief*, no. 89, April 2012, p. 5.

[29] Sarah Kliff, The mystery of the falling teen birth rate, September 22, 2014 (updated January 21, 2015)—http://www.vox.com/2014/8/20/5987845/the-mystery-of-the-falling-teen-birth-rate.

[30] Melissa S. Kearney and Phillip B. Levine, "Why is the Teen Birth Rate in the United States So High and Why Does It Matter?," *Journal of Economic Perspectives*, vol. 26, no. 2 (Spring 2012), p. 163.

assert that public policies targeted directly at teen pregnancy prevention such as sex education, improved access to contraception, and abstinence counseling are not likely to improve outcomes much for disadvantaged young women.[31]

Federal Strategies to Reduce Teen Pregnancy

Reducing nonmarital pregnancies is one of the explicit goals that were stipulated in the 1996 welfare reform law (P.L. 104-193). The 1996 welfare reform law also provided funding for and spearheaded the abstinence-only approach for preventing and reducing teen pregnancy.

Although the pregnancy rate, birth rate, and abortion rate for teens have all dropped in recent years, the teen birth rate in the United States is still far above that of most industrialized countries. The U.S. teen birth rate was one and one-half times that of the United Kingdom and nearly seven times that of Japan and Denmark. In 2012, teen birth rates were 4.3 births per 1,000 teens ages 15-19 in Japan, 4.4 births per 1,000 teens ages 15-19 in Denmark; 8.0 per 1,000 in Germany; 14.1 per 1,000 in Canada (2009 data); 19.8 per 1,000 in the United Kingdom; and 29.4 per 1,000 in the United States.[32]

Until recently, there was a great divide in the teen pregnancy prevention arena with one group maintaining that "abstinence-only education" programs (sometimes referred to as sexual risk avoidance programs) are the best and healthiest strategy to prevent unintended teen pregnancies and sexually transmitted infections among teenagers[33] (see "1996-2009: Abstinence Only" section below for additional arguments). The other group claims a comprehensive approach to sex education provides today's youth with the information and decision-making skills needed to make realistic, practical decisions about whether to engage in sexual activities. They contend that such an approach allows young people to make informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases.[34] Given that 47.4% (2011 data) of high school students have experienced sexual intercourse, advocates argue that abstinence-only messages provide no protection against the risks of pregnancy and disease for these youth. They further point out that according to one study, teens who break their virginity pledges were less likely to use contraception the first time than teens who had never made such a promise.[35] In addition, the high number of females under age 25 with sexually transmitted infections (STIs)[36] has re-energized efforts to persuade girls and young

[31] Ibid.

[32] United Nations Statistics Division, "Demographic Yearbook 2013," http://unstats.un.org/unsd/demographic/products/dyb/dyb2013/Table10.pdf, Table 10. See also "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries," by Susheela Singh and Jacqueline E. Darroch, *Family Planning Perspectives*, Alan Guttmacher Institute, vol. 3, no. 1, January/February 2000, pp. 14-23.

[33] U.S. House of Representatives, Committee on Energy and Commerce, *The Policy Paper Series: Transforming Ideas Into Solutions, vol. 1, issue 2*, "A Better Approach to Teenage Pregnancy Prevention-Sexual Risk Avoidance," prepared by the Energy and Commerce Committee Majority Staff, July 2012.

[34] Some contend that the abstinence-only approach leads to a substitution of other risky behaviors such as oral sex. They cite data that indicate that about 25% of virgin teens ages 15 through 19 have engaged in oral sex; Child Trends Data Bank, "New Indicator on Oral Sex," September 15, 2005, at http://www.childtrendsdatabank.org/whatsNew.cfm.

[35] Peter S. Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse," *American Journal of Sociology*, January 2001.

[36] This report uses the term sexually transmitted diseases (STDs) and sexually transmitted infections (STIs) interchangeably.

women to abstain from sexual activity or to use condoms (along with other forms of contraceptives) to prevent or reduce pregnancy and reduce their risk of getting STIs.[37]

A nationally representative survey conducted in 2012 found that (1) 93% of adults and 87% of teens agree that young people should get a strong message that they should not have sex until they are at least out of high school, and (2) a majority of adults (74%) and many teens (49%) want teens to get more information about both abstinence and contraception. Specifically with regard to federally funded programs, 62% of parents of teens indicated that teens should be provided with information about both postponing sex and about birth control or protection.[38] The American public—both adults and teens—support encouraging teens to delay sexual activity *and* providing young people with information about contraception.[39] They see encouraging teens to delay sex and providing teens with information about contraception as complementary, not contradictory strategies.

In 2010, HHS Secretary Kathleen Sebelius stated: "Teen pregnancy is a serious national problem and we need to use the best science of what works to address it. This investment will help bring evidence-based initiatives to more communities across the country while also testing new approaches so we can expand our toolkit of effective interventions."[40]

The CDC has identified teen pregnancy prevention as a winnable battle. According to the CDC:

> Through our experience, we know that we can prevent teen pregnancies by promoting teen-friendly interventions aimed at both increasing the number of teens who abstain from or delay sexual activity, and increasing the number of sexually active teens who consistently and correctly use effective contraceptive methods. This can be accomplished by involving more teens in evidence-based programs and linking prevention programs to clinical services.[41]

The following section examines federal strategies to reduce teen pregnancy by focusing on three time periods: 1981-1996, 1996-2009, and 2009 to the present.

1981-1996: Reducing Pregnancies and Helping Adolescent Mothers

The Adolescent Family Life (AFL) program (Title XX of the Public Health Service Act), created in 1981, was the first federal program to focus on adolescents. From 1981 to 1996, the AFL program was the only federal program that was required to use all of its funding directly (and exclusively) on the issues of adolescent sexuality, pregnancy, and parenting.

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[37] A Centers for Disease Control and Prevention (CDC) report indicated that approximately 19 million new sexually transmitted infections occur each year, almost half of them among young people ages 15 to 24; "Trends in Reportable Sexually Transmitted Disease in the United States, 2007," January 5, 2009.

[38] Bill Albert, *With One Voice 2012—America's Adults and Teens Sound Off About Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy and Unplanned Parenthood, August 2012, pp. 17-19, http://thenationalcampaign.org/sites/default/files/resource-primary-download/wov_2012.pdf.

[39] There appears to be significant public support for the involvement of religious groups in preventing teen pregnancy. In the survey associated with the "With One Voice report," adults (73%) and teens (75%) agreed that religious leaders and groups should be doing more to help prevent teen pregnancy. (Source: Bill Albert, *With One Voice 2012—America's Adults and Teens Sound Off About Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy and Unplanned Parenthood, August 2012, p. 38, http://thenationalcampaign.org/sites/default/files/resource-primary-download/wov_2012.pdf.)

[40] U.S. Department of Health and Human Services, *HHS awards evidence-based teen pregnancy prevention grants*, news release, September 30, 2010.

[41] Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Dear Colleague Letter by Thomas R. Frieden, Director, Centers for Disease Control and Prevention, January 14, 2011.

The AFL program authorized grants for three types of demonstrations: (1) projects that provide "care" services only (i.e., health, sex education information, including information about contraceptive methods, and social services to pregnant adolescents, adolescent parents, and their infants, families, and male partners);[42] (2) projects that provide "prevention" services only (i.e., services to promote abstinence from premarital sexual relations, including abstinence-only-focused educational information, for pre-teens, teens, and their families); and (3) projects that provide a combination of care and prevention services.

It is important to note that until 1998, the "prevention" services component of the AFL program offered a wide range of interventions, including contraception services, to help young people avoid pregnancy. It was only after implementation of the Title V Abstinence Education block grant to states (discussed later) that Congress mandated that AFL "prevention" demonstration grants were only to be awarded for programs that used an abstinence-only model (that adhered to the abstinence definition used by the Title V Abstinence Education program).

The AFL program also provided funding for research grants dealing with various aspects of adolescent sexuality, pregnancy, and parenting. Through its research component, the AFL program attempted to increase understanding of how to prevent adolescent pregnancies and their adverse consequences. Research projects have included studies that examined the causes and consequences of adolescent sexual relations, the use of contraceptives, the impact of pregnancy on adolescents, and child-rearing practices of adolescents. (The AFL program is described in greater detail later in this report.)

1996-2009: Abstinence Only

When the idea of abstinence-only education was being discussed during the 1994-1996 welfare reform debate, it was in the context of providing funding for abstinence education that was equal to amounts provided then for programs which, among other things, provided information about contraception and sexually transmitted diseases and sometimes referrals or access to contraception services to teenagers.

From 1996 through 2009, federal teen pregnancy prevention efforts relied heavily on using abstinence-only education as the primary tool.

Many commentators argued then (and now) that sexual activity in and of itself is wrong if the individuals are not married. Advocates of the abstinence education approach argue that teenagers need to hear a single, unambiguous message that sex outside of marriage is wrong and harmful to their physical and emotional health. These advocates contend that youth can and should be empowered to say no to sex. They argue that supporting both abstinence and birth control is hypocritical and undermines the strength of an abstinence-only message. They also cite research that indicates that teens who take virginity pledges to refrain from sex until marriage appear to delay having sex longer than those teens who do not make such a commitment. (One study found that teens who publicly promise to postpone sex until marriage refrain from intercourse for about a year and a half longer than teens who did not make such a pledge.)[43] They further argue that

[42] These care services projects are synonymous to what is now generally referred to as comprehensive sex education. Comprehensive sex education programs generally include one or more of the following components: (1) information about the benefits of abstinence, (2) information on the use of condoms and other contraceptive devices or methods for those who are sexually active, (3) information on the importance of early identification and treatment of sexually transmitted diseases, (4) information on how to resist negative peer pressure, and (5) information on how to improve communication skills (e.g., how to say no).

[43] Peter S. Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse," *American Journal of Sociology*, January 2001.

abstinence is the most effective means (i.e., 100%) of preventing unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.[44]

Until FY2010, three federal programs included funding that was exclusively for abstinence education: the Title V Abstinence Education Block Grant to states, the Community-Based Abstinence Education (CBAE) program, and the "prevention" component of the Adolescent Family Life (AFL) demonstration program. All of these programs were carried out by HHS and are discussed in detail, later in this report.

2009-Present: Evidence-Based

Until legislation passed in 2010 (P.L. 111-117 and P.L. 111-148), there was no federal funding stream exclusively for teen pregnancy prevention initiatives that included an array of intervention approaches including both abstinence-only and contraception information/services. The following two programs, established in the 111th Congress, provide federal funding for evidence-based teen pregnancy prevention initiatives: (1) the discretionary spending Teen Pregnancy Prevention (TPP) program and (2) the mandatory spending Personal Responsibility Education Program (PREP). These programs and their funding levels are discussed in detail in a later section of this report.

It appears that a consensus is now growing around the viewpoint that success in the teen pregnancy prevention arena does not necessarily have to be an "either-or" proposition in which "abstinence-only education" programs (sometimes referred to as sexual risk avoidance programs) are pitted against "comprehensive sex education" programs (sometimes referred to as sexual risk reduction programs).

The Obama Administration has indicated that it will use evidence-based approaches to expand programs that work and eliminate programs that do not work. The Obama Administration is supportive of using rigorous evaluation (i.e., a scientific method using experimental and control groups) to determine whether untested innovative programs are effective.[45] As discussed later, the Department of Health and Human Services (HHS) has compiled a list of 37 evidence-based program models that it has found to be effective in delaying sexual activity, increasing condom or contraception use for sexually active youth, or reducing teen pregnancy.[46] This list includes many programs designed to educate youth on both abstinence and contraception for the purpose of preventing teen pregnancy. It also includes a couple of programs that many would consider abstinence-only education programs.[47] The evidence-based approach to teen pregnancy prevention holds the view that whatever services or program components that are proven to be effective should be replicated or expanded upon by entities seeking federal dollars to prevent pregnancy among young people.

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[44] Those opposed to the abstinence-only education approach generally favor a comprehensive sex education approach, but also claim that abstinence-only programs often use medically inaccurate information regarding STDs, condoms, and other contraceptive devices. The Department of Health and Human Services (HHS) now requires grantees of abstinence education programs to sign written assurances in grant applications that the material/data they use are medically accurate.

[45] Ron Haskins and Jon Baron, *Part 6: The Obama Administration's Evidence-Based Social Policy Initiatives: An Overview*, Coalition for Evidence-Based Policy http://www.brookings.edu/~/media/Files/rc/articles/2011/04_obama_social_policy_haskins/04_obama_social_policy_haskins.pdf.

[46] See http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.

[47] The list of 37 evidence-based models includes several programs that are considered abstinence-only interventions: (1) Heritage Keepers Abstinence; (2) Making a Difference!; and (3) Promoting Health Among Teens! Abstinence-Only Intervention.

Evidence-based teen pregnancy prevention programs are varied and approach the problem from different frameworks. Some teen pregnancy prevention programs seek to delay the first time teens have sex. Others have an underlying goal of trying to decipher the root reasons behind teen pregnancy and childbearing. Is it loneliness or trying to find love or a sense of family? Is it carelessness (not bothering with birth control or using it improperly), or shame (not wanting to go to the doctor to ask about birth control or not wanting to be seen in a pharmacy purchasing birth control)? Is it a need to meet the sexual expectations of a partner? Is it trying to find individual independence or is it defiance (a mentality of "you can't boss me or control me—I'm grown")? Is it trying to validate and/or provide purpose to one's life? Is it realistically facing the probability that the entry-level job she can get at the age of 18 is the same or similar to the one she will likely have when she is 30, thus why should she wait to have a child?

In addition, the purpose of several teen pregnancy prevention programs is to prevent second or additional births to teens. The more successful of such programs recognize that a different approach is often needed to prevent secondary births as compared to first births. Research has indicated that teen pregnancy prevention programs that include mentoring components, enhanced case management, home visits by trained nurses and/or program personnel, and parenting classes have been effective in reducing subsequent childbearing by teens.[48]

According to The National Campaign to Prevent Teen and Unplanned Pregnancy:

> Most researchers agree that evidence-based teen pregnancy prevention programs share some common characteristics:
>
> • They have a strong theoretical underpinning that has both guided program development and informed the evaluation. Using theory helps program developers focus on specific risk and protective factors, which in turn strengthens their chances of changing behavior related to teen pregnancy.
>
> • They have been rigorously evaluated (that is, the evaluation tracked both implementation and outcomes, was based on randomized controlled trials or quasi-experimental methods, included adequate sample size and follow-up, addressed issues of retention/attrition, and used appropriate statistical analyses to control for confounding factors; some would add replication in multiple sites).
>
> • They change behavior—outcomes typically include delaying sex, increasing contraceptive use among sexually active teens, reducing the number of sexual partners, or reducing teen pregnancy itself. While positive changes in knowledge, attitudes, and behavioral intent are also encouraging, these outcomes are not as strongly tied to preventing teen pregnancy.
>
> • The evaluation results have been published in peer reviewed journals.[49]

The National Campaign to Prevent Teen and Unplanned Pregnancy also has stated the following:

> *In the ongoing debate over teen pregnancy prevention, some of these characteristics have been called into question. We believe that it is important to clarify that different programmatic approaches can be grounded in different theories of behavior change. That is, there is no single valid theory. To suggest that a program is not theory-based because one does not agree with the theory or the approach is simply inaccurate. It is also inaccurate to suggest that one approach is more effective because of its underlying theory—effectiveness is an empirical question that needs to be tested by looking at the*

[48] Erin Schelar, Kerry Franzetta, and Jennifer Manlove, "Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity," *Child Trends, Research Brief no. 2007-23*, October 2007.

[49] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Policy Brief: Key Points About Teen Pregnancy Prevention*, December 2012, p. 3.

results of the program. Similarly, it is not valid to compare a theory to a proven intervention.[50]

Federal Teen Pregnancy Prevention Programs[51]

Teen Pregnancy Prevention (TPP) Program

P.L. 111-117, the Consolidated Appropriations Act, FY2010, provided funding for a new discretionary TPP program that provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy and for the federal costs associated with administering and evaluating such grants and contracts. The TPP program is administered by the Office of Adolescent Health in the Office Assistant Secretary for Health in the Department of Health and Human Services (HHS).

The following types of entities are eligible to apply for TPP program funding: nonprofit organizations, for-profit organizations, universities/colleges, research institutions, hospitals, community-based organizations, faith-based organizations, Indian tribes and tribal organizations, state/local governments, and small businesses.

Of the $110 million appropriated for the TPP program for FY2010, $75 million was for "Tier 1" grants to replicate programs that had been proven through rigorous evaluation to be effective in reducing teenage pregnancy, behavioral factors underlying teen pregnancy, or other related risk factors;[52] $25 million was for "Tier 2" grants for research and demonstration projects; and $10 million was for training and technical assistance, outreach, and other program support. P.L. 111-117 also provided a separate $4.5 million for FY2010 (within the Public Health Service Act program evaluation funding) to carry out evaluations of TPP program approaches.

Within the TPP program, "Tier 1" grants are available on a competitive basis for two broad program types: (1) curriculum-based programs that seek to educate young people about topics such as responsible behavior, relationships, and pregnancy prevention; and (2) youth development programs that seek to reduce teenage pregnancy and a variety of risky behaviors through a broad range of approaches. Youth development programs usually incorporate multiple components, such as service learning, academic support, or opportunities to participate in sports or the arts. They also collaborate with multiple networks and/or provide youth with development-focused activities. In both cases, funding under this announcement can only be provided to applicants who seek to replicate evidence-based programs that have been shown to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors.[53] In most

[50] Ibid.

[51] See the **Appendix** for a funding history of the programs discussed in this section of the report. Also see The National Campaign to Prevent Teen and Unplanned Pregnancy, *Federal Funding Streams for Teen Pregnancy Prevention*, March 2014.

[52] Under a contract with HHS, Mathematica Policy Research conducted an independent, systematic review of the evidence base. This review defined the criteria for the quality of an evaluation study and the strength of evidence for a particular intervention. Based on these criteria, HHS has defined a set of rigorous standards an evaluation must meet in order for a program to be considered effective. HHS has compiled a list of 31 evidence-based program models that it has deemed to have met those standards. (The 31 evidence-based programs can be found at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs.html.

[53] U.S. Department of Health and Human Services (HHS), Office of Public Health and Science, Office of Adolescent Health, *Teenage Pregnancy Prevention: Replication of Evidence-based Programs*, Funding Opportunity Announcement and Application Instructions, 2010.

cases the Tier 1 grants must replicate an evidence-based program model that has been deemed by HHS to be effective.[54]

"Tier 2" grants are available on a competitive basis for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy.[55]

Since its inception in FY2010, TPP program funding has ranged from a high of $110 million in FY2010 to a post-sequester[56] low of $98.4 million in FY2013. Funding for TPP program evaluation was $4.5 million in FY2010 and $4.4 million in FY2011, it was increased to $8.5 million for each of FY2012 through FY2014, and was decreased to $6.8 million in FY2015 and FY2016. (See the **Appendix** for a funding history of the TPP program.)

P.L. 113-76 (the Consolidated Appropriations Act, 2014; enacted January 17, 2014) included funding of $101 million for the TPP program for FY2014. It also included funding of $8.5 million for program evaluation for FY2014.[57]

Pursuant to P.L. 113-164 (the Continuing Appropriations Resolution, 2015; enacted September 19, 2014), for FY2015 the TPP program was funded at the FY2014 rate of $101 million (plus $8.5 million for program evaluation) through December 11, 2014, or enactment of applicable appropriations legislation.

Pursuant to P.L. 113-235 (the Consolidated and Further Continuing Appropriations Act, 2015; enacted December 16, 2014), the TPP program was funded at $101 million for FY2015 (plus $6.8 million for program evaluation). On July 6, 2015, HHS announced that it had awarded $86.5 million in TPP grants to 81 nonprofit organizations, school districts, universities, and others.

Pursuant to P.L. 114-53 (the Continuing Appropriations Act, 2016; enacted September 30, 2015) the TPP is funded for FY2016 at the FY2015 rate of $101 million (plus $6.8 million for program evaluation) minus an across-the-board rescission of 0.2108%, through December 11, 2015, or enactment of applicable appropriations legislation.

Pursuant to P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015), the TPP is funded for FY2016 at $101 million (plus $6.8 million for program evaluation).

In July 2015, HHS awarded 81 new TPP program grants amounting to $86 million to nonprofit organizations, school districts, universities, and others.[58]

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[54] If an applicant for a Tier 1 TPP program grant wants to apply to replicate a program model that is not on the HHS list of 31 evidence-based models, it may do so only if it is able to meet stringent specified criteria. Such applicants may be more successful if they submit applications for the Tier 2 TPP program for the teen pregnancy prevention research and demonstration grants.

[55] U.S. Department of Health and Human Services (HHS), Office of Public Health and Science, Office of Adolescent Health & Administration for Children and Families, Administration on Children, Youth and Families, *Teenage Pregnancy Prevention (TPP): Research and Demonstration Programs and Personal Responsibility Education Program (PREP)*, Funding Opportunity Announcement and Application Instructions, 2010.

[56] The American Taxpayer Relief Act (ATRA, P.L. 112-240), enacted on January 2, 2013, made a number of significant changes to the procedures in the Budget Control Act of 2011 (BCA, P.L. 112-25). BCA, which included sequestration of most programs, projects, and activities included in the budget, was implemented on March 1, 2013. The sequestration of funds was ultimately applied at the program, project, and activity level within each account.

[57] For additional information on the TPP program, see the following webpage: http://thenationalcampaign.org/sites/default/files/resource-primary-download/overview_fedfunding.pdf.

[58] See http://www.hhs.gov/about/news/2015/07/06/hhs-awards-teen-pregnancy-prevention-program-grants.

Personal Responsibility Education Program

P.L. 111-148 (the Patient Protection and Affordable Care Act, ACA) established a new state formula grant program and appropriated $375 million at $75 million per year (mandatory spending) for five years (FY2010 through FY2014)[59] to enable states to operate a new Personal Responsibility Education Program (PREP), which is a broad approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted diseases. It also provides youth with information on several adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills). P.L. 113-93 (the Protecting Access to Medicare Act of 2014), which was enacted on April 1, 2014, extended PREP ($75 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10 (the Medicare Access and CHIP Reauthorization Act of 2015) extended PREP ($75 million per year) through FY2017 (i.e., September 30, 2017).

A total of 59 jurisdictions are eligible for PREP. Eligible entities include all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Federated States of Micronesia, the Marshall Islands, and Palau. PREP funds do not require a state match. PREP is administered by the Administration on Children, Youth and Families' (ACYF) Family and Youth Services Bureau (FYSB) in HHS.

PREP contains five components: (1) state PREP formula grants, (2) competitive PREP grants, (3) Tribal PREP, (4) PREP–Innovative Strategies (PREIS), and (5) funding for training, technical assistance, and evaluation.[60]

Most of the PREP appropriation (about $55.250 million annually) goes to states/territories (via a formula grant based on youth population). The formula for determining the PREP allocation to states and territories is derived by calculating the proportion of the number of youth between the ages of 10 and 19 of a state to the total number of youth between the ages of 10 and 19 in all of the states and territories. A state/territory's application for PREP funding must include a description of the state's plan for using the allotment to achieve stipulated goals especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under age 21, mothers who are under age 21, and youth residing in areas with high birth rates for youth.[61]

Currently 45 states, the District of Columbia, Puerto Rico, the Virgin Islands, and the Federated States of Micronesia receive PREP formula grant funds.[62]

If a state or territory failed to submit an application in FY2010 or FY2011, the state/territory was ineligible to apply for funds from the amounts allotted to the state or territory for each of FY2012, FY2013, and FY2014. Funds that would have gone to those jurisdictions for fiscal years 2010 through 2014 were used to award competitive three-year grants to local organizations and entities

[59] PREP also was subject to sequestration. The FY2013 post-sequester operating level for PREP was $71.2 million in FY2013. The FY2014 post-sequester operating level for PREP is $69.6 million in FY2014.

[60] U.S. Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, HHS, Administration for Children and Families, FY2015*, pp. 339-340.

[61] For a list of the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/2014-state-prep-awards.

[62] Florida, Indiana, North Dakota, Texas, and Virginia and the territories of American Samoa, Guam, the Marshall Islands, the Northern Mariana Islands, and Palau chose not to take state PREP funding (FY2015 data).

for the same purpose and in the same geographic regions.[63] An organization or entity awarded such a grant must agree to participate in a rigorous federal evaluation.

The first two components of PREP mentioned above (i.e., the state formula grant and the state competitive grant) are defined as programs designed to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, and at least three of the six stipulated adulthood preparation subjects. These two components of PREP also are required by law to replicate effective evidence-based programs or substantially incorporate elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth. They also are required to be medically accurate and age-appropriate. As mentioned earlier, HHS established, through a systematic review, a list of 31 program models that are considered evidence-based programs that have been found to be effective in achieving one of the behavioral outcomes: delaying sexual activity, increasing condom or contraception use for sexually active youth, or reducing pregnancy among youth. These evidence-based models are examples of programs that are eligible for replication and the programs from which states can incorporate significant elements. States are required to assure that their program (1) addresses both abstinence and contraception, and (2) incorporates at least three of the adult preparation subjects.

Tribal PREP (funded at $3.250 million annually) provides grants to tribes and tribal organizations to implement PREP. It supports 16 grantees and projects. Programs are encouraged to use models (or elements of models) of existing teen pregnancy prevention programs that have been proven by scientific research to be effective in changing behavior.

Of the funding not awarded to states/territories, the HHS Secretary is required to annually reserve $10 million for competitive discretionary PREIS grants to organizations/entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in, and aging out of, foster care; homeless youth; youth with HIV/AIDS; pregnant and parenting women who are under 21 years of age and their partners; and youth residing in areas with high birth rates for youth.[64] An entity that is awarded a PREIS grant is required to conduct a rigorous evaluation of their program and/or to agree, if selected, to participate in a rigorous federal evaluation of the activities funded by the grant.

In addition, the HHS Secretary is required to reserve $6.5 million annually for expenditures by the Secretary to (1) provide (directly or through a competitive grant process) research, training, and technical assistance for the programs and activities funded by PREP allotments or grants; and (2) evaluate the program and activities funded by PREP allotments or grants.[65]

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[63] If the state government opted not to apply after two years, the funding allotted to that state became available on a competitive basis to other organizations in the state. For the five states and three territories that opted not to take the PREP funding in FY2010 and FY2011, 37 Competitive Personal Responsibility Education Program grants totaling approximately $19 million were awarded for FY2012 to entities in those states and territories on a competitive basis. (These are three year grants, with the funding level listed being the FY2012 amount. FY2013 amounts were subject to sequestration. For a list of the grantees, see https://www.acf.hhs.gov/programs/fysb/resource/2012-cprep-awards).

[64] For a list of the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/preis-summaries.

[65] For additional information on PREP, see Personal Responsibility Education Program (PREP) Evaluation, OPRE Report #2014-27, FYSB Report #2014-1, *How States are Implementing Evidence-Based Teen Pregnancy Prevention Programs Through the Personal Responsibility Education Program*, by Susan Zief, Rachel Shapiro, and Debra Strong (Mathematica Policy Research), April 2014 http://www.acf.hhs.gov/sites/default/files/opre/prep_dis_brief_032814_edited.pdf.

Title V Abstinence Education

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the 1996 welfare reform law). The law provided $50 million per year for five years (FY1998-FY2002) in federal funds specifically for the abstinence education program. Subsequently, the block grant was funded through June 30, 2009, by various legislative extensions. The Title V Abstinence Education program is considered a mandatory program and is funded by mandatory spending. It is a formula grant program. State funding is based on the proportion of low-income children in the state compared to the national total. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds.

To ensure that the abstinence-only message is not diluted, the law (P.L. 104-193, §510 of the Social Security Act) stipulated that the term "abstinence education" means an educational or motivational program that (1) has as its exclusive purpose, teaching the social, psychological, and health gains of abstaining from sexual activity; (2) teaches abstinence from sexual activity outside of marriage as the expected standard for all school-age children; (3) teaches that abstinence is the only certain way to avoid out-of-wedlock pregnancy, STDs, and associated health problems; (4) teaches that a mutually faithful monogamous relationship within marriage is the expected standard of human sexual activity; (5) teaches that sexual activity outside of marriage is likely to have harmful psychological and physical effects; (6) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; (7) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (8) teaches the importance of attaining self-sufficiency before engaging in sex.

The Title V Abstinence Education program must be used exclusively for teaching abstinence and may not be utilized in conjunction with, or for any other purpose. Title V Abstinence Education programs must be medically accurate. To receive federal funds, a state must match every $4 in federal funds with $3 in state funds.[66] This means that full funding (from states and the federal government) for abstinence education must total at least $87.5 million annually. In FY2009, 27 states and Puerto Rico chose to sponsor a Title V Abstinence Education program.

The program's funding expired on June 30, 2009,[67] but P.L. 111-148, the Patient Protection and Affordable Care Act (ACA), reauthorized the program and restored funding to the Title V Abstinence Education formula block grant to states at the previous annual level of $50 million for each of the years FY2010 through FY2014 ($250 million over five years).[68] P.L. 113-93 (the Protecting Access to Medicare Act of 2014) which was enacted on April 1, 2014, extended the Title V Abstinence Education block grant ($50 million per year) through FY2015 (i.e., September 30, 2015). P.L. 114-10, the Medicare Access and CHIP Reauthorization Act of 2015, increased the Title V Abstinence Education block grant to $75 million per year for FY2016 and FY2017.

[66] States use a variety of methods to meet the federal matching requirement, such as state funds, private or foundation funds, matching funds from community-based grantees, and in-kind services (e.g., volunteer staffing and public service announcements).

[67] As mentioned above, since its inception, the Title V Abstinence Education Block Grant has been funded at a rate of $50 million per year. Funding for the program expired on June 30, 2009. Therefore, federal funding for the program for FY2009 was $37.5 million (i.e., a rate of $50 million per year for three-quarters of the fiscal year).

[68] The Title V Abstinence Education block grant also was subject to sequestration. The FY2013 post-sequester operating level for the Title V Abstinence Education block grant was $47.5 million in FY2013. The FY2014 post-sequester operating level for the Title V Abstinence Education block grant is $46.4 million in FY2014.

In FY2015, 36 states and 3 territories (Guam, Puerto Rico, and the Federated States of Micronesia) chose to sponsor a Title V Abstinence Education program.[69]

Adolescent Family Life Program

The Adolescent Family Life (AFL) program was enacted as Title XX of the Public Health Service Act (P.L. 97-35) in 1981. It is administered by the Office of Adolescent Pregnancy programs in the Department of Health and Human Services (HHS). The AFL program has two basic components, the "care" component and the "prevention" component. AFL care demonstration projects are required to provide comprehensive health, education, and social services (including life and career planning, job training, safe housing, decision-making and social skills), either directly or through partnerships with other community agencies, and to evaluate new approaches for implementing these services. AFL care projects are based within a variety of settings such as universities, hospitals, schools, public health departments, or community agencies. Many provide home visiting services and all have partnerships with diverse community agencies. The AFL program supports care demonstration projects to develop, test, and evaluate interventions with pregnant and parenting teens, their infants, male partners, and family members in an effort to ameliorate the effects of too-early childbearing for teen parents, their babies, and their families. Care services to parenting adolescents include pre- and post-natal care, nutrition counseling, continuing education, and vocational services.

From 1998 to 2009, the AFL appropriation was expended primarily on the prevention component of the AFL program (i.e., services for pre-teens, teens, and their families to promote abstinence from premarital sexual relations) to develop, test, and evaluate pregnancy prevention interventions designed to encourage adolescents to postpone sexual activity and reduce their risks for teenage pregnancy and sexually transmitted diseases. AFL prevention demonstration projects were required to develop, test, and use curricula that provide education and activities designed to encourage adolescents to postpone sexual activity until marriage. Since 1998, the prevention component of the AFL demonstration program was used to exclusively fund abstinence-only education projects that conformed to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states. Most of the AFL prevention projects tried to reach students between the ages of 9 and 14 in public schools, community settings, or family households; all involved significant interaction with parents to strengthen the abstinence message.

Any public or private nonprofit organization or agency was eligible to apply for an AFL demonstration grant. AFL projects could be funded for up to five years; all grantees were required to reapply each year of their continuing grant. Every program that received AFL grant funds was required to include an independent evaluation component.

The prevention component of the AFL demonstration program was funded at $9.0 million in FY1998 and FY1999; $9.1 million in FY2000 and FY2001; $10.2 million in each of the fiscal years FY2002 through FY2004; and $13.1 million in each of the fiscal years FY2005 through FY2009. No funding has been provided for the prevention component of the AFL program since FY2009.[70]

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[69] U.S. Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, HHS, Administration for Children and Families, FY2016*, pp. 403-404. For information on the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/2014-state-aegp-awards.

[70] According to HHS, in 2010-2011 the AFL program was supporting 27 care demonstration projects across the country. AFL care projects are programs primarily for pregnant or parenting adolescents.

The FY2010 appropriation for the care component of the AFL program was $16.7 million. P.L. 111-117 stipulated that none of the AFL funds were to be used for "prevention" services or projects.

Similarly, the FY2011 appropriation for the AFL program (P.L. 112-10) specified that the AFL funding was not to be used for AFL prevention services or projects. P.L. 112-10 included funding of $12.4 million for the AFL program for FY2011.[71] No funding has been provided for the program since FY2011.[72]

Community-Based Abstinence Education (CBAE) Program

Abstinence-only education funding (discretionary funding) provided through the Community-Based Abstinence Education (CBAE) program was included in annual appropriations legislation, from FY2001 through FY2009. Note that the CBAE program was known as the Special Projects for Regional and National Significance (SPRANS) until FY2005. The CBAE program was funded through Section 1110 of the Social Security Act for discretionary grants. P.L. 106-246 appropriated $20 million for abstinence education to HHS under the SPRANS program for FY2001 to bolster the abstinence-only message for adolescents ages 12 to 18. CBAE program competitive grants provided support to public and private entities for the development and implementation of abstinence-only education programs (that conform to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states) for adolescents ages 12 through 18 in communities nationwide. Funding for the CBAE program increased incrementally, from $20 million in FY2001 to $108.9 million in FY2008; in FY2009 CBAE funding dropped to $94.7 million. No CBAE funding has been appropriated since FY2009.

Competitive Abstinence-Only Grants

Several appropriation laws included an additional $5 million for *competitive grants* for abstinence-only education for each of FY2012, FY2013, FY2014, and FY2015. The most recent laws, P.L. 113-235/P.L. 113-164, included funding of $5 million for competitive grants for abstinence-only education for FY2015.[73]

P.L. 113-76, the Consolidated Appropriations Act, 2014 (enacted January 17, 2014), included funding of $5 million for competitive grants for abstinence-only education for FY2014.[74] P.L. 113-6, the Consolidated and Further Continuing Appropriations Act, 2013 (enacted March 26, 2013), included pre-sequester funding of $5 million for competitive grants for abstinence-only education for FY2013. The post-sequester amount of funding for the competitive grants for abstinence-only education was $4.7 million in FY2013. P.L. 112-74, the Consolidated

[71] Note that the $12.4 million figure accounts for the 0.2% across-the-board rescission that was also included in P.L. 112-10.

[72] The Obama Administration's budget request for FY2012 did not include funding for the AFL program for FY2012. FY2012 budget document commentary stated: "Mandatory funding for the Pregnancy Assistance Fund was included in the Patient Protection and Affordable Care Act. This new program directs resources to similar populations and activities-making the AFL program duplicative. Therefore HHS has not provided funding to continue the AFL program"; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf, p. 123.

[73] P.L. 113-164, the Continuing Appropriations Resolution, 2015 (enacted September 19, 2014) funded the competitive abstinence-only grants for FY2015 at the FY2014 rate of $5 million through December 11, 2014, or enactment of applicable appropriations legislation. Pursuant to P.L. 113-235, the Consolidated and Further Continuing Appropriations Act, 2015 (enacted December 16, 2014), the competitive abstinence-only grants are funded at $5 million for FY2015.

[74] For information on the grantees, see http://www.acf.hhs.gov/programs/fysb/resource/2013-caegp-awards.

Appropriations Act, 2012 (enacted December 23, 2011), included funding of $5 million for *competitive grants* for abstinence-only education for FY2012.

P.L. 114-113 (the Consolidated Appropriations Act, 2016; enacted December 18, 2015) included funding of $10 million for competitive grants that exclusively implement education in sexual risk avoidance (defined as refraining from nonmarital sexual activity) for FY2016.

Other Federal Programs

Although there are several federally funded programs that have a pregnancy prevention component and thereby may use their funds to provide pregnancy prevention information and/or contraception services to teenagers, they are not mandated by federal law to use any of their funds for teenagers. These programs include Medicaid Family Planning (Title XIX of the Social Security Act), Title X Family Planning, the Maternal and Child Health block grant (Title V of the Social Security Act), the Temporary Assistance for Needy Families (TANF) block grant (Title IV-A of the Social Security Act), the Title XX Social Services block grant, and several other HHS programs. As implied above, the services provided by these programs are primarily targeted to adult women rather than teenagers, and the programs themselves make no attempt to isolate program expenditures for information and/or contraception services provided to teens.[75]

As part of President Obama's Teen Pregnancy Prevention Initiative (TPPI), the Center for Disease Control and Prevention (CDC) is partnering with the federal Office of the Assistant Secretary for Health (OASH) "to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates. The OASH Office of Adolescent Health (OAH) is supporting public and private entities to fund medically accurate and age appropriate evidence-based or innovative program models to reduce teen pregnancy. The purpose of the program is to demonstrate the effectiveness of innovative, multicomponent, communitywide initiatives in reducing rates of teen pregnancy and births in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth aged 15–19 years."[76]

In addition, the mission of the CDC's Division of Adolescent and School Health (DASH) is to prevent the most serious health risks among children, adolescents, and young adults. Such health risks include preventing unintended pregnancies among children, teens, and young adults.

Evaluation of Teen Pregnancy Prevention Programs

There is a growing body of literature on effective interventions for reducing teen pregnancy. These evidence-based programs have demonstrated impacts on sexual activity (including delaying initiation of sexual activity), contraceptive use, STDs/STIs, and pregnancy or births.

Many analysts and researchers agree that effective teen pregnancy prevention programs (1) convince teens that not having sex or that using contraception consistently and carefully is the right thing to do; (2) last a sufficient length of time (i.e., more than a few weeks); (3) are operated by leaders who believe in their programs and who are adequately trained; (4) actively engage participants and personalize the program information; (5) address peer pressure issues; (6) teach communication skills; and (7) reflect the age, sexual experience, and culture of young persons in

[75] U.S. General Accounting Office, "Teen Pregnancy: State and Federal Efforts to Implement Prevention Programs and Measure Their Effectiveness," GAO/HEHS-99-4, November 1998. (GAO is now known as the Government Accountability Office.)

[76] For more information, see http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/about/communitywide.html.

the programs.[77] Others indicate that effective teen pregnancy prevention programs are often developed in cooperation with teens and experts, help clarify the teen's values and develop the coping skills of teens, provide medically accurate information, have clear goals, focus on specific health behaviors, address psychological risk and protective factors, use trained educators, and provide ongoing support.[78]

The Office of Adolescent Health (OAH), established within HHS in FY2010, coordinates adolescent health programs and initiatives across HHS related to adolescent health promotion and disease prevention. The OAH supports multi-disciplinary projects focused on improving adolescent health, collects and disseminates information on adolescent health to health professionals and the general public, and works in partnership with other HHS agencies to support evidence-based approaches to improving the health of adolescents. OAH provides a list of 37 programs/initiatives/interventions that it deems to be effective and suitable for replication.[79]

The list of 37 evidence-based models showcases a wide range of programs, including those that are curriculum-based (aimed at educating teens on responsible behaviors) and those that are clinic-based (aimed at teens seeking contraceptive services), in several types of settings (e.g., schools, community centers). The evidence-based programs vary in the types of program models used and the populations targeted (e.g., African American youth, Hispanic youth, persons in the juvenile justice system). They include programs that focus on abstinence as a way to prevent teen pregnancy and sexually transmitted infections and programs that focus on improving contraceptive use among sexually active teens.[80] The evidence-based approach to teen pregnancy prevention is based on the principle that services or programs that work (i.e., are proven to be effective) should be replicated or expanded upon by entities seeking federal dollars to prevent pregnancy among young people.

The list of 37 includes three abstinence-only education programs.[81] Prior to those three programs, which were found to be effective, it was widely held that the abstinence-only approach was ineffective.[82] Moreover, another study of the abstinence-only strategy, not counted in the 37, also found positive results. The scientifically based study assigned African American students in the 6th and 7th grades to (1) an 8-hour abstinence-only intervention to reduce sexual intercourse; (2) an 8-hour safer sex intervention to increase condom use; (3) 8-hour and 12-hour comprehensive interventions to reduce sexual intercourse and/or increase condom use; or (4) a control group

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[77] Katy Suellentrop, *What Works 2011-2012: Curriculum-Based Programs That Help Prevent Teen Pregnancy*, The National Campaign to Prevent Teen Pregnancy, p. 5.

[78] Kristen Anderson Moore (Child Trends), *What If We took Research Seriously: What Would Teen Pregnancy Programs Look Like?*, Presentation to the Healthy Teen Network, October 27, 2010.

[79] The list of the 37 programs can be found at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/tpp-searchable.html.

[80] The National Campaign to Prevent Teen and Unplanned Pregnancy, *Types of Programs Funded Through the Office of Adolescent Health Funding Announcement*, April 2010.

[81] The following are considered abstinence-only education programs: (1) Heritage Keepers Abstinence Education; (2) Making a Difference!; and (3) Promoting Health Among Teens! Abstinence Only Intervention.

[82] This viewpoint was in large part based on the 2007 Mathematica Policy Research, Inc., report that presented the final results from a multi-year, experimentally based impact study on several abstinence-only block grant programs. The report focused on four selected Title V abstinence education programs for elementary and middle school students. Based on follow-up data collected from youth (ages 10 to 14) four to six years after study enrollment, the report, among other things, presented the estimated program impacts on sexual abstinence and risks of pregnancy and STDs. The report found that program participants had just as many sexual partners as non-participants, had sex at the same median age as non-participants, and were just as likely to use contraception as non-participants; Christopher Trenholm, Barbara Devaney, Ken Fortson, Lisa Quay, Justin Wheeler, and Melissa Clark, "Impacts of Four Title V, Section 510 Abstinence Education Programs (final report)," Mathematica Policy Research, Inc., April 2007, http://aspe.hhs.gov/hsp/abstinence07/.

wherein an 8-hour health promotion intervention was used to improve healthy behaviors unrelated to sexual behavior (i.e., informed students about behaviors associated with heart disease, hypertension, stroke, diabetes, and certain cancers). The study found that only about 34% of the student participants in the abstinence-only intervention said that they had engaged in sexual intercourse,[83] whereas about 49% of the students in the control group reported (during the two-year follow-up interview) that they had engaged in sexual intercourse.[84] The authors also reported that among the participants in the abstinence-only intervention who had engaged in sexual activity during the demonstration, there was no significant difference between the abstinence-only intervention participants and the control group participants regarding consistent condom use.[85] The authors further noted that none of the interventions had significant effects on consistent condom use.[86]

The teen pregnancy prevention arena has grown substantially with respect to program evaluation. There is a growing evidence base of activities and services that have been shown to be effective in reducing teen pregnancy, delaying sexual activity among young people, and reducing sexually transmitted infections. Moreover, the number of evaluations/studies that have used a scientific approach with experimental and control groups (an approach that most analysts agree provides more reliable, valid, and objective information than other types of evaluations) have also increased.[87]

A recent report states:

> The movement to shift public and philanthropic funding to support "what works" has made real gains in the last few years. Government and philanthropy are seeking to identify high-impact programs that have been tested in rigorous trials and found to deliver superior results for society. However, it is not enough to identify what works—we also have to identify how it works so that other organizations can replicate the implementation of the program and get similar results.[88]

The teen pregnancy prevention programs (i.e., Tier 1 TPP and state formula and competitive PREP) are federally mandated to replicate evidence-based programs. Tier 2 TPP and PREIS are mandated to implement innovative strategies to prevent teen pregnancy and STIs. Both the TPP

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[83] The participants were interviewed two years after the intervention.

[84] John B Jemmott III, Loretta S. Jemmott, and Geoffrey T. Fong, "Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months," *Archives of Pediatrics and Adolescent Medicine*, v. 164, no. 2, February 2010, pp. 152-159. (**Note:** The authors remarked that the abstinence-only intervention studied would not meet the federal criteria for an abstinence-only program. One difference between the abstinence-only intervention studied and the Title V Abstinence Education block grant program was that the target behavior of the intervention was to abstain from any form of sexual intercourse (vaginal, anal, or oral) until a time later in life when the adolescent is more prepared to handle the consequences of sex, whereas one of the necessary components of the federal abstinence-only education programs was to teach school-age children that they were expected to abstain from sexual activity until they got married.)

[85] According to the study, 76% of the abstinence-only participants who had engaged in sexual activity had used condoms consistently during intercourse in the past three months, whereas 78% of the control group participants had used condoms consistently.

[86] John B Jemmott III, Loretta S. Jemmott, and Geoffrey T. Fong, "Efficacy of a Theory-Based Abstinence-Only Intervention Over 24 Months," *Archives of Pediatrics and Adolescent Medicine*, v. 164, no. 2, February 2010, p. 157.

[87] Ron Haskins and Greg Margolis, *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy*, Brookings Institution Press, Washington, DC, 2014. Also see Heather Fish, Jennifer Manlove, Kristin Anderson Moore, and Elizabeth Mass, Child Trends, What Works for Adolescent Sexual and Reproductive Health: Lessons From Experimental Evaluations of Programs and Interventions, Publication no. 2014-64,, December 2014.

[88] The Bridgespan Group, *What Does It Take to Implement Evidence-Based Practices? A Teen Pregnancy Prevention Program Shows the Way*, by Daniel Stid, Alex Neuhoff, Laura Burkhauser, and Bradley Seeman, November 11, 2013, p. 2.

program and PREP provide funding for evaluation. Replication of programs and evaluation of new programs will add to the evidence base regarding what works and what does not work with regard to teen pregnancy prevention.[89]

OAH supports several evaluation activities to continue to build the evidence base for what works to prevent teenage pregnancy. OAH currently provides funding to 35 Teen Pregnancy Prevention (TPP) grantees to conduct an independent, rigorous evaluation of their programs; 16 grantees are evaluating their efforts to replicate evidence-based programs and 19 grantees are evaluating new and innovative teen pregnancy prevention programs. In addition, OAH funds two large multi-site federal evaluations focused on teen pregnancy prevention.[90]

Upon authorizing the PREP program, Congress required that it be evaluated. The evaluation will help the federal government, states, tribes and tribal communities, and local service providers learn more about program design, implementation, and outcomes. The Administration for Children and Families (ACF) within HHS contracted with Mathematica Policy Research (and its subcontractors—Child Trends, Twin Peaks Partners, Decision Information Resources, Public Strategies, and Chapin Hall) to document and assess this large-scale replication effort. The evaluation will study PREP programs nationwide, collecting data from all grantees, and will also conduct an in-depth examination of a few selected PREP sites.[91]

[89] U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, *Evidence-Based Initiatives: Opportunities and Challenges*, by Barbara Broman (Associate Deputy Assistant Secretary for Human Services Policy).

[90] See the following webpage: http://www.hhs.gov/ash/oah/oah-initiatives/for-grantees/evaluation/.

[91] See the following webpage: http://www.prepeval.com/. Also see Personal Responsibility Education Program (PREP) Evaluation, OPRE Report #2014-27, FYSB Report #2014-1, *How States are Implementing Evidence-Based Teen Pregnancy Prevention Programs Through the Personal Responsibility Education Program*, by Susan Zief, Rachel Shapiro, and Debra Strong (Mathematica Policy Research), April 2014. Note: The first product of the PREP multi-component evaluation, led by Mathematica Policy Research, was published in October 2013 and is entitled "PREP: Launching a Nationwide Adolescent Pregnancy Prevention Effort" (OPRE Report 2013-37).

Appendix. Federal Teen Pregnancy Prevention Program Funding: FY1998-FY2015

Table A-1. Federal Teen Pregnancy Prevention Program Funding, FY1998-FY2016

(millions of dollars)

	Teen Pregnancy Prevention (TPP) Program	Evaluation Funds for TPP Program	Personal Responsibility Education Program (PREP)	Title V Abstinence Education Block Grant	Community-Based Abstinence Education (CBAE) Program	Evaluation Funds for CBAE Program	Competitive Abstinence-Only Grants	Adolescent Family Life (AFL) Program—"Care" Component	Adolescent Family Life (AFL) Program—"Prevention" Component
FY1998	—	—	—	$50.0	—	—	—	$7.7	$9.0
FY1999	—	—	—	50.0	—	—	—	8.7	9.0
FY2000	—	—	—	50.0	—	—	—	10.2	9.1
FY2001	—	—	—	50.0	$20.0	—	—	15.3	9.1
FY2002	—	—	—	50.0	40.0	—	—	18.7	10.2
FY2003	—	—	—	50.0	54.6	—	—	20.7	10.2
FY2004	—	—	—	50.0	70.0	$4.5	—	20.5	10.2
FY2005	—	—	—	50.0	99.2	4.5	—	17.6	13.1
FY2006	—	—	—	50.0	108.8	4.5	—	17.6	13.1
FY2007	—	—	—	50.0	108.9	4.5	—	17.6	13.1
FY2008	—	—	—	50.0	108.9	4.5	—	16.7	13.1
FY2009	—	—	—	37.5	94.7	4.5	—	16.7	13.1
FY2010	$110.0	$4.5	$75.0	50.0	0.0	0.0	—	16.7	0.0
FY2011	104.8	4.4	75.0	50.0	0.0	0.0	—	12.4	0.0

FY2012	104.8	8.5	75.0	50.0	0.0	0.0	$5.0	0.0	0.0
FY2013	98.4	8.5	71.2	47.5	0.0	0.0	4.7	0.0	0.0
FY2014	101.0	8.5	69.6	46.4	0.0	0.0	5.0	0.0	0.0
FY2015	101.0	6.8	75.0	50.0	0.0	0.0	5.0	0.0	0.0
FY2016	101.0	6.8	75.0	75.0	0.0	0.0	10.0	0.0	0.0
Total	**$721.0**	**$48.0**	**$515.8**	**$956.4**	**$705.1**	**$27.0**	**$29.7**	**$217.1**	**$132.3**

Source: Table prepared by the Congressional Research Service based on data from the Department of Health and Human Services (HHS).

Notes: These data reflect appropriations after all rescissions and post-sequester for FY2013 and FY2014. Dashes indicate that program was not yet authorized.

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Exhibit 3

An official website of the United States government

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Sexually Transmitted Infections (STIs)

Read the 2021–2023 Progress Report for the Sexually Transmitted Infections National Strategic Plan for the United States (2021–2025).

Download the Report [PDF, 914 KB]

</sites/default/files/sti-progress-report-2021-2023.pdf>

In the United States, recent data show that rates of sexually transmitted infections (STIs) reached an all-time high in 2021 among both females and males, and all racial and ethnic groups. According to the Centers for Disease Control and Prevention (CDC) <https://www.cdc.gov/sti-statistics/annual/index.html>, the number of combined cases of gonorrhea, syphilis and chlamydia was more than 2.4 million in 2023.While rates of gonorrhea and syphilis are slowing, reported STIs remain high and racial, ethnic, and sexual minority groups remain disproportionately affected.

The current rise of STIs is a serious public health concern that requires immediate attention. If left untreated, STIs can lead to severe health complications, including pelvic inflammatory disease (PID), increased risk of getting HIV, certain cancers, and even infertility.

The Office of the Assistant Secretary for Health (OASH) </ash/index.html> through the Office of Infectious Disease and HIV/AIDS Policy (OIDP) </oidp/index.html> has coordinated, along with other federal agencies, the development of an inaugural STI National Strategic Plan [PDF, 2.61 MB] </sites/default/files/sti-national-strategic-plan-2021-2025.pdf> (STI Plan). Stakeholders and the public had significant input into the development of this plan, through a variety of opportunities for public comment. The STI National Strategic Plan was released December 17, 2020, and provides a roadmap for prevention, diagnosis, treatment and care designed to meet significant measurable goals. The aim is for federal agencies and stakeholders to work together to reverse the alarming increase in STI rates and improve our nation's health. The National Strategic Plan 2021-2023 Progress Report [PDF, 914 KB] </sites/default/files/sti-progress-report-2021-2023.pdf> was released in November 2024 and provides an overview of federal progress on action steps but forward in the STI National Strategic Plan.

OIDP will continue to lead coordination of federal implementation of the STI Plan. Other stakeholders are encouraged to develop implementation plans for STI-related issues within their purview. Learn more about the STI Federal Implementation Plan [PDF, 1.02 MB] </sites/default/files/sti-implementation-plan-2021-2025.pdf>*.

Additional Resources

Read the STI Plan [PDF, 2.61 MB] </sites/default/files/sti-national-strategic-plan-2021-2025.pdf> and learn more about it </programs/topic-sites/sexually-transmitted-infections/plan-overview/index.html>.

*People using assistive technology may not be able to fully access information in these files. For assistance, contact the HHS Office of Infectious Disease and HIV/AIDS Policy by emailing Neelam.Gazarian@hhs.gov.

STI National Strategic Plan Overview </programs/topic-sites/sexually-transmitted-infections/plan-overview/index.html>

Guidelines & Best Practices

</programs/topic-sites/sexually-transmitted-infections/guidelines/index.html>

Resources </programs/topic-sites/sexually-transmitted-infections/resources/index.html>

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Announcements </programs/topic-sites/sexually-transmitted-infections/announcements/index.html>

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Sign-up to receive updates from the OIDP STI Team.

Content created by Office of Infectious Disease and HIV/AIDS Policy (OIDP)
Content last reviewed May 12, 2025

Exhibit 4

Sexually Transmitted Infections

National Strategic Plan

for the United States | **2021–2025**

VISION

The United States will be a place where sexually transmitted infections are prevented and where every person has high-quality STI prevention, care, and treatment while living free from stigma and discrimination.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

Acknowledgments: The Sexually Transmitted Infections National Strategic Plan (STI Plan) was developed through a robust process that included gathering feedback from stakeholders across health care and related fields. Partners throughout the federal government, as well as hundreds of nonfederal stakeholders, including state, tribal, territorial, and local governments, researchers, health plans and providers, community groups, and national and local organizations that work in STI and related fields, have helped shape the goals, objectives, and strategies in this plan. The Office of the Assistant Secretary for Health (OASH) and its Office of Infectious Disease and HIV/AIDS Policy (OIDP) of the U.S. Department of Health and Human Services (HHS) sincerely thank all those who contributed to making this STI Plan a reality, especially staff from the Centers for Disease Control and Prevention (CDC) Division of STD Prevention who provided technical and personnel support..

Language used in the STI Plan: The STI Plan places value on the lived experiences and choices of all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance. To reflect this vision, a concerted effort was made to use inclusive and person-first language throughout the STI Plan. Evidence-based, contemporary terminology is also used to convey respect and empowerment and to reduce stigma faced by communities and populations disproportionately impacted by these infections. Despite these efforts, specific terminology or language may be unintentionally offensive or stigmatizing to some individuals or populations. Language is subjective, and the meaning and use of language changes over time. This approach is intended to help the STI Plan's users to identify these societal shifts in preferred terminology and to communicate in a manner that reflects its vision for a collective, inclusive, and respectful national response..

Additional information regarding the STI Plan and associated activities may be accessed at www.hhs.gov/STI.

Suggested citation: U.S. Department of Health and Human Services. 2020. *Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025*. Washington, DC.

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EXECUTIVE SUMMARY

Over the past decade, the United States has witnessed alarming increases in rates of sexually transmitted infections (STIs) including syphilis, chlamydia, and gonorrhea, amounting to a public health crisis. From 2014 to 2018, the rates of reported cases of primary and secondary syphilis, congenital syphilis, gonorrhea, and chlamydia rose 71%, 185%, 63%, and 19%, respectively. Human papillomavirus (HPV), the most common STI, accounts for 14 million new infections each year.

The consequences of the STI epidemic are enormous. When left untreated, STIs can lead to long-term, irreversible health outcomes such as chronic pelvic pain, infertility, adverse pregnancy outcomes, neonatal death, and congenital abnormalities, and can facilitate HIV acquisition. HPV can cause numerous forms of cancer, although most HPV types associated with cancer are preventable through vaccination. HPV vaccination rates are lower than for other routinely recommended childhood and adolescent vaccinations in the United States despite evidence that the vaccine has a substantial impact on reducing HPV infections, HPV-associated pre-cancers, cancers, and genital warts. Many Americans largely underestimate the risk of STIs and for myriad reasons may not proactively seek care. In addition, racial and ethnic disparities contribute to an unequal burden of STIs in the United States.

As recognized by several national reports and authorities, efforts to date to address STIs have been fragmented and insufficient. Despite actions to reverse the trend, resources are often strained in many state and local public health settings. In addition, STIs cost Americans billions of dollars each year in direct medical expenses. Combined, the health and economic toll can affect the quality of life and prosperity of millions of people. Coordinated, innovative approaches and sustained efforts are needed to reverse this increasing trajectory and to curtail the ever-growing burden of STIs.

This inaugural STI National Strategic Plan (STI Plan) sets forth a vision for the nation with goals, objectives, and strategies to meaningfully prevent and control STIs in the United States. It is intended to serve as a roadmap for federal and nonfederal stakeholders at all levels to reverse the upward trends in STI rates. The STI Plan focuses on four of the STIs with the highest morbidity rates, the most persistent and pervasive STI inequalities according to national data, and the greatest impact on the health of the nation: chlamydia, gonorrhea, syphilis, and HPV. HIV, another significant STI, is the focus of a separate HIV National Strategic Plan. Hepatitis B and hepatitis C, which can also be transmitted sexually, are the focus of a separate Viral Hepatitis National Strategic Plan.

The STI Plan also includes indicators to measure progress and quantitative targets for each indicator. The components of the STI Plan are contained and discussed in Section III.

The STI Plan establishes the following vision:

VISION

The United States will be a place where sexually transmitted infections are prevented and where every person has high-quality STI prevention, care, and treatment while living free from stigma and discrimination.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

This vision is accompanied by five high-level goals, which frame the STI Plan's more specific objectives. The order of goals and objectives does not indicate any prioritization, and many are intertwined. The five goals and associated objectives are as follows:

Goal 1: Prevent New STIs

1.1 Increase awareness of STIs and sexual health

1.2 Expand implementation of quality, comprehensive STI primary prevention activities

1.3 Increase completion rates of routinely recommended HPV vaccination

1.4 Increase the capacity of public health, health care delivery systems, and the health workforce to prevent STIs

Goal 2: Improve the Health of People by Reducing Adverse Outcomes of STIs

2.1 Expand high-quality affordable STI secondary prevention, including screening, care, and treatment, in communities and populations most impacted by STIs

2.2 Work to effectively identify, diagnose, and provide holistic care and treatment for people with STIs by increasing the capacity of public health, health care delivery systems, and the health workforce

Goal 3: Accelerate Progress in STI Research, Technology, and Innovation

3.1 Support research and investments to develop STI vaccines and bring them to market

3.2 Support the development and uptake of STI multipurpose prevention technologies, antimicrobial prophylaxis regimens, and other preventive products and strategies

3.3 Support the development and uptake of innovative STI diagnostic technologies, therapeutic agents, and other interventions for the identification and treatment of STIs, including new and emerging disease threats

3.4 Identify, evaluate, and scale up best practices in STI prevention and treatment, including through translational, implementation, and communication science research

Goal 4: Reduce STI-Related Health Disparities and Health Inequities

4.1 Reduce stigma and discrimination associated with STIs

4.2 Expand culturally competent and linguistically appropriate STI prevention, care, and treatment services in communities disproportionately impacted by STIs

4.3 Address STI-related social determinants of health and co-occurring conditions

Goal 5: Achieve Integrated, Coordinated Efforts That Address the STI Epidemic

5.1 Integrate programs to address the syndemic of STIs, HIV, viral hepatitis, and substance use disorders

5.2 Improve quality, accessibility, timeliness, and use of data related to STIs and social determinants of health

5.3 Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving national STI goals

The vision, goals, objectives, and other components of the STI Plan were developed and approved by a dedicated Steering Committee, composed of subject matter experts from across the federal government, with public comment from numerous and varied stakeholders. The STI Plan is designed to be accessible to a broad audience, including people working in public health, health care, government, community-based organizations, private industry, research, and academia. It serves as a roadmap for all stakeholders at all levels to guide development of policies, initiatives, and actions for STI prevention and control. Because certain demographic groups and areas are disproportionately impacted by STIs, the STI Plan also identifies populations and geographic regions with higher rates of STIs (i.e., priority populations) so that federal agencies and other stakeholders can focus their resources to realize the greatest impact. The priority populations were identified based on national-level data. Stakeholders are encouraged to review the data for the populations they serve to help focus their efforts.

Interwoven throughout the STI Plan are approaches to address the individual, community, and structural factors and inequities that contribute to the spread of STIs, such as stigma and social determinants of health. The STI Plan highlights opportunities to integrate STI prevention and control into HIV, viral hepatitis, substance use disorders, and other public health efforts by leveraging capacity and infrastructure across the domains and breaking down operational and funding silos.

A recurring theme is the need for innovative solutions and approaches to address the ongoing and emerging challenges to STI prevention and control, including expanding the types of community and clinical sites that address STIs and developing vaccines, point-of-care diagnostic tools, and therapeutics. The plan is designed to facilitate a whole-of-nation response to the STI epidemic in the United States and to successfully prevent and reduce STI-associated morbidity and mortality.

The STI Plan includes indicators for measuring progress and quantitative targets for each indicator. There are seven core indicators, some of which are stratified to measure progress in addressing disparities in STIs (i.e., disparities indicators). Although focused on the years 2021–2025, the STI Plan includes annual targets through 2030 because STIs will continue to pose a threat to the public's health. To ensure implementation and accountability, a Federal Implementation Plan that documents the specific actions that federal partners will take to achieve the STI Plan's goals and objectives will be released subsequent to the STI Plan. Progress toward meeting the STI Plan's goals will be monitored and reported annually.

I. INTRODUCTION

A. The Need for the STI National Strategic Plan

1. RISE IN STIs AND PURPOSE OF THE PLAN

Persistent rises in the rates of sexually transmitted infections (STIs) in the United States constitute an epidemic and public health crisis with profound implications for all Americans. In recent decades, rates of chlamydia, gonorrhea, syphilis, and congenital syphilis have increased significantly. The rate of chlamydia, the most commonly reported bacterial STI, increased by approximately 19% from 2011 to 2018.[1] Over the span of a decade, the rate of gonorrhea rose by greater than 80% from a historic low in 2009. The rates of primary and secondary syphilis and of congenital syphilis increased almost every year since 2001 and 2012, respectively. Human papillomavirus (HPV), the most common viral STI, accounts for 14 million new STI infections each year.[2]

Left untreated, STIs can lead to serious health consequences such as pelvic inflammatory disease (PID), chronic abdominal pain, infertility, ectopic pregnancy, miscarriage, neonatal death, and congenital abnormalities.[1] Chlamydia, gonorrhea, and syphilis are also associated with increased risk of HIV transmission.[3] HPV leads to approximately 35,000 cases of cancer in both men and women each year, despite being preventable through a safe and effective vaccine.[2]

In the United States, some groups are more affected by STIs than others.[1] People aged 15–24 represent one-half of new STI infections, but only one-quarter of the sexually active population.[4] In 2018, more than one-half of primary and secondary syphilis infections occurred among men who have sex with men (MSM).[1] In addition, rates of chlamydia, gonorrhea, and syphilis are higher among American Indians/Alaska Natives (AI/AN) and African Americans (Blacks)* than among whites.[5] The South and West, as defined by the U.S. Census Bureau,[6] are the U.S. regions most heavily impacted by the STI epidemic.

STIs significantly impact the U.S. economy and health care system. A 2008 analysis from the Centers for Disease Control and Prevention (CDC) estimated the total direct cost of chlamydia, gonorrhea, syphilis, and HPV was $2.4 billion annually.[7] This estimate does not include the cost of adverse pregnancy outcomes, productivity losses due to illness, and the cost of STI screening and prevention programs.[7]

To spur action to reduce STI rates and their public health impacts, the U.S. Department of Health and Human Services (HHS) led the development of this inaugural STI National Strategic Plan (STI Plan or Plan). The STI Plan outlines national goals, objectives, strategies, and indicators to target four of the STIs with the highest morbidity rates, the most persistent and pervasive STI inequalities according to national data, and the greatest impact on the health of the nation: chlamydia, gonorrhea, syphilis, and HPV. † However, most of its components are also applicable to other STIs, such as herpes simplex virus infection, trichomoniasis, and

> The term sexually transmitted infection (STI) refers to a virus, bacteria, fungus, or parasite that has infected a person's body via sexual contact, whereas the term sexually transmitted disease (STD) refers to a recognizable disease state that has developed from an STI. Some stakeholders commonly use the term STI, and some commonly use the term STD. This STI Plan generally uses the term STI because the goal is to prevent and treat infections before they develop into a disease state. However, the term STD is used when referring to data or information from sources that use the term STD.

* In this STI Plan, Blacks will be used to refer to African Americans and Blacks.

† HIV, another significant STI, is addressed in a separate HIV National Strategic Plan (HIV Plan). Hepatitis B and hepatitis C, which can also be transmitted sexually, are addressed in a separate Viral Hepatitis National Strategic Plan (Hepatitis Plan).

Mycoplasma genitalium. A roadmap for federal and nonfederal stakeholders at all levels and sectors, the STI Plan envisions a whole-of-nation response to preventing and controlling STIs in the United States.

2. NATIONAL STI REPORTS: A CALL TO ACTION

Several foundational reports have been published on the STI epidemic, its impact on public health, and possible solutions to the crisis. These critical calls to action helped guide this STI Plan.

A groundbreaking 1997 report from the Institute of Medicine (IOM), *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, concluded that "the scope and impact of the STI epidemic are underappreciated... and largely hidden from public discourse."[8(p20)] The reasons for this under-appreciation remain as relevant today. STIs may be asymptomatic and therefore undetected; a significant amount of time may lapse between initial infection and serious health consequences (e.g., infertility and HPV-associated cancers); and stigma associated with STIs inhibits traditional interventions such as education and public discourse. The report also highlighted other important drivers of the epidemic, including social determinants of health such as poverty, lack of education, and disparities in health care access.

A panel of the National Academy of Public Administration (NAPA), on behalf of the National Coalition of STD Directors (NCSD), released two reports in 2018 and 2019 that expanded on the IOM report.[9,10] The NAPA reports, which explored the effectiveness of STI prevention and control efforts as well as the challenges of frontline programs, highlighted many of the same themes and recommendations. Their findings documented reductions in federal, state, and local funding that have left programs without the resources or capacity to provide the STI prevention and treatment services needed to respond to increasing STI rates. Further, technology challenges—such as incompatibility across surveillance systems, the inability to link electronic health record data, and the lack of public health informatics staff—are hindering the collection, reporting, and use of surveillance data essential to prevention and control activities.

Funding restrictions often prevent integrated, coordinated programing necessary to address contributing factors to STIs. In addition, the closing of many STI clinics has left vulnerable populations without access to timely sexual health care. Social stigma remains an overriding issue on the frontlines and a continuing barrier to STI education and screening. The reports underscored that many entities are involved in STI mitigation and recommended development of a comprehensive, unified national strategy to combat STIs, which would include the following specific actions.

- Designate a national STI champion to coordinate federal, state, and local efforts and to lead the development and implementation of a national STI strategy.
- Frame the STI narrative as a health and wellness issue to destigmatize the discourse.
- Expand science-based, health-centric STI education and awareness among the public and health care providers to reduce stigma, encourage healthy behaviors, and increase screening, testing, and treatments.
- Expand access to care, with a focus on delivering community-sensitive and patient-centered care.
- Improve data collection, reporting, and evaluation and enable more research to inform interventions and bring best practices to scale.
- Expand funding and resources and enhance agility across STI programs.

In another 2019 report commissioned by NCSD, the Treatment Action Group (TAG) highlighted serious gaps in the development of new tools for STI prevention (e.g., vaccines), diagnostics/testing (e.g., rapid tests), and treatment and called for major new investment in STI research.[11] TAG recommendations for community advocates and key stakeholders included the following:

- Invest substantially in new prevention modalities, particularly vaccine research and development for chlamydia, gonorrhea, and syphilis.

- Consider scaling up pre-exposure prophylaxis (PrEP) and/or post-exposure prophylaxis (PEP) for syphilis and chlamydia.
- Pave the way for development and access to novel antibiotics for treatment of gonorrhea.
- Develop reliable, easy-to-use, widely accessible (including point-of-care [POC] and self-testing) rapid tests for STIs.
- Focus STI advocacy efforts to aggressively address structural, social, financial, and research barriers, in addition to condoms and behavioral interventions.
- Synergize STI and HIV advocacy—STI prevention and treatment success is integral to the success of HIV prevention and treatment.
- Address underfunding and declining funding of STI infrastructure and clinics in the United States.

These frameworks and calls to action recognize and highlight the need for a cohesive national approach to address the STI epidemic. Other national frameworks have also informed this STI plan and include *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior (2001),*[12] the *National Prevention Strategy* (2011),[13] the *National Strategy for Combating Antibiotic Resistant Bacteria* (CARB) (2014),[14] and the *Healthy People framework*.[15]

B. The STI Epidemic: Challenges and Opportunities

Several challenges must be addressed to curtail the rising STI rates. Although the United States is in the midst of an STI epidemic and more than one-half of Americans will acquire an STI in their lifetime, a large majority remain unaware of the high prevalence of STIs.[16] Disparities in rates among certain population groups and geographic regions highlight the need for focused prevention strategies that address contributing factors such as health behaviors, substance use, stigma, and social determinants of health.[1] Other ongoing and emerging challenges must also be addressed including workforce skill and program capacity, the increasing threat of antimicrobial resistance (AMR), and the need for innovations in STI prevention, diagnosis, and treatment. To reverse the high rates of STIs, the field must shift from a fragmented and insufficient approach to one that is coordinated, sustained, and population-based and leverages innovation.[9, 17]

Many aspects of the STI epidemic are intertwined with other public health challenges such as HIV, viral hepatitis, and substance use disorders (SUDs). For example, stigma crosscuts each of these issues and leads to significant disparities as well as prevention and treatment challenges. The STI Plan provides a framework for addressing many of these challenges and opportunities in an integrated fashion.

1. HEALTH DISPARITIES, STIGMA, AND THE ROLE OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health—the social and economic conditions that influence the health of individuals and communities—loom large in the STI epidemic and the unequal burden of STIs in the United States. Individual behaviors that contribute to STIs occur in a broad context that involves a complex interplay of factors such as poverty, stigma, housing and food insecurity, discrimination, racism, medical mistrust, violence/trauma, access to care, and education.

Stigma, driven by medical, social, and cultural conditions, has long been a challenge in the prevention and control of STIs. Even when other barriers (e.g., health care access) are eliminated, stigma can discourage individuals from seeking STI testing and treatment.[18] Stigmatizing attitudes that associate STIs with immoral or irresponsible behavior hinder public discourse, disclosure, information sharing, care-seeking, and treatment.[19] Bias in provider behavior and interactions with patients may inhibit patients from seeking testing and accepting STI prevention education.[1] Such bias often goes unrecognized by the provider, and the lack of patient engagement in prevention and care may be perceived by the provider as a client issue, not a care delivery issue. In addition, approximately 11 states have laws that criminalize behaviors that can potentially expose another person to communicable or infectious diseases including STIs.[20] These laws add to the stigma associated with STIs and barriers to prevention and treatment.

A number of opportunities exist to address the social determinants of health that affect STI prevention and control efforts. Public education and awareness that involves schools, families, and communities is needed, especially among populations most affected by STIs. Partnering with the communities and groups being served strengthens the impact of STI prevention and control messaging. Education and awareness efforts should include positive messaging that reduces the negative connotations of STIs, engaging national and local champions and ensuring that campaigns reduce—and do not perpetuate—STI-related discrimination and stigma. In addition, efforts to increase provider education and awareness and to take a holistic approach to sexual health may promote the provision of prevention strategies such as immunization and counseling on risk-minimizing behaviors. Embracing a more holistic approach also provides avenues to support other health and wellness issues and to connect individuals to critical social services that can help address poverty, housing, and/or food insecurities.

A Focus on Health Inequities

Certain racial and ethnic minority groups, such as Blacks, AI/AN, and Hispanics, have higher rates of STI incidence and prevalence, compared with rates for non-Hispanic whites.[1] The COVID-19 pandemic has further exposed the health disparities and health inequities faced by people of color. Health disparities can stem from inequities in the social determinants of health and highlight the need to focus not only on STI prevention and care efforts, but also on how programs, practices, and policies affect communities of color. Racial and ethnic minority groups are more likely to be uninsured compared to non-Hispanic whites,[21] limiting their access to health care. Barriers to health care access include lack of transportation and childcare, inability to take time off from work, communication and language barriers, racism, discrimination, and lack of trust in health care providers.[22]

Sexual and gender minority (SGM) populations also face health disparities.[23, 24, 25, 26, 27] Barriers to health care include stigma, discrimination, medical mistrust, and lack of access to affirming mental health care.[28] SGM face greater health challenges than heterosexual and cisgender individuals due in part to inequities such as stigma and discrimination.[29] CDC data demonstrate that MSM are disproportionately impacted by STIs, as presented below in Section III.D. Other SGM populations, particularly those who are transgender, may engage in higher-risk behaviors and experience adverse social determinants of health as well as face stigma daily.[28] Disaggregated data for SGM populations are lacking for STIs other than HIV.[25] Among the 3 million HIV testing events reported to CDC in 2017, the percentage of transgender people who received a new HIV diagnosis was three times the national average.[30] The National Institutes of Health's *Strategic Plan to Advance Research on the Health and Well-Being of Sexual and Gender Minorities: Fiscal Years 2021-2025* addresses the need to encourage sexual orientation and gender identity data collection in health care and related settings including through national datasets.[31]

The STI Plan recognizes the importance of addressing social determinants of health to improve health outcomes for racial, ethnic, and sexual minority groups. By working to establish policies and programs that positively influence social and economic conditions that facilitate opportunities for changes in individual behavior, health can be improved and sustained, and disparities reduced. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce.[32] Application of a "health in all policies" strategy, a cross-sector collaborative approach to integrating health into policies and programs,[13, 33] to close the health gaps can be implemented across all areas and levels of government to foster achievement of these aims.

2. PROVIDER EDUCATION, AWARENESS, AND TRAINING

STI screening and treatment—including stopping the progression of STIs to serious health consequences or diseases—is critical for protecting the health of people affected by STIs. Lack of training and provider reticence are commonly documented reasons for providers not adequately addressing sexual health issues with patients.[34] Providers with sexual health education and training may be more likely to address individual

sexual health needs such as recommending testing and screening during routine health visits[34, 35] and offering expedited partner therapy for exposed partners (where recommended).[35, 36] Awareness, education, and training are particularly relevant for providers seeing preteen and teen patients. Research suggests that not enough teens get private and confidential time with their providers. One study found that only 38% of teens aged 15–17 had one-on-one time with a provider during a clinic visit in the prior year.[37] In another study, only 68% of medical visits attended by a parent involved time alone between the provider and the teen.[38]

There is a clear need and opportunity to expand overall sexual health education and training among all health care provider types throughout the stages of their career including during training (e.g., medical school, residency) and once in practice (e.g., through continuing education, certification, and maintenance of certification). This training can strengthen provider confidence and skills across a variety of practice settings, promote sexual health conversations that can help reverse STI-related stigma, and reduce adverse sexual health outcomes through all life stages of individuals.[34] Among providers caring for preteens and adolescents, strengthening privacy and confidentiality while implementing practices that encourage sexual health assessments and increase risk-avoidance behaviors can further reduce STIs and STI-related stigma and shame.[39, 40] Telemedicine and telehealth may also be useful tools for addressing stigma and discomfort with discussing sexual health concerns because patients may feel more comfortable addressing these concerns from the privacy of where they live.

Provider training in cultural competency and humility can help reduce health inequities and disparities. Such training can also help address a provider's interactional and interpersonal skills that may inadvertently manifest unknown bias or judgment. Moreover, there is a need to strengthen the capacity and competency of the STI workforce to engage effectively with people who use drugs, given the frequent co-occurrence of STIs and substance use.[41, 42] This engagement includes providing a welcoming environment and taking a harm reduction approach, such as providing naloxone and referring to comprehensive syringe services programs.

3. PROGRAM CAPACITY AND ACCESS TO PREVENTION AND CARE SERVICES

Most types of STIs are treatable and curable. However, as noted by the NAPA reports, funding cuts to STI programs have reduced access to essential prevention and care services. STI specialty clinics played a key role in reducing STI rates to their lowest levels in the early 2000s, but since then more than one-half of state and local STI programs have cut budgets, laid off staff, reduced clinic hours, and increased patient co-pays. STI specialty clinics typically offer onsite testing and treatment services (e.g., rapid tests for gonorrhea and syphilis, 3-site testing, dark-field microscopy for primary and secondary [P&S] syphilis, HIV ribonucleic acid [RNA] testing, injectable medications to treat gonorrhea and syphilis, expedited partner therapy) that often are not routinely available in alternative sites of care, such as primary care clinics. They also often have disease intervention specialists (DIS) on staff to conduct partner services, which help avert further transmission and repeat infections. Further, STI specialty clinics have been fundamental to the provision of affordable, quality STI care, especially to men (including MSM), adolescents and young adults, racial and ethnic minorities, and individuals without the resources to seek treatment in the private sector.[43] As STI clinics close or reduce hours across the United States, these key populations may forego care or turn to general practice settings and emergency departments, where sexual health expertise and adherence to STI clinical management guidelines may be inconsistent and providers may lack training in sexual history taking and client-centered risk avoidance and risk-reduction counseling. Because most people are unaware of their infections due to lack of symptoms, if sexual health is not addressed, then recommended screening is not performed. Budget cuts have also negatively impacted critical prevention tools such as STI surveillance and partner services.[9]

As emerging infectious diseases continue to pose threats to populations around the world, continued focus on STI screening and treatment is essential. For example, in 2016 the arrival of Zika virus in the United States required significant disease control efforts including STI screening and counseling.[44] In 2020, disruptions due

to the COVID-19 pandemic further exposed vulnerabilities in the STI infrastructure. Two months into the pandemic, greater than 60% of state and local health programs reported a negative impact on surveillance, reduced capacity to treat STIs, and difficulty addressing syphilis and HIV caseloads.[45] In addition, there have been reports of antimicrobial shortages as well as STI lab supplies and personnel being diverted for COVID-19.[46] Greater than 57% of DIS reported that they or other DIS in their jurisdictions had been deployed to COVID-19 efforts, and only 32% of DIS had the capabilities to perform field visits remotely or virtually.[45]

Targeted public health funding to strengthen STI surveillance and STD clinic infrastructure and to expand DIS and partner services may reduce the burden of STIs; increases in federal STI prevention funds have been linked to decreases in STI case rates.[47] Although STI specialty clinics remain a critical part of our health care infrastructure, more and more Americans are getting tested and treated in other settings, including primary care, HIV care, and family planning clinics. Strategies throughout the STI Plan aim to enhance and strengthen STI care in all of these settings in order to provide the highest-quality STI care.[48] Providing multiple options for high-quality STI prevention and care is an important approach to meeting all people's needs. Harnessing opportunities to increase resources and implement innovative approaches, especially during public health emergencies such as COVID-19, is necessary to ensure access to and continuity of STI services. The COVID-19 pandemic has sparked the use of innovative approaches and a recognition of the need to offer multiple modalities of care to best meet all people's needs. Going forward this means, for example, increased telehealth capacity, self-testing outside of clinical facilities, and referrals to alternate treatment and care settings (e.g., pharmacies, retail health clinics), as well as in-person health care provider visits.

Furthermore, the use of trusted community-based organizations working in the field of STIs may provide opportunities to reach populations that would not otherwise present at an STI clinic or in a traditional health care setting. Community-based organizations have the knowledge and the trust of the populations they serve and may be able to help deliver effective messaging about the importance of screening and treatment of STIs.

4. ACCELERATE PROGRESS IN STI RESEARCH, TECHNOLOGY, AND INNOVATION

Inadequate investment in STI research, technology, and innovation has resulted in a lack of new vaccines, rapid diagnostics, and therapeutic and preventive antimicrobials.

STI Vaccines

Vaccines are widely recognized as an effective primary prevention strategy against infectious diseases.[49] However, no vaccine exists to prevent syphilis, gonorrhea, or chlamydia. Significant barriers to STI vaccine development remain.[50] Concerns about the ability to achieve reasonable returns on the investment required to bring a vaccine to market have slowed STI vaccine development. The potential for lower than anticipated consumer demand and uptake, an ongoing challenge for the HPV vaccine, further undermines STI vaccine development efforts. Innovation in vaccine development, care delivery models for providing vaccinations, and communication are critical to advancing STI vaccines and ultimately STI prevention.

Diagnostics and Self-Testing

Some high-quality STI diagnostic tests exist, but affordable STI tests that allow for rapid POC diagnosis are not available in the wide array of STI care settings.[11] Reliable, affordable, and user-friendly POC tests are needed to rapidly identify and treat STIs. Deficits in STI testing and contact tracing due to the COVID-19 pandemic have revealed an urgent need for availability and access to affordable home-based tests or self-collection specimen kits for use outside of clinics. However, technological advancement has been limited by lack of investment and other barriers.[11, 51] Public knowledge, access, and the cost of self-test options, which are not typically covered by insurance carriers, are additional barriers to widespread use.[51] Furthermore, cultural practices, language, and educational level also serve as barriers to widespread use. The development of tests across STI pathogens and of a national distribution plan would also accelerate progress.

Therapeutic and Preventive Antimicrobials

In 2019, the World Health Organization (WHO) named AMR among the top 10 threats to global health, and CDC included gonorrhea (*Neisseria gonorrhoeae*) as one of five pathogens that are urgent public health threats and requiring urgent and aggressive action.[52, 53] Gonococcal infections are increasingly resistant to at least one antibiotic, and only one recommended treatment option remains.[1, 35] Yet the drug development pipeline lacks effective antimicrobials to reduce the spread of STIs in general, especially for the rising number of resistant gonococcal infections and their related complications. For example, Benzathine penicillin G is currently the only recommended treatment option for pregnant women with syphilis who have no evidence of neurosyphilis. Shortages of Benzathine penicillin G, its high cost, storage issues, and penicillin drug allergies present challenges and underscore the need for alternative therapeutic options for syphilis.

Antibiotic susceptibility testing can help with decisions about which therapeutic options are the most likely to be effective for a specific patient's infection. Using the most effective treatment regimen also can mitigate the emergence of resistant organisms. Novel diagnostics with antibiotic susceptibility markers to help select the best antibiotic for the patient can reduce the need for broad spectrum, costly antibiotics and can contribute to antibiotic stewardship, one of the CARB priority goals in the U.S. CARB plan.[54] Preventive antimicrobials warrant more investigation as promising tools in STI prevention. These include microbicides—topical products containing drugs designed to reduce the risk of STI transmission—and PrEP and PEP. Unlike other prophylactic interventions such as condoms, microbicides can be used discreetly and may be applied without the consent or knowledge of a sexual partner.[55] Although pilot data suggest that some PrEP and PEP approaches might be effective, further research is needed on efficacy, target population, community acceptability, behavioral risk compensation, dosing regimens and formulations, long-term safety, AMR, cost-effectiveness, and risk–benefit.[56]

5. STIs, HIV, VIRAL HEPATITIS, AND SUBSTANCE USE DISORDERS—A HOLISTIC APPROACH TO THE SYNDEMIC

The nation's opioid epidemic has been linked to outbreaks of bloodborne infections and STIs such as HIV, hepatitis A (HAV), hepatitis B (HBV), hepatitis C (HCV), gonorrhea, chlamydia, and syphilis.[57] The syndemic, which refers to the co-occurring and interrelated epidemics of HIV, viral hepatitis, SUDs, and STIs, is also associated with social determinants of health such as poverty, housing, education, underemployment, and disparities.[58, 59]

In 2020, TAG and the National Academies of Sciences, Engineering, and Medicine (NASEM) each released a report that highlights the importance of addressing components of the syndemic through integrated health services in traditional and nontraditional settings.[11, 57] For example, HIV, viral hepatitis, and SUD programs can and should integrate STI prevention, testing, and linkage to care, and vice versa. STI screening and linkage to care should also be integrated into nontraditional settings such as emergency departments, correctional facilities, retail health clinics, and pharmacy-based services. This approach is recognized throughout the STI Plan. The interplay between social determinants of health and components of the syndemic also must be recognized and addressed through integrated efforts.[60] Opportunities exist to address comorbidities of STIs and social determinants of health by aligning strategies in the STI Plan with those in other national strategic plans to promote innovative programs and policies to provide patients with resources including housing, education, transportation, food, and employment.

A **syndemic** is a set of linked health problems that interact synergistically and contribute to excess burden of disease in a population.

A syndemic occurs when health-related problems cluster by person, place, or time.

A prominent syndemic for this STI Plan involves STIs, viral hepatitis, HIV, and substance use disorders.

Social determinants of health and stigma also play a significant role in this syndemic.

COVID-19 and the Syndemic

This plan is being released during an unprecedented pandemic. In early 2020, SARS-CoV-2, the coronavirus that causes COVID-19 disease, spread rapidly across our nation and the globe, infecting millions, claiming the lives of hundreds of thousands of people, and causing great uncertainty, including for people at risk for STIs, HIV, and viral hepatitis.

The pandemic has exacerbated existing challenges in the nation's public health care system, further exposing decades, if not centuries, of health inequities including among social determinants of health. Clinical services have been limited due to the pandemic, with many staff understandably redeployed to address the public health emergency. Many of the populations and communities disproportionately affected by STIs, HIV, and viral hepatitis are particularly vulnerable to the service disruptions and the economic consequences of the pandemic, including unemployment, housing and food insecurity, and obstacles to practicing safe social distancing. The economic impact of the pandemic may have long-lasting impacts on service availability, because of budget constraints and permanent closures or reduction in hours of clinics and practices, and on the socioeconomic conditions that people face. Implementation of the plan should take into account these long-lasting effects.

As the nation responds to the pandemic, while working to maintain STI, HIV, and viral hepatitis prevention, screening, and care, innovative approaches have expanded and evolved, including meeting with clients via telemedicine, distributing self-testing collection kits, increasing use of expedited partner therapy to ensure timely treatment, offering multi-month medication refills, and partnering with pharmacies and retail health clinics to ensure continuity of care. Some of these adaptations may prove to be sustainable and effective in achieving our national goals.

Our understanding of COVID-19 will continue to evolve as effective therapeutics and vaccines are developed and implemented. The ways in which the COVID-19 pandemic will continue to influence our responses to STI, HIV, and viral hepatitis remain unknown. However, stakeholders' commitment to addressing the syndemic remains firm. The nation's evolving response will require continued innovation and identification of opportunities to integrate and leverage resources and lessons that advance efforts to address infectious diseases that threaten public health.

C. Scope, Approach, and Development of the STI National Strategic Plan

Although there are more than 30 types of STIs,[61, 62, 63] the STI Plan focuses on four of the STIs with the highest morbidity rates, the most persistent and pervasive inequalities of STI burden according to national data, and the greatest impact on the health of the nation: chlamydia, gonorrhea, syphilis, and HPV.[1] Chlamydia, gonorrhea, and syphilis are the three nationally notifiable STDs ‡ for which there are federally funded control programs.[1] Chlamydia and gonorrhea are the first and second most commonly reported conditions in the United States, excluding COVID-19.[1] Primary and secondary syphilis (see Section II.C for descriptions) rates have increased steadily since reaching a historic low in 2000 and 2001, and the rate of congenital syphilis has increased every year since 2012.[1] HPV is included as part of the STI Plan because it is the most common viral STI, is easily transmitted, and can lead to cancers in both men and women, and 92% of cancers caused by HPV can be prevented by an underutilized HPV vaccine.[64] Additional information about each of these STIs is provided in Section II. All of the goals and most of the objectives and strategies delineated in this STI Plan are not infection specific. Thus, they can be used to guide prevention, care, and treatment for other prevalent STIs as well.

‡ With the exception of HPV, the scope of this plan focuses on nationally notifiable STDs in the United States for which there are federally funded control programs. Chlamydia, gonorrhea, and syphilis are "notifiable" diseases, but other STIs such as genital herpes are not. A disease is "notifiable" if health care providers and/or laboratories in all 50 states are required by state law or statute to report the diagnosis or the positive lab test, respectively, to their state or local health departments. The Council of State and Territorial Epidemiologists works with CDC to determine whether a particular disease should be nationally notifiable, based on several criteria. Other common but not nationally notifiable STIs such as genital herpes and trichomoniasis are neither specifically addressed in the plan, nor are emerging sexually transmitted pathogens such as *Mycoplasma genitalium*; however, this should not deter stakeholders from using available data to identify where their resources will have the most impact. The scope of future iterations of the STI Plan may be broadened to include other common STIs.

The STI Plan is intended to serve as a roadmap for federal and other stakeholders to reverse the upward trends in STI rates in the United States. It was developed by subject matter experts across the federal government with input from a variety of stakeholders as well as the public. The STI Plan presents a strategic framework for integrating and leveraging synergistic policies, programs, and resources. It sets forth a vision and goals for the nation, with objectives and strategies for each goal. The order in which the goals, objectives, strategies, and indicators are presented is not associated with any prioritization. The objectives and strategies offered in this plan are intertwined and overlapping and may be used to make progress toward more than one goal. Because STIs disproportionately affect certain demographic groups, the STI Plan also identifies priority populations (i.e., those populations most impacted by STIs based on national data) to guide national efforts and funding to realize the highest impact on reducing STIs.

The STI Plan also identifies indicators to track progress toward each goal and quantitative targets for each indicator. Although this is a 5-year plan, it sets 10-year quantitative targets for each indicator—reflecting the reality that it will take more than 5 years to reverse, not just slow, the upward trajectory of rising STI rates, and to eliminate the epidemic. The STI Plan will be re-evaluated in 2025.

These components—vision, goals, objectives, strategies, priority populations, indicators, and 5- and 10-year targets—are all set forth in Section III of the STI Plan. The methodology for developing the STI Plan, including stakeholder input, is explained in Appendix A; the baseline measures and annual targets for each indicator are set forth in full in Appendix B.

Utilizing a whole-of-nation approach, the STI Plan assumes the active participation of state, tribal, local, and territorial health departments and organizations, health plans and health care providers, schools and other academic institutions, community-based and faith-based organizations, scientists, researchers, and the public in this effort. The priority populations, indicators, and quantitative targets, especially the methods used to determine them, are intended to help focus efforts and limited resources to realize the most impact. Stakeholders are encouraged to focus on activities that resonate the most with the needs of the populations they serve and the services they provide, and to develop their own plans to reverse the rise of STIs and improve the health of their communities, states, tribal nations, territories, and the nation.

Recognizing the importance of addressing the syndemic of STIs, HIV, viral hepatitis, and SUDs, the STI Plan was developed concurrently and is aligned with the next iterations of the HIV Plan and the Hepatitis Plan, both planned to be released in fiscal year 2021. The next iteration of the National Vaccine Plan, also scheduled for release in fiscal year 2021, will support and enhance the elements of these three plans that focus on developing vaccines as an effective approach to preventing infection. These national plans are also aligned with the *Ending the HIV Epidemic: A Plan for America* (EHE) initiative, which aims to reduce new HIV infections by 90% by 2030. EHE provides further opportunities for STI prevention and control measures such as leveraging the infrastructure for HIV services as an entry point for people seeking STI prevention and treatment services (see Box 1). Three of the infections of focus—HPV, syphilis, and gonorrhea—also align with WHO's priority infections in its 2016–2021 global strategy on STIs.[65]

BOX 1

ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA

The *Ending the HIV Epidemic: A Plan for America* (EHE) initiative is a bold initiative by the current Administration to end HIV in this nation by 2030. Efforts to control HIV have cross-cutting effects on the control of other STIs. For example, EHE's funding and support of STI clinics in three jumpstart jurisdictions—Baltimore City, Maryland; DeKalb County, Georgia; and East Baton Rouge Parish, Louisiana—support both missions.

Scaling Up HIV Prevention Services in Specialty STI Clinics

In 2019, the three jurisdictions were awarded $1.3 million to strengthen the infrastructure of STI clinics serving a high proportion of racial/ethnic and sexual minorities as part of the implementation phase of EHE. In just a few months, the jurisdictions implemented innovative, evidence-based approaches to scale up clinic capacity and HIV prevention services with self-registration kiosks, express visits with self-testing, virtual visits for PrEP follow-up, and a city-wide health resource directory to connect STI clinic patients with key resources.

This is one example of the STI Plan's integrated approach to addressing all parts of the syndemic.

Federal partners will contribute to the development of a Federal Implementation Plan, which will document the actions they will take to help the nation reach the goals of the STI Plan and to strengthen the collective national response to the STI epidemic. The Federal Implementation Plan will be public; progress toward meeting the STI Plan's goals will be monitored and reported annually to ensure transparency and accountability.

II. OVERVIEW OF EACH STI

This section provides a very high-level overview of each of the four STIs in the scope of the STI Plan: chlamydia, gonorrhea, syphilis, and HPV. State and local STI prevention and control programs provide CDC with case reports for these conditions when confirmed by laboratory testing. Because STIs are often asymptomatic and may remain undiagnosed, case report data underestimate the number of infections that occur in the U.S. population.[1] The exception of the four is HPV, which is not a nationally notifiable disease, rendering case report data unavailable.

The following section lists each infection separately. However, in a clinical setting, screening for STIs should be integrated and use a holistic approach, taking into account the patient's individual needs, geographic location, past medical history and risk, among other factors. The snapshots include screening criteria are based on current CDC guidelines and reported surveillance data. More robust information on the STIs of focus, STI surveillance data, and screening and treatment guidelines may be found on the CDC website through the links in Box 2.

BOX 2

STI SURVEILLANCE AND FACT SHEETS

CDC's Sexually Transmitted Disease Surveillance 2018 report presents trends for nationally notifiable STDs in the United States through 2018. Additional data about the four STIs covered by the STI Plan are available in the following STI-specific documents prepared by CDC:

Chlamydia Detailed Fact Sheet

Gonorrhea Detailed Fact Sheet

Syphilis Detailed Fact Sheet

HPV Vaccination: What Everyone Should Know

Information on current guidelines for screening and treating people who have or are at risk for STDs can be found on CDC's Treatment and Screening website, which is updated as new guidelines are released.

A. Chlamydia

BOX 3

CHLAMDYIA SNAPSHOT

- Treatable and curable
- Untreated chlamydia can lead to pelvic inflammatory disease (PID), which may cause infertility
- Screening recommended annually for sexually active females < age 25, females ≥ age 25 at increased risk, and MSM; screening in MSM should be based on anatomic site(s) of exposure

Epidemiological Facts

1,758,668 REPORTED CASES (2018)

19% RATE INCREASE (2014–2018)

Rates increased among males, females, all geographic regions, and all racial/ethnic groups

80% OF CASES were reported from providers other than STD clinics

Populations Disproportionally Impacted

- Females of reproductive age
- Adolescents and young adults
- Adolescent racial/ethnic minorities

Consequences When Left Untreated

- PID
- Infertility
- Ectopic pregnancy
- Chronic pelvic pain
- Increased risk of HIV
- Epididymitis

Current Challenges

- Asymptomatic infections
- Lack of provider and public awareness about screening recommendations
- Limited resources to support screening
- Lack of an available vaccine

Sources: CDC[1], Workowski and Bolan[35], Jones et al.[66]

Chlamydia, the most common bacterial STI in the United States, is caused by *Chlamydia trachomatis*. It is transmitted through sexual contact with an infected partner.[67] Left untreated, chlamydia can cause debilitating or lifelong consequences. In women, it can result in an increased risk for PID, which can result in chronic pelvic pain, infertility, and ectopic pregnancy, which can be life-threatening.[67] Gonorrhea and other infections that are not sexually transmitted can also cause PID. Chlamydia in pregnancy can lead to premature birth or may affect the health outcomes of the newborn.[67] Untreated chlamydia may increase a person's chances of acquiring or transmitting HIV.[68]

Rates of reported chlamydial infections in the United States have risen steadily for the past 10 years (see Figure 1). In 2018, 1,758,668 cases of *Chlamydia trachomatis* infection were reported to CDC.[1] This number of cases corresponds to a national rate of 539.9 chlamydia cases per 100,000 persons and a 19% increase in the rate of chlamydia cases since 2014.[1] Females aged 15–24 account for nearly one-half (44%) of reported cases

and face the most severe sequelae from undiagnosed infection.[1] Chlamydia is currently the most common public health condition reported to CDC excluding COVID-19.[1]

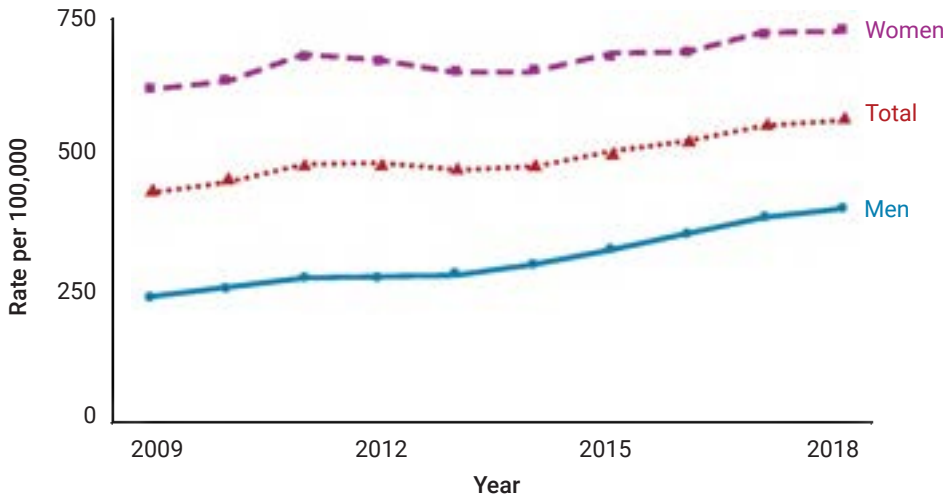


Figure 1. Chlamydia—Rates per 100,000 reported cases by sex, United States, 2009–2018[1]

CHALLENGES

A significant challenge to reducing the incidence of chlamydia is the large proportion of cases that are asymptomatic. A recent study demonstrated that greater than 84% of females and 94% of males did not report symptoms within 12 months after infection.[69] If symptoms do appear, they often do not manifest until weeks after exposure. Asymptomatic individuals often do not seek testing yet can still transmit the infection to a sexual partner. As a result, many cases go undiagnosed and unreported.[67]

Given that most chlamydial infections are asymptomatic, screening for chlamydia is critical to identify and then treat the infection. Although chlamydia screening has expanded over the past two decades, many women who are at risk are still not being tested. For example, in 2017, rates of chlamydia screening for sexually active women aged 16–24 were 48.9% in commercial health maintenance organizations (HMOs) and 57.6% for those covered by Medicaid.[1, 70]

B. Gonorrhea

BOX 4

GONORRHEA SNAPSHOT

- Treatable and curable
- Gonorrhea can lead to pelvic inflammatory disease (PID), which may cause infertility
- Screening recommended annually for sexually active females < age 25, females ≥ age 25 at increased risk, and MSM; screening in MSM should be based on anatomic site(s) of exposure

Epidemiological Facts

583,405 CASES
(2018)

63% RATE INCREASE
(2014–2018)

137% rate increase among MSM

51% OF ALL ISOLATES
tested in 2018 were resistant to at least one antibiotic

Populations Disproportionally Impacted

- Females of reproductive age
- MSM
- Adolescent racial/ethnic minorities

Consequences When Left Untreated

- PID
- Infertility
- Ectopic pregnancy
- Chronic pelvic pain
- Increased risk of HIV
- Disseminated gonococcal infection
- Epididymitis

Current Challenges

- Antimicrobial resistance—gonorrhea has developed resistance to all but one class of antibiotics, and half of all infections are resistant to at least one antibiotic
- Lack of point-of-care diagnostics to test antibiotic susceptibility
- Asymptomatic infections
- Limited resources to support screening
- Lack of an available vaccine

Sources: CDC[1], Workowski and Bolan[35], Jones et al.[66]

Gonorrhea is caused by the bacteria *Neisseria gonorrhoeae*, which infects the mucous membranes in the reproductive tract, as well as in the mouth, throat, eyes, and rectum. It is the second most common notifiable disease in the United States that is reported to CDC.[1, 71] Asymptomatic infections may lead to gonorrhea going untreated, which in women can result in PID, ectopic pregnancy, and infertility. In men, it can cause epididymitis (inflammation of the testicles). In adults, gonorrhea can disseminate through the bloodstream and cause sepsis, arthritis, meningitis, and endocarditis. Gonococcal infection of the newborn occurs from exposure to infected cervical secretions during delivery[72] and may result in blindness and less commonly sepsis.[35, 72] Untreated gonorrhea may increase a person's chances of acquiring or transmitting HIV.[68]

During 2018, CDC received reports of 583,405 gonorrhea cases, representing a national rate of 171.9 cases per 100,000 population. Rates of reported gonococcal infection in the United States have risen annually for the past 5 years (see Figure 2).[1] From 2014 to 2018, the overall rate in the United States increased 63%,[1] with rate increases among both females and males in all regions of the United States and among all racial/ethnic groups, as well as a significant rate increase among MSM.[1]

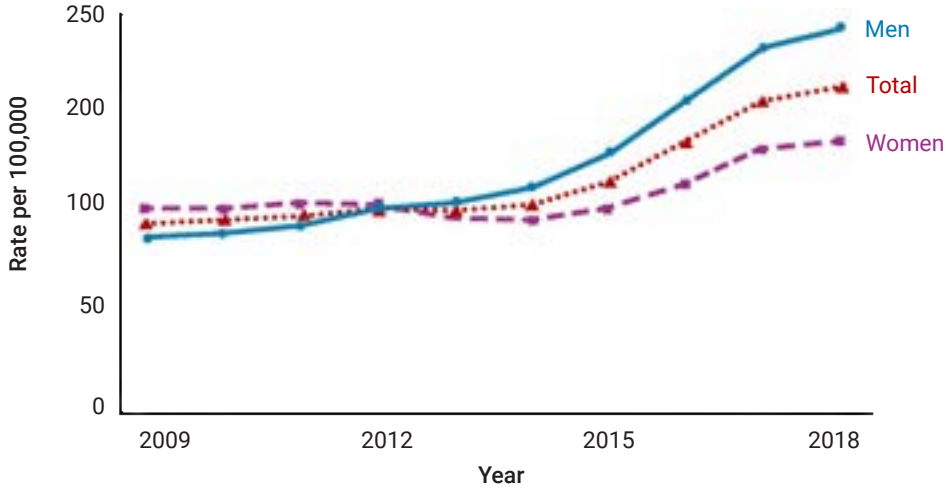


Figure 2. Gonorrhea—Rates per 100,000 reported cases by sex, United States, 2009–2018[1]

CHALLENGES

The greatest challenge to gonorrhea prevention and control is its growing AMR. Gonorrhea typically can be treated with antibiotics; however, *N. gonorrhoeae* is demonstrating resistance against previously recommended treatments, and resistance to currently recommended therapy is increasing. For example, in the United States alone, it is estimated that nearly one-half (550,000) of the estimated annual 1.14 million new infections each year are resistant to at least one antibiotic.[53] Because of this increased resistance, CDC treatment recommendations (see Box 2) are modified as needed to ensure that the most effective regimen is recommended.

Resistance to oral extended-spectrum cephalosporins has been reported in more than 50 countries.[73, 74] Gonorrhea completely resistant to recommended treatment has been detected in other countries. Without intervention, it may only be a matter of time before untreatable gonorrhea emerges in the United States. In addition, developing the capacity for rapid detection of antibiotic susceptibility testing would help public health entities identify and respond to outbreaks more quickly, and would be a major advancement in gonorrhea control.

The critical need for more advanced diagnostic tools and additional therapeutics, as well as vaccines, to prevent infection is further discussed in the innovation goal and strategies in this document.

C. Syphilis

BOX 5

SYPHILIS SNAPSHOT

- Treatable and curable
- Primary and secondary (P&S) syphilis (early-stage disease) may progress to late-stage disease in about 15% of infections, when left untreated
- Screening recommended at least annually for sexually active MSM
- Screening recommended for all pregnant women at the first prenatal visit and, if at high risk for syphilis acquisition during pregnancy, again at 28 weeks and delivery

Epidemiological Facts

115,045 REPORTED CASES OF ALL STAGES (2018)

MSM accounted for 54% of all P&S cases

71% RATE INCREASE OF P&S SYPHILIS (2014–2018)

42% OF MSM WITH P&S SYPHILIS are known to be living with HIV

185% RATE INCREASE IN CONGENITAL SYPHILIS (2014–2018)

Populations Disproportionally Impacted

- MSM
- Pregnant people
- Racial/ethnic minorities

Consequences When Left Untreated

- Ocular and neurologic morbidity
- Cardiovascular, bone, skin, and other organ system morbidity
- Increased risk of HIV
- Congenital syphilis, which can lead to preterm birth, stillbirth, and infant death

Current Challenges

- Lack of provider awareness and training on diagnosis, management, and stages of syphilis
- Need for better diagnostics to detect active infection
- Lack of prenatal screening and timely treatment
- Only one antibiotic available to treat syphilis in pregnancy and newborns
- Shortages of recommended antibiotics for treatment
- Lack of an available vaccine

Sources: CDC[1], Workowski and Bolan[35]

Syphilis is caused by the bacterium *Treponema pallidum*. Disease begins with P&S syphilis, which generally occurs within a few weeks to months of infection. Primary syphilis manifests as a genital sore(s) or lesion(s), generally at the anatomical site where the bacteria first entered the body. Secondary syphilis is characterized by skin rashes and mucous membrane lesions (sores) or both at a site(s) distant from the primary lesion.[75]

After a period of latency (during which time there are no visible signs or symptoms), often decades later, it may progress because of a lack of diagnosis, treatment, and/or timely care to tertiary syphilis, the most advanced stage of the disease. Tertiary syphilis is rare but can affect multiple organ systems including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints.[75] However, ocular and neurologic syphilis can occur at any stage of disease. Congenital syphilis occurs when a pregnant woman passes the infection to her fetus during pregnancy (see the next section for details).

During 2018, CDC received 115,045 reports of syphilis cases, including 35,063 cases of P&S syphilis.[1] Rates of P&S syphilis increased by 71% during 2014–2018 (see Figure 3).[1]

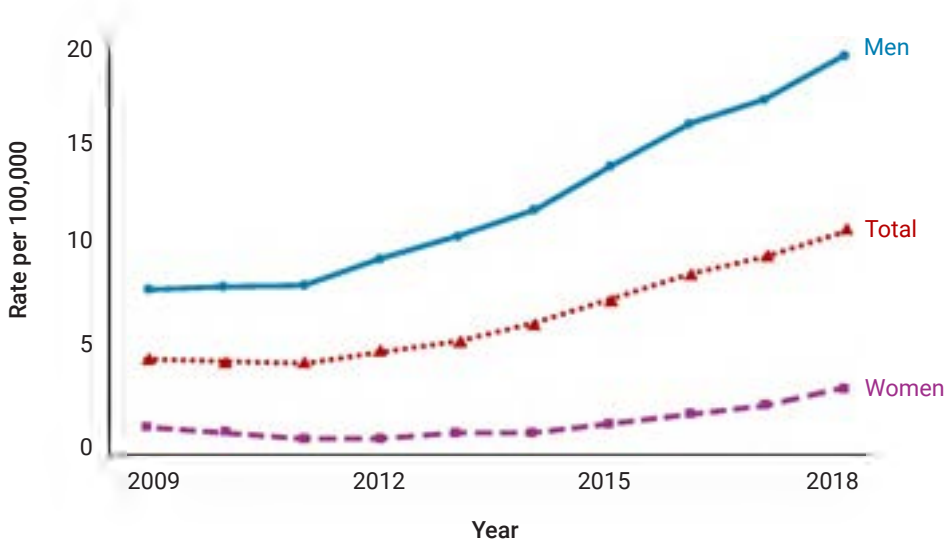


Figure 3. P&S Syphilis—Rates per 100,000 reported cases by sex, United States, 2009–2018[1]

P&S syphilis cases have risen disproportionately among MSM. From 2014 to 2018, the estimated rate of P&S syphilis among MSM increased 49%. In 2018, MSM accounted for 54% of all reported P&S syphilis cases.[1] Among MSM with P&S syphilis, 42% were known to be living with diagnosed HIV.[1]

CONGENITAL SYPHILIS

Congenital syphilis occurs when a pregnant woman who is infected with syphilis transmits the infection to her fetus. Congenital syphilis is considered a sentinel health event and may reflect multiple missed opportunities for prevention and the timely diagnosis and treatment of syphilis among pregnant women.§ Pre-conception care and the support for planned pregnancies is the first step to preventing congenital syphilis. In primary care, people of childbearing potential should be counseled about STI prevention and the benefits of planned pregnancies, and tested for syphilis if at risk. Once in prenatal care, pregnant women should be tested for syphilis at the first prenatal visit and, if at high risk for syphilis acquisition during pregnancy, again at 28 weeks and delivery.[35] Pregnant women who test positive for syphilis should be treated immediately to protect the fetus. Their sexual partners should receive treatment as well. The consequences of untreated syphilis in pregnancy can include miscarriage, stillbirth, and preterm birth. Infants who survive can experience meningitis, anemia, bone abnormalities, and other physical and neurological disabilities.[76]

§ A sentinel health event is a preventable disease, disability, or untimely death whose occurrence serves as a warning signal that the quality of preventive and/or therapeutic medical care may need to be improved.

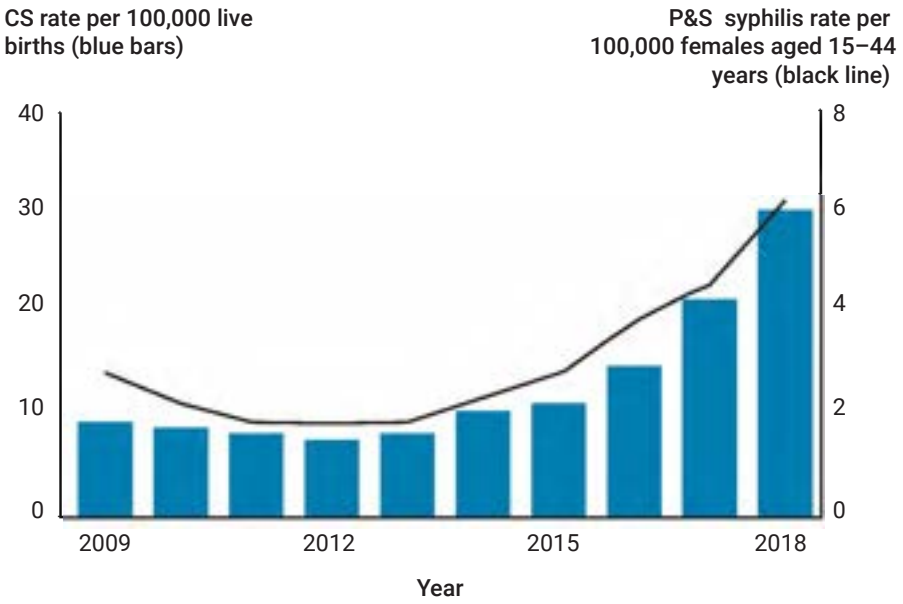


Figure 4. Congenital syphilis—Reported rates by year of birth and reported rates of P&S syphilis among females aged 15–44, United States, 2009–2018[1]

During 2018, CDC received 1,306 reports of congenital syphilis cases, representing a national rate of 33.1 cases per 100,000 live births. From 2014 to 2018, there was an alarming 185% increase in the rate of congenital syphilis in the United States (see Figure 4).[1] Increases in the rate of congenital syphilis have paralleled increases in the rate of P&S syphilis among females of reproductive age (i.e., 15–44 years). During 2018, the highest rates of congenital syphilis cases were in the West and in the South (as defined by the U.S. Census Bureau).

CHALLENGES

The control of both P&S syphilis and congenital syphilis in the United States is challenging for numerous reasons. Often labeled an "imitator," syphilis is notoriously difficult to diagnose, especially for providers who lack awareness and training to diagnose syphilis in the differentiated stages. The most commonly used tests are cumbersome, difficult to interpret, unable to diagnose early infections, and may lead to treatment delays. Tests to directly detect the presence of syphilis-causing bacteria in lesions are not widely available. There is a critical need for commercially available, direct-detection tests to detect active infection. Quick and accurate tests to diagnose the disease, such as POC tests, may reduce the adverse consequences and transmission.

A number of challenges have the most impact on congenital syphilis. Early prenatal care and screening and treatment (including of partners) are critical ways to prevent congenital syphilis and to lower the prevalence of adverse outcomes generally. Providers are missing cases among some people who do receive prenatal care. Further, an examination of U.S. congenital syphilis cases reported in 2018 found that one in two newborn syphilis cases in the United States occur due to gaps in testing and treatment during prenatal care.[77] Data revealed that most cases occur when pregnant women are not tested early during prenatal care (10%), are diagnosed but not adequately treated for syphilis (31%), or acquired syphilis later in pregnancy after an initial negative test (11%). Although most failures occur while pregnant women are receiving some level of prenatal care, one in four cases occur in the absence of timely prenatal care. Commonly missed opportunities also differed by region, underscoring the importance of tailoring prevention solutions to the needs of affected communities. Policy changes to address these screening and treatment lapses and other barriers to obtaining early and adequate prenatal care for pregnant women at high risk may curb the rise of congenital syphilis.

Lack of provider training, drug shortages, and lack of new treatment options further thwart the effort to control syphilis. In addition to training on diagnosis, clinicians require training on recommended treatment across the different stages and on best practices for managing syphilis, including monitoring for treatment efficacy and tracing and managing contacts. The shortage of Benzathine penicillin G, which the WHO reports has been routinely observed, is especially problematic when treating pregnant women because penicillin is the only known effective antimicrobial for preventing maternal transmission to the fetus and for treating fetal infection.[78] Research on new treatment options is critical to prevention of congenital syphilis.[77]

D. HPV and HPV Vaccination

BOX 6

HPV AND HPV VACCINATION SUPPORT

- Up to 92% of cancers that are attributed to HPV can be prevented with the HPV
- HPV vaccination recommended for youth aged 11–12 and young adults through age 26 who are not up-to-date with vaccine recommendations

Epidemiological Facts

APPROXIMATELY 79 MILLION AMERICANS ARE CURRENTLY INFECTED WITH HPV

Young people aged 15–24 account for 49% of HPV infections

ONLY 54% OF FEMALES AND 49% OF MALES AGED 13–17 were up-to-date with a completed HPV vaccine series, as of 2018

PREVALENCE OF CANCER-ASSOCIATED HPV DECREASED 86% AND 71%, among females aged 14–19 and 20–24, respectively, in the decade following introduction of the vaccine

Populations Most In Need of Vaccination

- Adolescents and young adults
- HPV vaccination rates are lowest in the South.

Consequences

- Cervical cancer
- Anal cancer
- Vulvar cancer
- Penile cancer
- Vaginal cancer
- Genital warts
- Oropharyngeal cancer

Current Challenges

- Lack of public awareness of HPV vaccine as cancer prevention
- Lack of provider awareness and training on HPV vaccination and vaccine communication strategies
- Missed opportunities to administer vaccine
- Lack of vaccine confidence among parents/caregivers/patients
- Financial barriers for patients and providers; confidentiality barriers

Sources: CDC[1, 79], Workowski and Bolan[35], McClung et al.[80], Senkomago et al.[64]

HPV remains the most common STI in the United States. Yet HPV strains that can lead to cancers and genital warts in both men and women are preventable by a widely available, safe vaccine.[81] HPV is transmitted through vaginal, anal, or oral sex, whether or not an infected individual is symptomatic.[79] Approximately 43% of adults aged 18–59 in the United States had HPV genital infection during 2013–2014.[82] It is estimated that 90% of HPV infections resolve without any intervention within 2 years because the body is able to clear the virus.[83] However, in cases where the immune system does not clear the HPV infection, it becomes persistent and can cause more serious health consequences. These can include genital warts (and warts in other areas of contact) and cervical, vulvar, vaginal, anal, penile, and oropharyngeal cancers. It is estimated that as many as 92% of cervical cancers and 70% of oropharyngeal cancers are caused by HPV.[64, 84]

HPV Vaccine

Safe and highly effective vaccines prevent infection with types of HPV that cause most genital warts and cancers caused by HPV.[81] Within a decade following introduction of the vaccination program, prevalence of vaccine targeted HPV types decreased 86% among females aged 14–19 and 71% among females aged 20–24.80 Since the end of 2016, the vaccine available in the United States prevents infection with nine HPV types, two that cause genital warts and seven that cause cancers. Vaccination is most effective when administered prior to the onset of sexual activity.[85] However, series completion rates of HPV vaccination in the United States remain low. As of 2018, only 54% of females and 49% of males aged 13–17 had completed the HPV vaccine series,[1] and only 40% of adults aged 18–26 had received one or more doses of the HPV vaccine.[86, 87]

For up-to-date vaccine recommendations, please refer to the most recent recommendation provided by CDC's Advisory Committee on Immunization Practices (ACIP).

Challenges

There are a number of challenges to the provision of the HPV vaccine as recommended. Some are provider-related, some are related to parental knowledge of and confidence in the vaccine, and some are caused by system-level barriers.

Studies have consistently shown that a strong recommendation from providers is the single best predictor of vaccination, for any vaccine.[88] Delays to vaccine initiation may result in HPV exposure or infection. Yet adherence to HPV vaccination recommendations by providers is lower than that of other childhood immunizations.[89] Failure to recommend and initiate HPV vaccination during adolescent primary care visits or during a visit to administer other routine vaccinations are considered "missed opportunities."[90] Efforts to increase HPV vaccination during annual checkups could provide greater coverage among children and adolescents at a time during the lifespan when the vaccine is most effective. This could be accomplished by increasing provider training in several areas such as the benefits of HPV vaccination and its administration schedule; vaccine counseling to address questions and concerns of parents, caregivers, and patients; and building skills in sexual health conversations and assessments for adolescents and adults. In addition, understanding the disparities in HPV vaccine coverage, such as lower rates in rural areas and in the South, may help providers make a more conscious effort to increase administration of this cancer-preventive vaccine to recommended populations.

A lack of vaccine confidence—caused by limited information or misinformation—prevents some parents from vaccinating their children and some young adult patients from accepting vaccination. Common barriers to HPV vaccination are concerns about safety and side effects, and misunderstanding about the benefits from vaccination and doing so prior to sexual debut.[91] Expanding public awareness of the cancer prevention benefits of the vaccine and implementing strategies to improve parent-provider communication will support the effort to increase HPV vaccination rates.

System-level barriers relating to HPV vaccination also pose issues for patients and providers.[91] People enrolled in Medicaid through Medicaid expansion can obtain routinely recommended vaccines with no cost-sharing, as can people covered by most private health insurance when services are received in-network. However, others may have cost-sharing or no coverage at all, which can be a deterrent to vaccination.[91]

Studies have consistently noted poor insurance coverage as well as reimbursement and cost to purchase the vaccine as barriers to vaccination.[91] Other barriers for adolescents and young people exist regardless of the type of insurance of health care coverage. These include confidentiality and consent issues, less frequent opportunities to interact with a health care provider, confusion about health care decision-making and autonomy, and concerns about STI-associated stigma.[91] A future without HPV-associated cancers is within reach if vaccination rates improve. To accomplish this vision for the future, policies and strategies must effectively address these system-level barriers.

III. STI NATIONAL STRATEGIC PLAN

The vision, goals, objectives, and strategies (Sections III.A, B, and C) set forth in the STI Plan are designed to address the alarming increases in STI rates nationwide, prevent STIs, and prevent and reduce the adverse consequences of STIs. Disproportionately impacted populations and geographical regions (Section III.D) were identified using nationwide data to provide stakeholders with a method to focus limited resources for the greatest impact. Indicators and quantitative targets (Section III.E and Appendix B) will help measure progress toward reducing this public health epidemic. The goals, objectives, and strategies are cross-cutting; their delineation and placement is not intended to limit their applicability to other aspects of addressing STIs. The order within the goals, objectives, strategies, priority populations, and indicators do not indicate any prioritization among them. The methodology for developing the components of the STI Plan is described in Appendix A.

A. Vision

The United States will be a place where sexually transmitted infections are prevented and where every person has high-quality STI prevention, care, and treatment while living free from stigma and discrimination.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.

B. Goals

In pursuit of this vision, the STI Plan establishes five goals:

1. Prevent new STIs

2. Improve the health of people by reducing adverse outcomes of STIs

3. Accelerate progress in STI research, technology, and innovation

4. Reduce STI-related health disparities and health inequities

5. Achieve integrated, coordinated efforts that address the STI epidemic

C. Objectives and Strategies

The STI Plan sets forth objectives for each goal, and strategies for each objective (see Table 1 for definitions). These objectives and strategies are designed to guide federal partners and other stakeholders in achieving the STI Plan's vision and goals. The objectives provide direction for the attainment of each goal. The strategies recommend approaches to achieve the objectives. Numerous objectives and strategies could fit under more than one goal. However, each one has been placed under the goal in which it most closely aligns. A separate STI Federal Implementation Plan (to be released subsequent to this STI Plan) will detail federal partners' plans and activities to implement the goals, objectives, and strategies set forth in this document.

Table 1. Definitions Included in the STI Plan[a]

STI Plan	Federal Implementation Plan
Goals: Broad aspirations that enable a plan's vision to be realized	**Action Steps:** Specific activities that will be performed to implement the strategies and achieve the goals of the plan
Objectives: Changes, outcomes, and impact a plan is trying to achieve	**Progress Reports:** Reports on progress, successes, and challenges
Strategies: Choices about how to best accomplish objectives	

[a] Adapted from the HHS Office of the Assistant Secretary for Planning and Evaluation.

GOAL 1: PREVENT NEW STIs

Goal 1 objectives and strategies exemplify the use of primary prevention to halt the spread of STIs, specifically by preventing them before they occur, including through raising awareness and education. In its clinical prevention guidance for STIs, CDC defines primary prevention methods for health care providers as including an assessment of behavioral risk, which entails an assessment of the patient's sexual behaviors that may increase risk for infection with an STI.[35] The guidance stresses the need to use the clinical encounter to effectively obtain sexual histories and to impart primary prevention messaging such as risk-avoidance and risk-reduction methods. Prevention methods cited in the guidelines include pre-exposure vaccination for STIs where applicable (e.g., HPV, HAV, and HBV), abstinence, client-centered prevention counseling for those who are or have been sexually active, reduction of number of sex partners, and condom use.

Several community-based programs and interventions are recognized as effective approaches to primary prevention of STIs and are described in CDC's *Compendium of Proven Community-Based Prevention Programs*.[92] Examples include interventions to reduce high-risk sexual practices, to delay first intercourse among adolescents in low-income housing developments, to distribute free condoms state-wide, and to collaborate with community champions to increase condom usage among MSM.

The STI Plan recognizes that increasing awareness of STIs, expanding comprehensive STI prevention programs, and engaging health care providers, schools, families, and communities to prevent STIs and promote sexual health are critical activities for enhancing primary prevention of STIs. Suitable primary prevention approaches should be age-appropriate, linguistically and culturally informed, community-centered,

inclusive, stigma-reducing, and grounded in science and medicine. According to the American Academy of Pediatrics, developmentally appropriate and evidence-based education about human sexuality and sexual reproduction provided over time by pediatricians, schools, other professionals, and parents is important to help children and adolescents make informed, positive, and safe choices about healthy relationships, responsible sexual activity, and their reproductive health.[93, 94] As an example, primary prevention for adolescents who are not yet sexually active should encourage open and honest dialogue about the benefits of delaying the onset of sexual activity, completing the HPV vaccination series, and other aspects of sexual health as appropriate. Primary prevention should be a part of comprehensive sexual education, particularly for youth, including abstinence or delayed initiation of sexual activity for those who are not yet sexually active, and non-judgmental information about safer sexual activity for those who are sexually active. CDC advises that the most reliable way to avoid STIs is to not have sex (i.e., anal, vaginal, or oral). Also, for those engaging in sexual activity, being in a long-term mutually monogamous relationship with an uninfected partner is one of the most reliable ways to avoid STIs. CDC also recommends reducing the number of sex partners to decrease risk for STIs and notes that correct and consistent use of the male latex condom is highly effective in reducing STI transmission.[95]

GOAL 1: PREVENT NEW STIs

Objectives

1.1 Increase awareness of STIs and sexual health

1.2 Expand implementation of quality, comprehensive STI primary prevention activities

1.3 Increase completion rates of routinely recommended HPV vaccination

1.4 Increase the capacity of public health, health care delivery systems, and the health workforce to prevent STIs

Youth can also benefit from increased private and confidential time with their providers during preventive care visits to improve the value of screening and counseling on STIs, reproductive health, pregnancy prevention, mental health, and SUDs.[96] Primary prevention also involves activities, strategies, and policies that improve youth connectedness—that is, foster a sense of being cared for, supported, and connected to school, family (e.g., parents and caregivers), providers, or other important people and organizations in their lives.[97] Youth who feel connected at school and home are less likely to experience negative health outcomes related to sexual risk, SUDs, violence, and mental health.[97]

Unlike for chlamydia, gonorrhea, and syphilis, a safe and efficacious vaccine is available for HPV. Increasing HPV vaccination rates and reducing the incidence of new STI infections will require strategic efforts to improve vaccine confidence and increase opportunities to access HPV vaccination. Here the STI Plan intersects with the Vaccines National Strategic Plan 2021–2025, which addresses the issue of vaccine confidence in great detail. Among other strategies, the Vaccines Plan emphasizes the importance of engaging trusted community members and organizations to develop effective messages and strategies to enhance vaccine confidence and acceptance in these communities.

Additional capacity, resources, incentives, training, partnerships, and integration of efforts are all critical elements that must be addressed before we will be able to reverse the alarming trend of rising STI rates in the United States.

Primary prevention and interventional approaches informed the development of objectives that will support the goal of preventing new STIs. The following objectives and strategies are critical to achieve the goal of preventing new STIs.

Objective 1.1: Increase awareness of STIs and sexual health

Strategies:

1.1.1 Develop and implement culturally sensitive and linguistically appropriate campaigns to provide education on sexual health, STI primary prevention, testing, and treatment that reduce STI-associated stigma and promote sexual health.

1.1.2 Support a non-stigmatizing, comprehensive approach to sexual health education and sexual well-being, especially in adolescents and young adults, that promotes healthy sexual development and relationships and includes both risk-avoidance and risk-reduction messaging at the community level in schools, faith-based organizations, and other community-based organizations.

1.1.3 Integrate STI messaging into existing public health campaigns and strategies.

1.1.4 Increase awareness of STI testing among adolescents, young adults, MSM, and pregnant women.

1.1.5 Increase awareness and education especially among MSM and their providers on the importance of extragenital testing.

Objective 1.2: Expand implementation of quality, comprehensive STI primary prevention activities

Strategies:

1.2.1 Ensure that prevention programs are accessible, comprehensive, and culturally, linguistically, and age appropriate.

1.2.2 Implement STI prevention activities in a broad range of health care delivery, education, and community-based settings through innovative, evidence-based approaches.

1.2.3 Promote safe and supportive environments such as school, family, and community that encourage adolescents and young adults to avoid and decrease STI risk.

1.2.4 Increase private and confidential time for providers with their adolescent patients during preventive care visits to improve the effectiveness of risk assessment, screening and counseling on STIs, reproductive health, mental health, and substance use disorders.

1.2.5 Establish partnerships with both public and private entities to expand and strengthen STI prevention efforts.

Objective 1.3: Increase completion rates of routinely recommended HPV vaccination

Strategies:

1.3.1 Increase confidence in the HPV vaccine by implementing messaging and evidence-based interventions to address scientifically documented barriers to uptake and emphasizing that it prevents cancer.

1.3.2 Dispel myths that lead to HPV vaccine hesitancy in communities by working with trusted community leaders, community-based organizations, and providers to guide strategies and provide culturally affirming messages about HPV vaccination.

1.3.3 Reduce missed opportunities to promote and provide routinely recommended HPV vaccination including catch-up HPV vaccination in accordance with current Advisory Committee on Immunization Practices recommendations.

1.3.4 Integrate HPV vaccination into routine clinical care for adolescents and young adults.

1.3.5 Provide HPV vaccination at a broad range of clinical and nontraditional community-based settings, including pharmacies, retail clinics, and dental offices.

1.3.6 Reduce the financial and system barriers encountered by providers and consumers to providing HPV vaccination.

Objective 1.4: Increase the capacity of public health, health care delivery systems, and the health workforce to prevent STIs

Strategies:

1.4.1 Provide resources, incentives, training, and technical assistance to expand health workforce and systems capacity.

1.4.2 Increase diversity of the workforce that delivers STI prevention services.

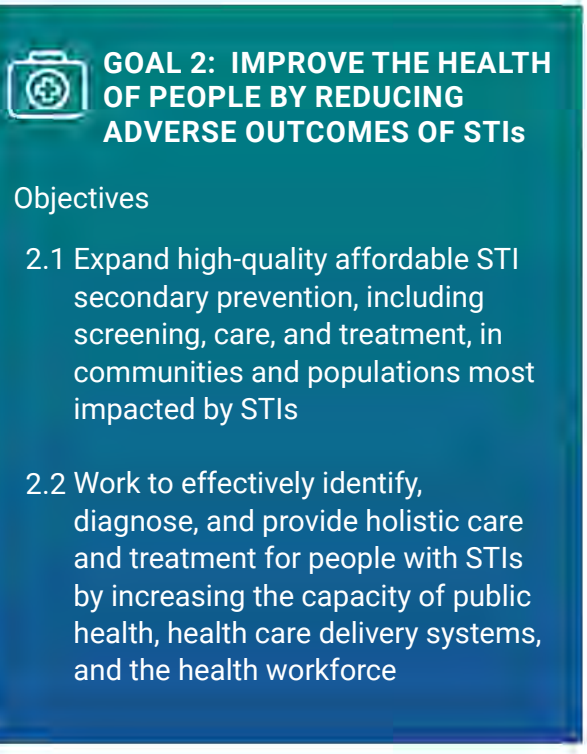
1.4.3 Partner with professional societies and academic institutions to increase awareness and knowledge of sexual health including STI prevention, screening, and treatment, and to strengthen and expand clinical practices that lead to high-quality STI care provided by public health personnel, health care professionals, and paraprofessionals.

1.4.4 Integrate STI prevention with HIV, viral hepatitis, and substance use prevention services across workforces and delivery systems.

GOAL 2: IMPROVE THE HEALTH OF PEOPLE BY REDUCING ADVERSE OUTCOMES OF STIs

Goal 2 objectives and strategies exemplify secondary and tertiary prevention approaches to impede the progression from infection to disease and to treat disease when it occurs. The United States should strengthen efforts to rapidly identify individuals infected with an STI and then provide them with appropriate and timely treatment. Improved screening, care, and treatment for people with STIs is critical to preventing adverse health outcomes associated with untreated infections. Efforts to strengthen our response to STIs will require integrating STI care and treatment into settings beyond medical clinics, expanding the role of DISs, reducing barriers to testing and care, and increasing linkage to care across programs.

STI patients will benefit from expanded and integrated patient-centered care models that address comorbidities. The presence of STIs are recognized as a risk for HIV acquisition, and STI screening is viewed as being "an essential and underutilized component of an STD/HIV risk assessment in most clinical settings."[35] For patients who seek treatment or evaluation for a particular STI (or pregnancy prevention or testing), health care providers are encouraged to screen also for other STIs based on prevalence within their specific community and national recommendations and to perform a comprehensive risk assessment. Increasing STI clinical decision support systems in electronic health records and increasing patient sexual health portals would facilitate this effort. Prevention partners can help improve health outcomes by supporting efforts to increase the capacity of health care systems and providers to screen, diagnose, and treat STIs. Disruptions during the COVID-19 pandemic forced many programs to rapidly innovate and shift to telehealth models and to offer self-collection STI specimen kits. They also underscore the critical need for use of expedited partner therapy, the expertise and need to expand the DIS workforce, as well as the importance of remote models for contact tracing to interrupt transmission and further prevent the



spread of disease. Workforce knowledge of and experience in STIs can be advanced through evidence-based, innovative programs such as Project ECHO® (Extension for Community Healthcare Outcomes), which connects community providers with specialists at centers of excellence in regular, real-time collaborative sessions designed around STI case-based learning and mentorship.

Secondary prevention and interventional approaches informed the development of objectives that emphasize the need to expand screening, while maintaining a focus on the communities most impacted by STIs, and to foster improvements at the system level to increase capacity to diagnose, treat, and provide holistic care for people affected by STI.

The following objectives and strategies are necessary to achieve the goal of improving health by reducing adverse outcomes of STIs.

Objective 2.1: Expand high-quality affordable STI secondary prevention, including screening, care, and treatment, in communities and populations most impacted by STIs

Strategies:

2.1.1 Integrate STI screening, diagnosis, care, and treatment as a routine part of a wide variety of programs and settings including those that screen, diagnose, and treat people for other whole health and public health issues such as primary care, urgent care, emergency departments, pediatrics, family planning, HIV, viral hepatitis, substance use disorders, correctional facilities, and school-based health centers.

2.1.2 Support expanded staffing and role of disease intervention specialists in programs and settings that serve communities and populations disproportionately impacted by STIs.

2.1.3 Reduce systems and financial barriers to receiving STI testing, care, and treatment, including those related to laboratory services and coverage for point-of-care testing, self-collected testing, extragenital testing, expedited partner therapy, and partner services.

2.1.4 Increase STI screening and testing for adolescent and young women, pregnant women, and MSM, including extragenital STI testing among MSM, in accordance with CDC guidelines.

2.1.5 Increase linkage to care between public health, correctional facilities, syringe services programs, substance use disorder treatment facilities, emergency departments, pharmacies, retail clinics, school-based health centers, and other health care providers and community-based organizations to provide coordinated, comprehensive care and treatment for people with STIs.

2.1.6 Increase STI quality measurement and incentives to promote high-quality STI screening, care, and treatment and to reduce missed opportunities in clinical settings.

2.1.7 Increase patient sexual health portals and STI clinical decision support systems in electronic health records to support high-quality sexual health assessments, STI screening, and integrated care models.

Objective 2.2: Work to effectively identify, diagnose, and provide holistic care and treatment for people with STIs by increasing the capacity of public health, health care delivery systems, and the health workforce

Strategies:

2.2.1 Expand workforce knowledge and experience in STI prevention, screening, diagnosis, and treatment through education and training, maintenance of certification, and continuing education programs for health professionals and paraprofessionals.

2.2.2 Expand the capacity of the health workforce to provide STI screening, testing, and care through innovative, evidence-based models such as Project ECHO, mentoring programs, telehealth, express visits, and other models described in Strategy 2.1.5.

2.2.3 Optimize, expand use of, and improve the effectiveness of expedited partner therapy, STI partner services, and linkage to care in programs and settings that provide STI testing and treatment.

2.2.4 Expand integrated, coordinated, patient-centered, trauma-informed care models that address the syndemic of STIs, HIV, viral hepatitis, and substance use disorders, including related comorbidities and social determinants of health.

GOAL 3: ACCELERATE PROGRESS IN STI RESEARCH, TECHNOLOGY, AND INNOVATION

A robust innovation agenda is needed that prioritizes American discovery while streamlining mechanisms to bring scientific advances from the laboratory into clinical practice.[98]

Recognizing the value of innovation is directly relevant to the goals of the STI Plan. Given the significant challenges facing the U.S. public health system, the National Institutes of Health (NIH) recently provided recommendations regarding biomedical research goals to drive development of innovative diagnostics, vaccines, and therapeutics for STIs.[99] Advances in these areas are not only critical to addressing STIs at the societal level, but also needed to achieve the objectives of Healthy People 2030, which include decreases in rates of gonorrhea and syphilis and increases in screening for chlamydial infections.[100]

Support for innovation will strengthen STI prevention, diagnosis, care, and treatment. To accelerate STI innovation, federal partners should prioritize and promote the development and assessment of appropriate data to support approval of STI prevention tools such as vaccines, diagnostics, therapeutics, and microbicides. Timely diagnosis and effective treatment of STIs to avert disease progression will be facilitated by advancing STI POC diagnostics; addressing AMR to STI treatments; and scaling up evidence-based, innovative STI service delivery models (e.g., express visits, telehealth, and self-testing outside of clinical facilities). In some settings, STI express visits have been shown to increase clinic capacity,[101, 102] decrease cost, reduce time to treatment,[103] and reduce patient visit time.[104] Modeling studies have shown that express-testing models could lead to reduced transmission through increased testing and early detection.[105] The urgent threat of AMR gonorrhea dictates the need to scale up effective antimicrobial stewardship programs to ensure optimal use of antimicrobial drugs and preserve their effectiveness and to develop tests that can quickly assess the level of susceptibility to relevant antibiotics without resorting to culture. CDC is working to strengthen infrastructure to combat resistant gonorrhea.[106] Enhancement of the capacity

GOAL 3: ACCELERATE PROGRESS IN STI RESEARCH, TECHNOLOGY, AND INNOVATION

Objectives

3.1 Support research and investments to develop STI vaccines and bring them to market

3.2 Support the development and uptake of STI multipurpose prevention technologies, antimicrobial prophylaxis regimens, and other preventive products and strategies

3.3 Support the development and uptake of innovative STI diagnostic technologies, therapeutic agents, and other interventions for the identification and treatment of STIs, including new and emerging disease threats

3.4 Identify, evaluate, and scale up best practices in STI prevention and treatment, including through translational, implementation, and communication science research

to rapidly detect susceptibility and resistance and development of novel rapid molecular tests, which signal use of the most appropriate drug, would be major advancements toward control of gonorrhea.

Rapid POC STI tests are the most efficient way to improve early diagnosis and support same-day treatment. For example, a new U.S. Food and Drug Administration (FDA)-cleared, 30-minute molecular POC assay for the detection of chlamydia and gonorrhea has shown high specificity and sensitivity in both women (vaginal swab) and men (first-catch urine).[107] Mathematical modeling suggests that rapid POC tests with high sensitivity (>90%) may substantially reduce infections and PID cases. In addition to the use of rapid tests conducted by providers, a market has grown for the use of self-collected tests for home use and other opportunities outside of clinical settings. The COVID-19 pandemic has magnified the need for and benefit of such tests. However, no self-collection–based tests for chlamydia, gonorrhea, or syphilis are currently approved by FDA. More work is needed to ensure universal self-collection for appropriate specimens, and a program or method to ensure affordable access to them for insured and uninsured patients is critical. In addition, states that prohibit distribution and possession of self-tests should revisit their laws and policies, but remain in conformance with relevant FDA regulations. Increased use of collaborative practice agreements will expand care and treatment in different settings. Scale-up of express testing, self-testing, and delivery of non-vaccine injectables administered by pharmacists (e.g., ceftriaxone) will enable integration of STI testing in alternative settings (e.g., SUD programs, pharmacies, retail clinics) and will increase reach to people at increased risk for STIs who may not seek care in traditional clinical settings.

The development of other innovative preventive products such as multipurpose prevention technologies (MPTs), which are all-in-one tools that combine contraception with protection against STIs including HIV, require support and exploration.[108, 109] To date condoms are the most basic example of MPTs; development of MPTs has focused mostly on tools that prevent HIV, rather than other STIs, and unintended pregnancy. MPTs may have broad prevention appeal as they have the potential to meet both the sexual and reproductive health needs of an individual. Several unique regulatory issues will need to be addressed by FDA and other relevant regulatory agencies, such as design and implementation of clinical efficacy studies and evaluation of drug-drug interactions.

Investment in research, commercialization, and translation into practice will lead to more innovative, evidence-based prevention models, technologies, and products to reduce the incidence of STIs and the STI epidemic. In addition, the affordability and supply of new and existing preventive and therapeutic agents need to be considered to better ensure translation into practice and access. Innovations in payment models, such as subscription approaches, can support innovators' and manufacturers' return on investment while ensuring access for the public and appropriate use. Development of major biomedical interventions—such as vaccines for chlamydia, gonorrhea, and syphilis, which may reduce the spread of infection and mortality—should be prioritized. To complement innovative service delivery models, comprehensive communication strategies should be crafted with the aims of emphasizing the importance of sexual health, reducing stigma, and linking patients to STI services. These strategies should be informed by behavioral, social, clinical, and epidemiologic science as well as health economics. Regulatory support, commercial investment, and academic, public, and private partnerships are all needed to successfully accelerate progress in these areas.

The following objectives and strategies are recommended to achieve the goal of fostering innovations in STI prevention, care, and treatment.

Objective 3.1: Support research and investments to develop STI vaccines and bring them to market

Strategies:

3.1.1 Increase research to improve understanding of STI pathogenesis, immunity, and correlates of protection.

3.1.2 Develop and leverage academic, public, and private partnerships for vaccine development, approval, and manufacture.

3.1.3 Ensure that critical pathways exist to facilitate STI vaccine approval and to bring newly licensed STI vaccines to market.

3.1.4 Ensure vaccine development and distribution is rooted in racial, ethnic, and sexual and gender identity equity and is community-informed to best serve those disproportionally affected by STIs.

Objective 3.2: Support the development and uptake of STI multipurpose prevention technologies, antimicrobial prophylaxis regimens, and other preventive products and strategies

Strategies:

3.2.1 Develop and leverage academic, public, and private partnerships for the development, approval, and manufacture of multipurpose prevention technologies and other preventive technologies and products.

3.2.2 Advance research on pre-exposure and post-exposure prophylaxis.

Objective 3.3: Support the development and uptake of innovative STI diagnostic technologies, therapeutic agents, and other interventions for the identification and treatment of STIs, including new and emerging disease threats

Strategies:

3.3.1 Develop new STI treatment options to address antimicrobial resistance, supply chain limitations, and other barriers.

3.3.2 Support the development of molecular diagnostic tests to rapidly identify and characterize antimicrobial resistance.

3.3.3 Advance the development and uptake of point-of-care and self-collected STI diagnostics.

3.3.4 Develop and leverage academic, public, and private partnerships for the development, approval, and manufacture of new, as well as short supplied and/or high cost existing, STI diagnostic technologies, therapeutic agents, and other interventions.

Objective 3.4: Identify, evaluate, and scale up best practices in STI prevention and treatment, including through translational, implementation, and communication science research

Strategies:

3.4.1 Expand implementation of innovative, evidence-based models that increase the quality and convenience of STI testing, care, and treatment, such as telehealth, STI express clinics, pharmacy-based services, self-collected testing, mobile field-based units, and expedited partner therapy.

3.4.2 Develop, assess, and support the scale-up of innovative STI service delivery models in settings such as clinics, pharmacies, schools, mental health programs, substance use disorder programs, retail clinics, and field and community settings.

3.4.3 Develop policies that facilitate the implementation of innovative and effective STI prevention and treatment models and technologies, including the appropriate use of antibiotics.

3.4.4 Advance communications and implementation science to raise the visibility of STIs and sexual health, promote uptake of STI vaccines, and scale up novel STI prevention technologies and products.

GOAL 4: REDUCE STI-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

STIs disproportionately affect specific communities and populations. These disproportionate impacts may be attributable to social determinants of health such as lack of access to STI preventive programs and services, discriminatory practices, and social stigma that can negatively affect access to care and outcomes. As part of its report on STIs, the NAPA Panel addressed health equity concerns, recognizing that certain communities are "uniquely vulnerable" to STIs as a result of a range of social and economic factors.[9] Among the factors contributing to disproportionate rates of STI among certain groups, the report cites limited access to services, increased likelihood of high-risk behaviors, and distrust of the health care system. A CDC study examining social determinants of health and STDs found that rates of syphilis, HIV/AIDS, chlamydia, and gonorrhea were 5.4 to 17.8 times higher in Black communities than among white communities.[110] The report also acknowledged that disparities can be due to geographic segregation, health care provision and use, and socioeconomic status. In addition to the disparities cited among racial and ethnic groups, sexual and gender minority populations experience higher rates of some STIs.[111] Individuals who identify with multiple minority populations and experience intersecting stigmas may have increased burden of STIs.[112, 113] In addition, poverty, lack of insurance, unstable housing, and underemployment are all associated with higher rates of STIs in communities.

GOAL 4: REDUCE STI-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

Objectives

- 4.1 Reduce stigma and discrimination associated with STIs
- 4.2 Expand culturally competent and linguistically appropriate STI prevention, care, and treatment services in communities disproportionately impacted by STIs
- 4.3 Address STI-related social determinants of health and co-occurring conditions

To address the STI epidemic, recognizing the negative impacts of stigma and the importance of cultural competence is required. CDC's *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020*, provides recommendations to U.S. health care providers for quality clinical services for STIs in both primary and STI specialty care settings. The report acknowledges IOM's framework for health care quality that is "essential for provision of quality [STI] clinical care services."[48, 114] The framework includes the element of patient-centeredness, which is intended to "ensure attention to issues that disproportionally affect vulnerable populations" and to facilitate a "friendly and welcoming environment through cultural sensitivity."[48] Lastly, the framework includes the element of equity, with the intent of ensuring universal access to quality health care. For example, 11 states have laws that criminalize behavior that potentially exposes others to STIs.[20] Criminalization laws are another and tangible negative impact of stigma that often do not reflect the evidence. The U.S. Department of Justice, in guidance still in effect in the context of HIV, has encouraged states to use scientific evidence to re-examine such laws.[115]

Federal partners have a role in reducing STI-related health disparities by supporting communities to engage in local solutions and training providers to deliver culturally competent, trauma-informed, and compassionate comprehensive sexual health care, free of judgment and discrimination. Social determinants of health and comorbidities must be addressed to reduce STI-related health disparities and inequities. Efforts to do so include promoting STI prevention and care in programs such as those involving housing, education, and the justice system, as well as those linking STI patients to medical home, behavioral health, housing, food, and employment resources. For example, CDC has funded the *Community-based Approaches to Reducing STDs* initiative to support efforts to improve the health of populations disproportionately affected by STIs.[116] The initiative's key strategies include responding to social determinants of sexual health, improving the design and

implementation of STI prevention services, and promoting individual health care–seeking behavior in more than 12 unique communities. Structural changes that grew out of the projects have led to new referral systems in the areas of education, substance use treatment, and even employment.

The STI Plan's tailored objectives support the goal of reducing STI-related health disparities and health inequities. These include objectives that emphasize patient-centered improvements such as reducing stigma associated with STIs and fostering treatment service environments that are more conscious of the needsof affected populations. In addition, an important objective is intended to foster improvement in social determinants of health and comorbidities, which can both amplify and perpetuate the negative impact of STIs.

The following objectives and strategies are critical to achieve the goal of reducing STI-related health disparities and health inequities.

Objective 4.1: Reduce stigma and discrimination associated with STIs

Strategies:

4.1.1 Support and encourage training of health care and health systems personnel in cultural sensitivity, bias, discrimination, and disparities associated with STIs.

4.1.2 Work with communities to address misconceptions and reduce stigmas that negatively affect STI prevention, screening, testing, care, and treatment.

4.1.3 Expand and encourage self-collected testing, opt-out testing for STIs, and other approaches that promote sexual health and STI testing in health care delivery.

4.1.4 Promote privacy and confidentiality of individual personal health and public health records especially for adolescents and young adults.

4.1.5 Re-examine laws that criminalize behavior that potentially exposes another person to an STI.

Objective 4.2: Expand culturally competent and linguistically appropriate STI prevention, care, and treatment services in communities disproportionately impacted by STIs

Strategies:

4.2.1 Train providers, including primary care, specialty, and nontraditional providers, to deliver high-quality, culturally and linguistically appropriate, nondiscriminatory, nonjudgmental, compassionate, and comprehensive sexual health services to populations disproportionately impacted by STIs.

Objective 4.3: Address STI-related social determinants of health and co-occurring conditions

Strategies:

4.3.1 Expand policies and approaches that promote STI prevention and care in programs involving housing, education, transportation, the justice system, and other systems that impact social determinants of health.

4.3.2 Promote innovative programs and policies that provide patients with resources that address social determinants of health, including housing, education, transportation, food, and employment.

4.3.3 Improve data collection and surveillance of STIs in populations that are underrepresented in current data.

GOAL 5: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE STI EPIDEMIC

Coordination among programs, including the input of community-based organizations, is essential to address adequately the ongoing STI epidemic. Such efforts help identify synergies, reduce duplication of efforts, and integrate policies and programs across the syndemic. Coordination across services and programs—including the input of community-based organizations—at the individual level also facilitates more patient-centered, comprehensive approaches to care.

GOAL 5: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE STI EPIDEMIC

Objectives

5.1 Integrate programs to address the syndemic of STIs, HIV, viral hepatitis, and substance use disorders

5.2 Improve quality, accessibility, timeliness, and use of data related to STIs and social determinants of health

5.3 Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving national STI goals

Integration among efforts is needed to address the syndemic of STI, viral hepatitis, HIV, and SUD. A 2020 NASEM report acknowledges that "overlapping risk factors, injection opioid use and risky sexual behaviors undermine national strategies to end HIV … viral hepatitis, and other infectious diseases [including other STIs]"[57] and recommends that integrated medical services be used to address the syndemic.

The need for integrated care is also set forth in CDC's *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services*.[48] The federal government is already making efforts to integrate programs. For example, as part of EHE,[117] integrated services are being strengthened in response to the syndemic through funding opportunities and use of core funds. These activities allow for programs to scale up HIV prevention services in STI specialty clinics, enhance and expand integrated screening activities (e.g., STIs, viral hepatitis, and/or tuberculosis) conducted in conjunction with HIV testing with accompanying referral for prevention care and services, and diagnose and treat STIs for uninsured or underinsured people receiving care in not-for profit or government clinics when conducted in conjunction with HIV testing.

A more coordinated approach to the epidemic will require that STI prevention, care, and treatment are integrated across services and programs. This cross-cutting theme is also central to other national strategic plans that HHS, in collaboration across its agencies and other federal departments, expects to release this year—the HIV Plan and the Hepatitis Plan—all of which have been developed in alignment with each other. These strategic plans and other federal initiatives provide further opportunities to incorporate STI prevention and control measures similar to the efforts discussed above. Further mechanisms should be explored to leverage the established infrastructure for HIV services as an entry point for people seeking prevention and treatment services for other STIs. For all services and programs, at all levels, cross-agency collaboration can create efficiencies that are cost-effective, facilitate exchange of ideas and strategies, support efforts to improve data quality and accessibility, align translational and implementation research efforts, and improve people's health.

The objectives for Goal 5 focus on areas where national programs (or programs on a state or local level) align or should align, improving quality of prevention and care in a variety of ways including through collection and use of data, coordination across programs, and monitoring and evaluation of progress. These steps will allow for reinforcement and sharing of successful approaches as well as rapid corrections when the desired outcomes are not being achieved. A system of regular reporting also enables entities to make informed decisions about the allocation of resources and to better advocate for unmet needs.

The following objectives and strategies are recommended to establish integrated, coordinated efforts that address the STI epidemic across programs and agencies.

Objective 5.1: Integrate programs to address the syndemic of STIs, HIV, viral hepatitis, and substance use disorders

Strategies:

5.1.1 Establish and scale up integration of STI-related efforts, policies, and programs involving all components of the syndemic.

5.1.2 Integrate STI prevention, screening, testing, care, and treatment in funding opportunities that address other components of the syndemic.

Objective 5.2: Improve quality, accessibility, timeliness, and use of data related to STIs and social determinants of health

Strategies:

5.2.1 Strengthen and expand existing surveillance infrastructure and methods including the capacity for more real-time data sharing between public health authorities and health care providers.

5.2.2. Incorporate novel scientific approaches for monitoring, identifying, and responding to trends in STIs and STI sequelae and social determinants of health related to STIs.

5.2.3 Strengthen and expand surveillance to identify rapidly cases of antimicrobial resistant STIs.

5.2.4 Strengthen and expand existing health care data and quality measures to assess provider adherence to recommended guidelines for STI screening, care, and treatment.

5.2.5 Leverage technology and invest in data solutions to modernize and improve the efficacy of partner services.

5.2.6 Ensure timely dissemination of data and analyses related to STI surveillance, public health, and health care data to inform decision-making.

5.2.7 Work to align indicators across programs that address STI, HIV, viral hepatitis, preventive care, maternal care, pediatrics, family planning, and substance use disorder treatment and services.

Objective 5.3: Improve mechanisms to measure, monitor, evaluate, report, and disseminate progress toward achieving national STI goals

Strategies:

5.3.1 Encourage entities to integrate STIs and sexual health into existing and future implementation plans that address or relate to other communicable infections or substance use disorders.

5.3.2 Monitor, review, evaluate, and regularly communicate progress on STI program implementation according to an established schedule and address areas of deficiency.

5.3.3 Develop and implement recommendations promoting policies, programs, and activities that accomplish goals and address areas for improvement.

D. Priority Populations and Geographic Areas

Although STIs affect millions of Americans nationwide and from all social, economic, and racial and ethnic groups, they disproportionately impact certain populations and communities. STI prevention and control efforts can be more efficient and effective by identifying and focusing efforts on those populations that bear a disproportionately higher burden of infection. Focusing on such priority populations will also reduce health disparities and have the most impact on the health of the nation. This approach should not diminish efforts to increase awareness of, prevent, and treat STIs among all Americans and integrate STI efforts across other components of the syndemic.

PRIORITY POPULATIONS BASED ON NATIONAL-LEVEL DATA

National incidence, prevalence, and morbidity rates indicate that adolescents and young adults, MSM, and pregnant women are most impacted by the four STIs addressed in the STI Plan (see Table 2). Within each of these populations, certain racial and ethnic minorities (Blacks, AI/AN, and Hispanics) and certain regions of the United States (South and West) are further disproportionately impacted by these STIs. People may belong to none, one, or several of these populations and communities. The priority populations identified are not specific to each particular STI. Not surprisingly, these priority populations overlap with those most impacted by some other components of the syndemic such as HIV. This underscores the need for an integrated approach to addressing the components of the syndemic. As described below, jurisdiction- or community-level data may indicate different and/or additional populations and communities disproportionately impacted by STIs.

There are limited national data and analyses on the incidence of STIs in certain populations due to the lack of accurate disaggregated data, incomplete reporting of data both at the patient and provider level, and data reporting biases. For example, data among persons with disabilities, certain racial and ethnic groups, incarcerated persons, sexual and gender minorities,** among others, may be inaccurately or insufficiently reported. The data-driven approach of this STI Plan in identifying priority populations did not result in these groups being identified as the most disproportionately impacted in the nation. However, the stigma, discrimination, and inequities faced by some minority populations are discussed in this plan and should be recognized and further studied. Thus, the plan includes strategies that call for the expansion of data collection and the improvement of surveillance systems to better account for and understand any disparities that may exist.

National-level data for calendar year 2018, provided below for each priority population and subgroup, illustrate the disparate impact of the four STIs. Additional data are available in CDC's 2018 Sexually Transmitted Disease Surveillance report and are posted on CDC's website as they become available. This report is the source for all data cited below unless otherwise specified.

** Beginning January 2018, CDC added separate data elements for gender identity and sexual orientation to the National Notifiable Disease Surveillance System regarding STDs, provided guidance to implement data elements, and requested jurisdictions begin reporting the new data elements. The National Electronic Telecommunications System for Surveillance (NETSS) CDC Implementation Plan for STD Surveillance Data (effective as of January 2018), available at: https://www.cdc.gov/std/program/STD-NETSSIMPLN-V5_2018Jan.pdf; National Notifiable Diseases Surveillance System Message Mapping Guide for Sexually Transmitted Diseases, available at: https://wwwn.cdc.gov/nndss/case-notification/message-mapping-guides.html.

Table 2. Priority Populations and Summary National-Level Data, Calendar Year 2018

Adolescents and Young Adults

- People aged 15–24 account for approximately 50% of the 20 million new STIs in the United States each year, yet approximately 25% of the sexually active population.
- People aged 15–24 account for 62% of chlamydia cases.
- Among females, those aged 20–24 had the highest rate of reported gonorrhea cases; those aged 15–19 had the second highest rate.
- The rate of P&S syphilis among females aged 15–24 increased 100% from 2014 to 2018.
- Young people aged 15–24 account for 49% of HPV infections.[118] Yet only 51% of adolescents and young adults are fully vaccinated against HPV.[87]

Men Who Have Sex with Men

- MSM accounted for 54% of reported P&S syphilis cases.
- The rate of P&S syphilis among MSM in 2018 was 37 times the national rate of 10.8 P&S syphilis cases per 100,000.[a]
- Gonococcal isolates from MSM are more likely to exhibit AMR than isolates from men who have sex with women only.
- Ten percent of new HIV infections among MSM are estimated to be attributable to gonorrhea and chlamydia, equating to 2,600 HIV infections each year.[66]
- Less than 20% of MSM living with HIV receive extragenital gonorrhea or chlamydia screening, based on CDC screening recommendations for MSM.[119]

Pregnant Women

- The rate of P&S syphilis among females aged 15–44 increased 165% from 2014 to 2018 (2.6–6.9 cases per 100,000).
- The rate of congenital syphilis cases has increased 185% since 2014, with 1,306 cases and a rate of 33.1 cases per 100,000 live births in 2018.
- In 2018, congenital syphilis cases included 78 syphilitic stillbirths and 16 infant deaths, a mortality rate of 7.2%.

[a] Estimated rates of P&S syphilis among MSM were calculated by dividing the number of P&S syphilis cases reported among MSM in 2018 by the estimated number of MSM in 2018. See CDC 2018 Surveillance Report (Figure 39) for numerator and Grey et al.[120] for denominator.

Subgroups

Racial and Ethnic Minorities

Blacks, AI/AN, and Hispanics have higher reported rates of STI than whites.

Chlamydia: The rate of reported chlamydia cases among Black males was 6.8 times the rate among white males; among Black females was 5.0 times the rate among white females; among AI/AN was 3.7 times the rate among whites; and among Hispanics was 1.9 times the rate among whites.

Gonorrhea: The rate of reported gonorrhea cases among Blacks was 7.7 times the rate among whites; among AI/AN was 4.6 times the rate among whites; and among Hispanics was 1.6 times the rate among whites.

P&S Syphilis: The rate of reported P&S syphilis cases among Blacks was 4.7 times the rate among whites; among AI/AN was 2.6 times the rate among whites; and among Hispanics was 2.2 times the rate among whites.

Congenital Syphilis: The rate of reported congenital syphilis cases among Blacks was 6.4 times the rate among whites; among AI/AN was 5.9 times the rate among whites; and among Hispanics was 3.3 times the rate among whites.

Figure 5 depicts disparities in the rates of reported chlamydia, gonorrhea, P&S syphilis, and congenital syphilis among selected racial and ethnic groups. Please note that the scale among each of the graphs below are different.

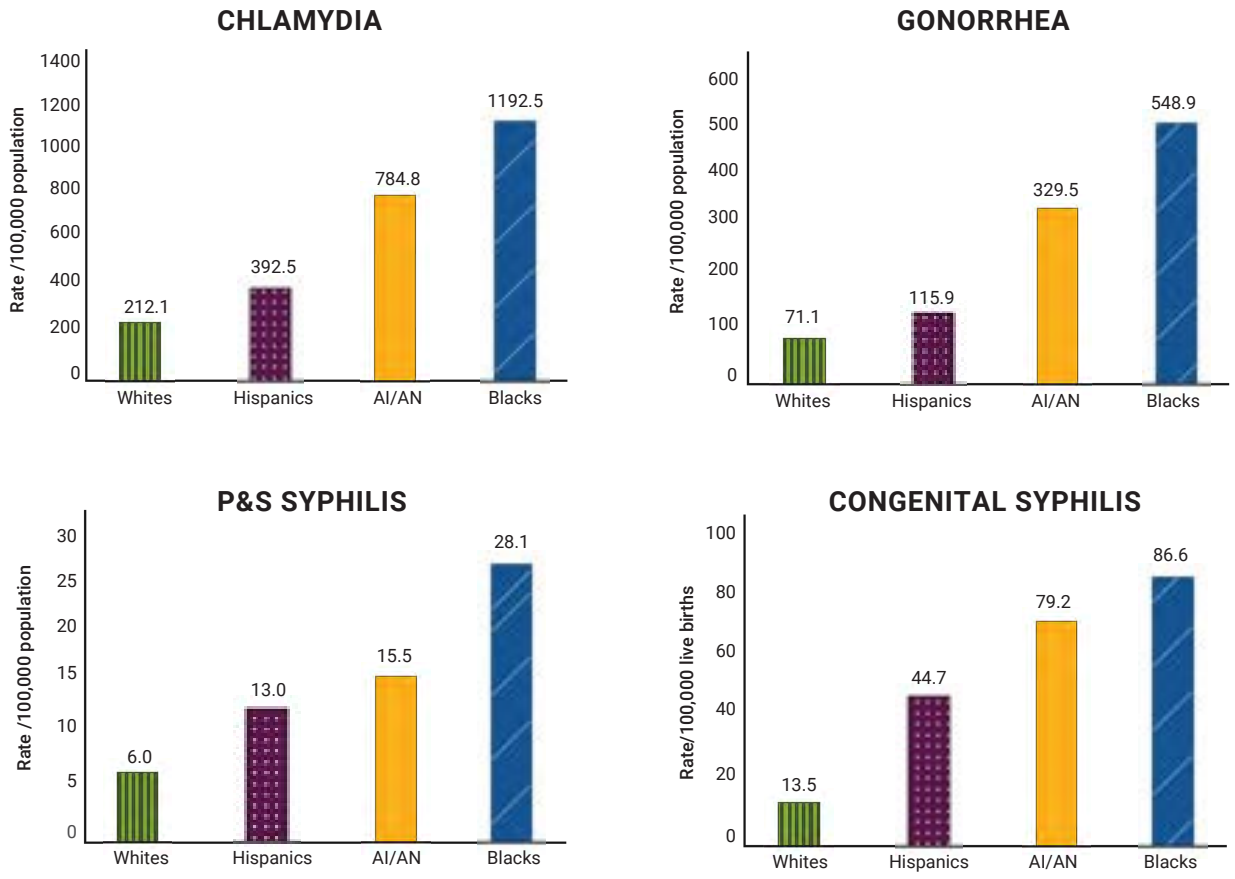


Figure 5. Disparities in reported rates of STIs by race/ethnicity, 2018[1]

Geographic Regions

The South and West, as defined by the U.S. Census Bureau, are the U.S. regions most heavily impacted by the overall STI epidemic (see Figures 6 and 7). The 2018 rates of reported cases for each of the three STIs including congenital syphilis (Figure 6), along with rates of HPV vaccination (Figure 7), were as follows:

- **Chlamydia:** highest in the South
- **Gonorrhea:** highest in the South and the West
- **P&S Syphilis:** highest in the West
- **Congenital Syphilis:** highest in the West
- **HPV** vaccination series initiation and completion rates: lowest in the South[121]

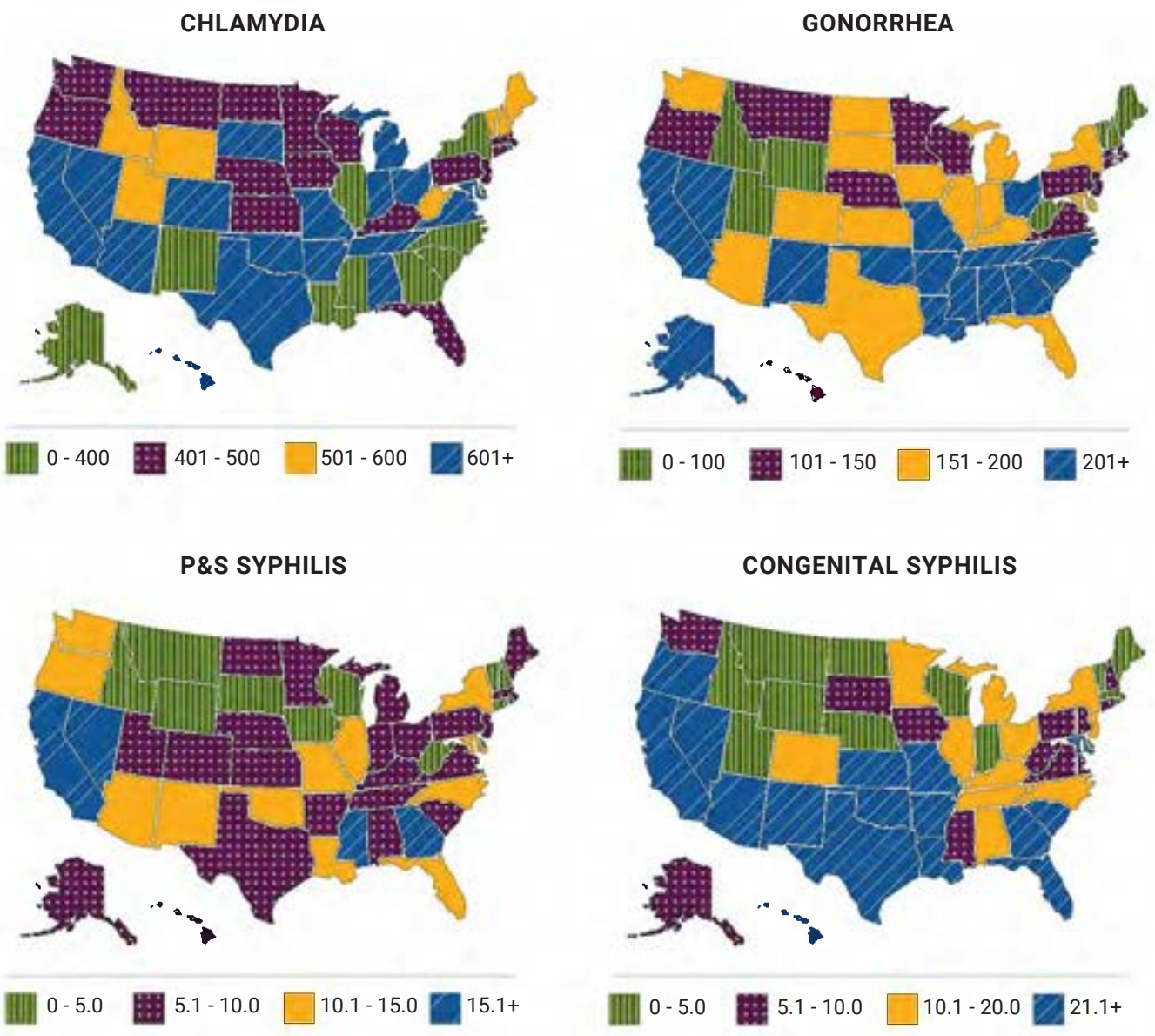


Figure 6. Rates of reported cases by state, per 100,000 population, 2018.[1] For congenital syphilis, rates of reported cases by state, per 100,000 live births.

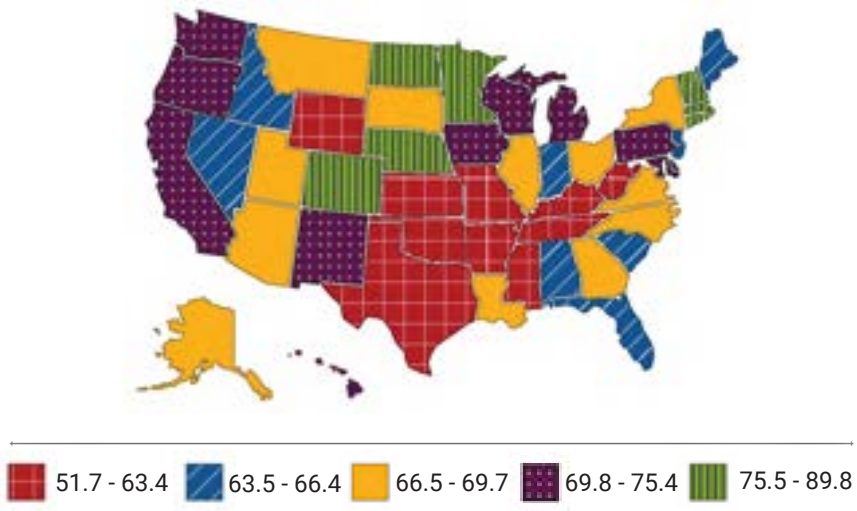


Figure 7. Percentage of adolescents (male and female, ages 13–17) who have received at least one dose of the HPV vaccine, 2018[121]

High-Impact Settings

Using a syndemic approach, work to engage these groups may be more efficient and effective by identifying settings where people with STIs and other risk factors commonly receive services. Settings with high numbers of people who are members of priority populations or are affected by other components of the syndemic can also provide opportunities to efficiently identify, screen, treat, and vaccinate large numbers of disproportionately affected populations. These settings include schools and institutions of higher learning, career training programs, military bases, correctional institutions, homeless service providers, crisis centers, SUD treatment programs, and syringe services programs. Outreach to and assessment of individuals as part of regular intake in settings with a high proportion of people at risk can maximize limited staff and resources and identify individuals in need of prevention and screening.

PRIORITY POPULATIONS MAY DIFFER BY STAKEHOLDER

Understanding of the priority populations highlighted in this plan will be useful for federal and nonfederal partners whose purview includes the whole nation. However, different and/or additional populations and communities may be disproportionately impacted by STIs, depending on the stakeholder's jurisdiction, community, or purview.

Stakeholders whose purview is more specific are encouraged to review the data for their population(s)—and the interplay with the social determinants of health—to help prioritize their STI interventions and guide efforts for the most impact. For example, on a federal level, agencies such as the Indian Health Service, Department of Veterans Affairs, Department of Defense, and Administration for Community Living serve specific populations within the United States. State, tribal, territorial, and local jurisdictions, as well as schools and other educational institutions and systems, should review the data that pertain to their jurisdiction. Health care providers, health plans, community-based and faith-based organizations, and advocacy groups should review the data that pertain to the populations and communities they serve. Stakeholders are also encouraged to consider those who may be at-risk for STIs and face barriers to prevention and care, for whom data might not be available. Clinical guidelines for risk assessment further identify groups recommended for STI screening and should help inform stakeholders' approaches.[35] These reviews will help each stakeholder determine how and where best to focus its efforts and resources to achieve results with the highest impact.

E. Indicators

The STI Plan identifies seven core indicators to measure progress. Some of the core indicators are also stratified by one or more of the priority populations or their subgroups so that progress can be measured toward reducing disparities, establishing seven disparities indicators.

Indicators were selected based on the following criteria:

- relate to at least one of the STIs covered by the STI Plan;
- relate to at least one of the STI Plan's goals;
- reflect current STI science, policy, and medical screening practices and guidance;
- convey improvement (or lack of improvement) in STI health;
- use quantitative data from a robust nationally representative data source;
- can be stratified including by priority populations; and
- have a significant impact on the STI epidemic.

For each indicator, the STI Plan records baseline measurements and establishes annual targets through 2030. This approach provides sufficient time to reverse the worsening trends in STI rates in the United States. Appendix A describes the methodology for choosing indicators and the target-setting process. Appendix B sets forth the annual targets for each core and disparities indicator as well as describes the data source for each indicator.

Both the core and disparity indicators use existing data sources based on national data (described in the Data Sources section of Appendix B). These sources were selected because they

- generate data regularly and consistently—enabling nationwide, cross-year comparisons; and
- allow for stratification by age, geographic region, race, ethnicity, and sex, and, when available, sex of sex partners.

Finally, the STI Plan recommends development of three additional indicators—referred to as developmental indicators. Nationally representative data for these developmental indicators are not currently collected, and doing so would fill in critical gaps in measuring the nation's efforts to address the STI epidemic.

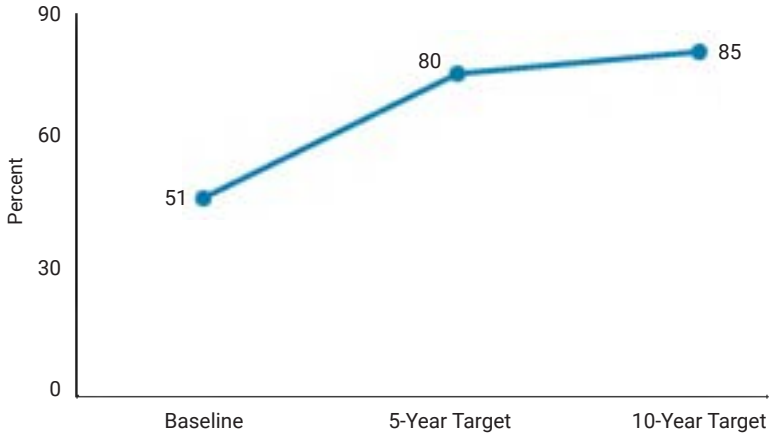
Table 3. STI Plan Core Indicators

Core Indicator	Related STI Plan Goals	Measure	Baseline[a]	5-Year Target	10-Year Target	Data Source[b]
1. Increase the percentage of adolescents aged 13–17 years who receive the routinely recommended doses of HPV vaccine						
	1, 2, 4	Percentage	51.0 (2018 baseline)	80.0	85.0	NIS-Teen
2. Reduce P&S syphilis rate[c]						
	1, 2	Rate/100,000	13.6	13.2	12.2	NNDSS
3. Reduce rates of congenital syphilis rate[c]						
	1, 2, 4	Rate/100,000	67.7	57.6	33.9	NNDSS
4. Reduce gonorrhea rates[c]						
	1, 2	Rate/100,000	221.9	215.3	199.7	NNDSS
5. Increase chlamydia screening in sexually active females aged 16–24 years						
	1, 2, 4	Percentage	58.8	66.4	76.5	HEDIS
6. Reduce PID in females aged 15–24 years[c]						
	1, 2, 4	Rate/100,000	171.6	161.3	137.3	HCUP NEDS
7. Increase condom use at last sexual encounter among sexually active high school students[c]						
	1, 4	Percentage	51.3	53.5	56.5	YRBSS

[a] 2020 unless indicated otherwise. 2020 data points are projected based on indicator trajectory in recent years.
[b] See Appendix B for descriptions of data sources.
[c] This core indicator has a corresponding disparities indicator(s).

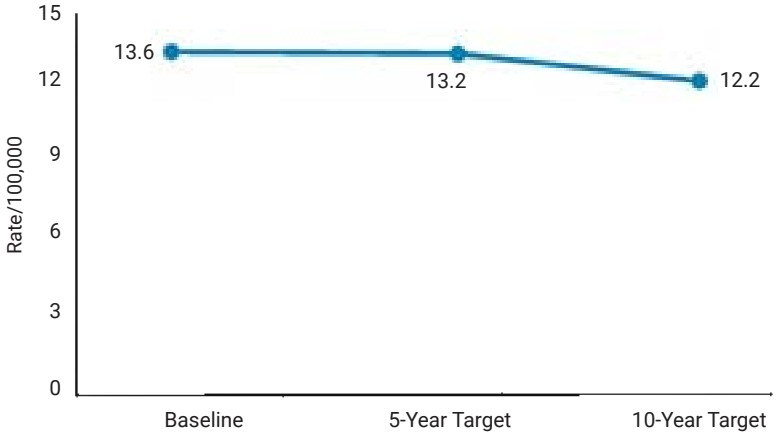
1. Increase the percentage of adolescents aged 13–17 years who receive the routinely recommended doses of HPV vaccine to 80% by 2025 and 85% by 2030

Approximately 92% of HPV- associated cancers can be prevented by the safe and effective HPV vaccine.[64] The ACIP currently recommends that all preteen boys and girls receive the HPV vaccine at ages 11 or 12; the series can begin at age 9.[122] In addition, adolescents and young adults aged 13–26 are recommended to receive a catch-up vaccination series.[123] Increasing HPV vaccination among adolescents will have a significant impact in reducing HPV infections, precancerous lesions, and HPV- associated cancers.



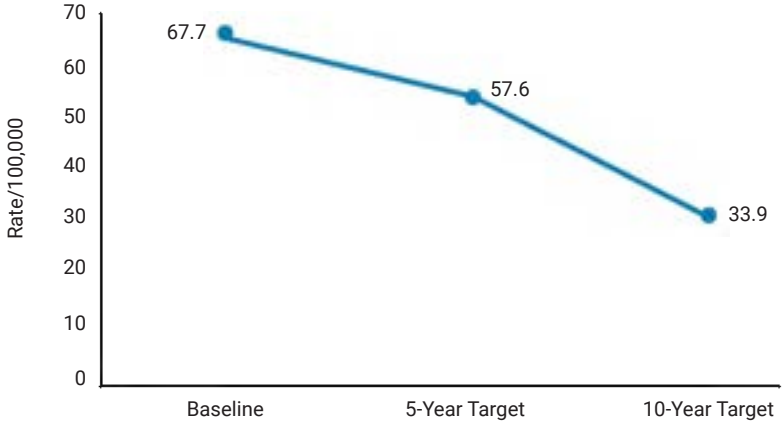
2. Reduce P&S syphilis rate by 3% by 2025 and 10% by 2030

The rate of P&S syphilis increased by 71% from 2014 to 2018.[1] Cases have risen disproportionately among MSM, accounting for 54% of the total reported P&S syphilis cases in 2018.[1] Rates of P&S syphilis among females have increased substantially in recent years as well,[1] suggesting a rapidly growing heterosexual epidemic. Reducing the rate of P&S syphilis will prevent the spread of new infections and the adverse health outcomes associated with P&S syphilis, such as neurosyphilis, ocular syphilis, and congenital syphilis. Reducing P&S syphilis among MSM will also help avert future HIV infections.



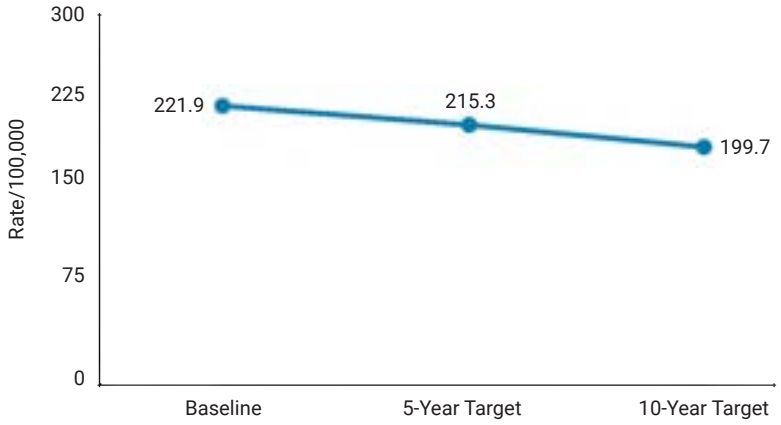
3. Reduce congenital syphilis rate by 15% by 2025 and 50% by 2030

Congenital syphilis reflects multiple missed opportunities for prevention, timely diagnosis, and treatment of syphilis in a pregnant woman. From 2014 to 2018, the rate of congenital syphilis cases increased by 185%, paralleling increased rates of P&S syphilis among reproductive-aged women in the United States.[1] Reducing the rate of congenital syphilis will result in fewer stillbirths, infant deaths, miscarriages, and long-term health consequences.



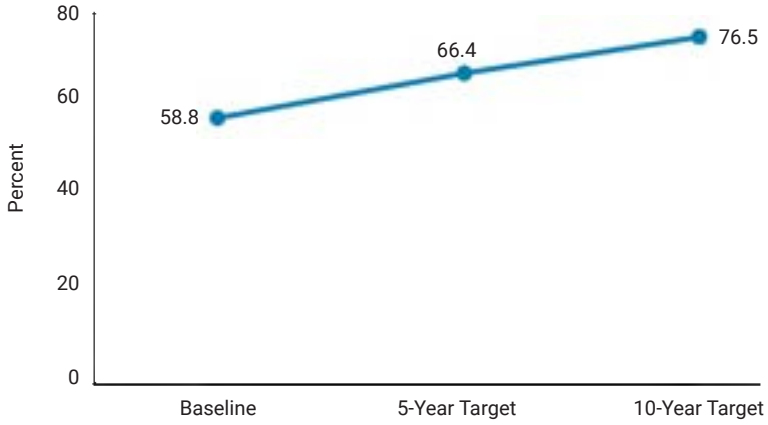
4. Reduce gonorrhea rate by 2% by 2025 and 10% by 2030

Rates of reported gonorrhea increased by 63% from 2014 to 2018.[1] Untreated gonorrhea can lead to PID and facilitate HIV transmission.[124] Treatment and control of *N. gonorrhoeae* have been complicated by AMR. Because of the development of AMR to multiple classes of antibiotics, including current first-line therapies, the organism has been designated as one of five urgent threat–level pathogens in the United States in 2019.[53] Reducing gonococcal infections can reduce these adverse health outcomes and treatment challenges and can reduce further transmission.



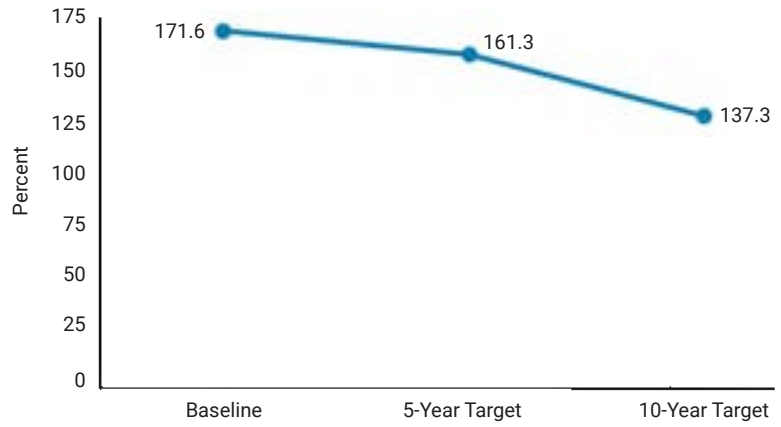
5. Increase chlamydia screening in sexually active females aged 16–24 years by 13% by 2025 and 30% by 2030

Chlamydia, the most common bacterial STI, had a reported rate of 539.[9] for every 100,000 people in the United States in 2018.[1] It is often asymptomatic, and disproportionately impacts adolescent girls and young women. When left untreated, it can lead to long-term health consequences such as PID and infertility; routine screening can shorten duration of infection and prevent PID.[68, 125, 126, 127] Both CDC and the United States Preventive Services Task Force (USPSTF) recommend annual screening for chlamydia in sexually active women younger than age 25; [35] however, screening remains suboptimal.



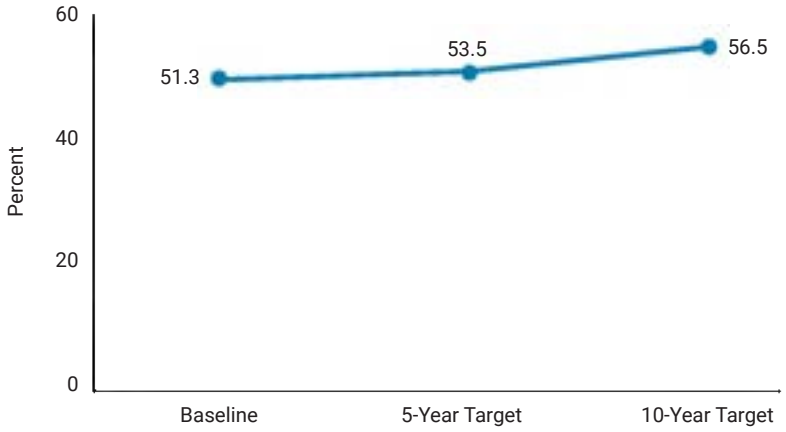
6. Reduce PID in females aged 15–24 years by 6% by 2025 and 20% by 2030

In women, untreated chlamydial and gonococcal infections can cause PID. Data from studies suggest that as much as 10% of untreated chlamydial infections progress to clinically diagnosed PID, and the PID risk with untreated gonococcal infection may be even higher.[128, 129, 130] PID can result in inflammation and damage to the fallopian tubes, elevating the risk of infertility and ectopic pregnancy. It can also be a cause of chronic pelvic pain.[1] An important public health measure for preventing PID in young women is through prevention and early identification and treatment of chlamydial and gonococcal infections.



7. Increase condom use at last sexual intercourse among sexually active high school students by 4% by 2025 and 10% by 2030

When used consistently and correctly, condom use can reduce the risk of acquiring and transmitting STIs.[131] Adolescents and young adults aged 15–24 account for approximately 25% of the sexually active population, yet represent approximately 50% of the 20 million new STIs in the United States each year.[132] Increasing condom use among sexually active youth is a critical STI prevention strategy and complements other primary and secondary prevention efforts to reduce the incidence and prevalence of STIs.



DISPARITIES INDICATORS

Disparities indicators are core indicators stratified by the priority population most impacted by the STI or related issue. (See Section III.D and Figure 5 for data on disparities by race/ethnicity.) Each disparities indicator uses the same data source as its corresponding core indicator. The geographic regions South and West are defined by and align with U.S. Census regions. Table 4 presents baseline measures (estimated for 2020) as well as 5- and 10-year targets for each disparities indicator. The annual targets for each disparities indicator are presented in Appendix B.

Table 4. STI Plan Disparities Indicators

Disparities Indicator	Measure	Baseline[a]	5-Year Target	10-Year Target
8. Reduce P&S syphilis rate in MSM				
	Rate/100,000	461.1	440.4	392.0
9. Reduce congenital syphilis rate among African American/Blacks				
	Rate/100,000	167.5	139.9	75.4
10. Reduce congenital syphilis rate among AI/AN				
	Rate/100,000	207.6	173.3	93.4
11. Reduce congenital syphilis rate in the West				
	Rate/100,000	89.7	74.9	40.3
12. Reduce gonorrhea rate among African Americans/Blacks				
	Rate/100,000	632.9	604.5	538.0
13. Reduce gonorrhea rate in the South				
	Rate/100,000	211.3	201.0	179.6
14. Increase condom use at last sexual encounter among sexually active MSM high school students				
	Percentage	53.8	56.9	61.9

[a] 2020 unless indicated otherwise. 2020 data points are projected based on indicator trajectory in recent years.

DEVELOPMENTAL INDICATORS

Developmental indicators focus on the need to develop data sources and collect critical data to monitor efforts to reduce STIs in the United States; they represent high-priority issues that do not currently have reliable, nationally representative baseline data. Targets cannot be established for them until the data are collected and trend analysis is performed. Federal partners are encouraged to work toward collecting and analyzing the suggested data. Three developmental indicators are recommended to supplement the core and disparities indicators.

1. Increase the percentage of patients with gonorrhea who are treated with a recommended regimen.
2. Increase the percentage of patients with syphilis who are treated with a recommended regimen.
3. Increase extragenital chlamydia and gonorrhea screening among MSM.

IV. IMPLEMENTATION AND ACCOUNTABILITY

A. Federal Partners

The STI Plan presents a framework for reducing the rates and effects of STIs in the United States. Development of the STI Plan was a collaborative process led by federal partners across multiple departments and agencies with input from a wide range of stakeholders.

Federal partners will collaborate to develop an implementation plan to support the STI Plan goals, objectives, and strategies. The Federal Implementation Plan will set forth federal partners' commitments to policies, initiatives, and activities to meet the goals of the STI Plan, and will be published for transparency and accountability. Federal partners' roles in implementation will vary based on the purview of their agencies and how much their activities overlap with the components of the plan.

As part of their ongoing commitment to reduce STIs in this nation, federal partners have committed to serve on an STI implementation working group, continuing to provide their expertise and guidance. This implementation working group will collaborate on addressing STIs in an integrated fashion including with other components of the syndemic. The working group will meet regularly to coordinate activities across agencies and departments, implement lessons learned from epidemiological data and research findings, monitor progress toward the indicator targets, course correct as needed, and report on national progress. As scientific, medical, and public health advances and challenges emerge, new and innovative policies will be developed to complement the existing plan.

B. Nonfederal Partners

Addressing STIs is not solely a federal activity. Success depends on coordinated action by state, tribal, territorial, and local governments; community-based and faith-based organizations; health plans and providers and other health-related organizations; private industry; nongovernmental organizations; foundations; schools and other avenues for educational activities; researchers; families; and patients and their partners. Its success also depends on a holistic approach to the various parts of the syndemic, including HIV, viral hepatitis, SUD, stigma, and social determinants of health.

Each community and stakeholder brings a unique perspective and plays a critical role in preventing and responding to STIs. Stakeholders are encouraged to use this STI Plan to build their own roadmap to reduce STIs and STI-related health disparities and inequities, and end the STI epidemic among the populations and communities they serve. Stakeholders should consider adopting the vision and goals of this STI Plan; examining challenges from a health equity lens; implementing the objectives and strategies relevant to their role, population(s), and community(ies); applying other evidence-based objectives and strategies; using available data to identify where their resources will have the most impact; and identifying indicators and targets to measure their progress. A data-driven strategy will help stakeholders focus and efficiently and effectively use limited resources. Integrating STI prevention and treatment efforts with other components of the syndemic, including emerging issues such as the COVID-19 pandemic, is also strongly encouraged.

APPENDIX A: PROCESS/METHODOLOGY FOR DEVELOPING AND ADOPTING THE STI PLAN

The process for developing the STI Plan included engaging federal leadership, experts, and a variety of nonfederal partners to compile subject matter evidence and recommendations on STIs. These data were then synthesized and developed into the vision, goals, objectives, strategies, indicators, and quantitative targets that are the core of the STI Plan. This process also included aligning the components of the STI Plan with the next HIV Plan and Hepatitis Plan.

FEDERAL LEADERSHIP

Steering Committee

A federal Steering Committee set the vision, goals, and priority populations and discussed key challenges to be addressed in the STI Plan. The Steering Committee's work and decision-making was informed by presentations and discussions of national-level data, the work being done and being funded—especially by federal departments and agencies—related to STIs, challenges and gaps in addressing STIs in this nation, and how to integrate and leverage the work being done in other components of the syndemic. The Steering Committee also provided direction for the overall process. In addition, the Steering Committee formed subcommittees to study and propose objectives, strategies, and indicators for each of the STI Plan's goals and, in doing so, consider information gathered during the public input period. Development of the objectives and strategies was an iterative process among the Steering Committee, the various subcommittees, and those developing the HIV Plan and Hepatitis Plan. The Steering Committee voted on each component of the STI Plan (e.g., vision, goals, objectives, strategies, indicators, and priority populations) and provided input into the quantitative targets for the indicators. The Steering Committee consisted of senior representatives from five federal departments and 15 HHS agencies and offices (see Table A.1) and met monthly from April 2019 through January 2020.

Table A.1. Composition of Federal Steering Committee

Federal Departments	HHS Agencies and Offices	
• Department of Defense • Department of Education • Department of Health and Human Services • Department of Housing and Urban Development • Department of Veterans Affairs	• Administration for Children and Families • Administration for Community Living • Centers for Disease Control and Prevention • Centers for Medicare & Medicaid Services • Food and Drug Administration • Health Resources and Services Administration • Indian Health Service • National Institutes of Health	• Office of the Assistant Secretary for Health » Office of Infectious Disease and HIV/AIDS Policy » Office of Minority Health » Office of Population Affairs » Office of the Surgeon General » Office of Women's Health • Substance Abuse and Mental Health Services Administration

Subcommittees

The federal Steering Committee formed five subcommittees and selected subject matter experts from their agencies and offices to participate:

- Primary Prevention;
- Secondary and Tertiary Prevention Including Care;
- Education and Communications;
- Disparities and Coordination; and
- Indicators.

The subcommittees were charged with developing and recommending objectives, strategies, and indicators that address the goals of the STI Plan including the following cross-cutting elements identified by the Steering Committee:

- Disparities;
- Integration with other infectious diseases such as HIV and viral hepatitis;
- Rapid implementation of new scientific advances;
- Social determinants of health; and
- Stigma and discrimination.

The subcommittees met twice per month between July 2019 and October 2019, and the Indicators Subcommittee continued its work through January 2020. The subcommittees developed and prioritized objectives and strategies, as well as indicators and indicator targets. These were then reviewed and refined through an iterative process involving the Steering Committee and OIDP leadership. Extensive analyses by OIDP identified overlaps, gaps, alignments, and additional areas of integration among the STI Plan, the HIV Plan, and the Hepatitis Plan. The Indicators Subcommittee also worked with its counterparts for developing the HIV Plan and Hepatitis Plan to ensure that the same criteria and methods were used across plans, as appropriate.

PUBLIC INPUT

A crucial component in developing the STI Plan was engagement and input from nonfederal stakeholders. Stakeholders from all sectors and at all levels (i.e., community, state, regional, national) and people whose lives have been affected by STIs were encouraged to provide input on the STI Plan.

Solicitation of Public Input

To assist in developing the STI Plan, public input on the plan was solicited. Between March and June 2019, two listening sessions were held via webinar and four were held during national conferences and meetings of relevant stakeholders. The webinars drew more than 1,000 participants, representing 45 states, three U.S. territories, and Canada; comments were received from 125 participants through this process. In addition, a Request for Information (RFI) published in the *Federal Register* on May 3, 2019, resulted in the receipt of 115 sets of written public comments.

Method of Analysis

Comments from the virtual listening sessions were professionally transcribed. All verbal and written comments were collated by commenter and organization. A pre-determined coding structure was developed based on questions posed during the listening sessions and in the RFI. Two coders analyzed all comments and coded the comments to themes. Coders reviewed the comment data and updated the codebook based upon dominant and emergent themes present in both listening session and RFI comments. Staff performed a qualitative analysis of all comments using NVivo 12.0, examined them for dominant themes and sub-themes, and matched them to STI Plan goals.

Commenters

A total of 240 commenters were identified and categorized into various respondent types. Overall, there was strong representation from health care providers (n=48), local health departments (n=34), community-based organizations/faith-based organizations (n=30), national organizations (n=26), and tribes and Indian Country (n=26) (see Figure A.1).

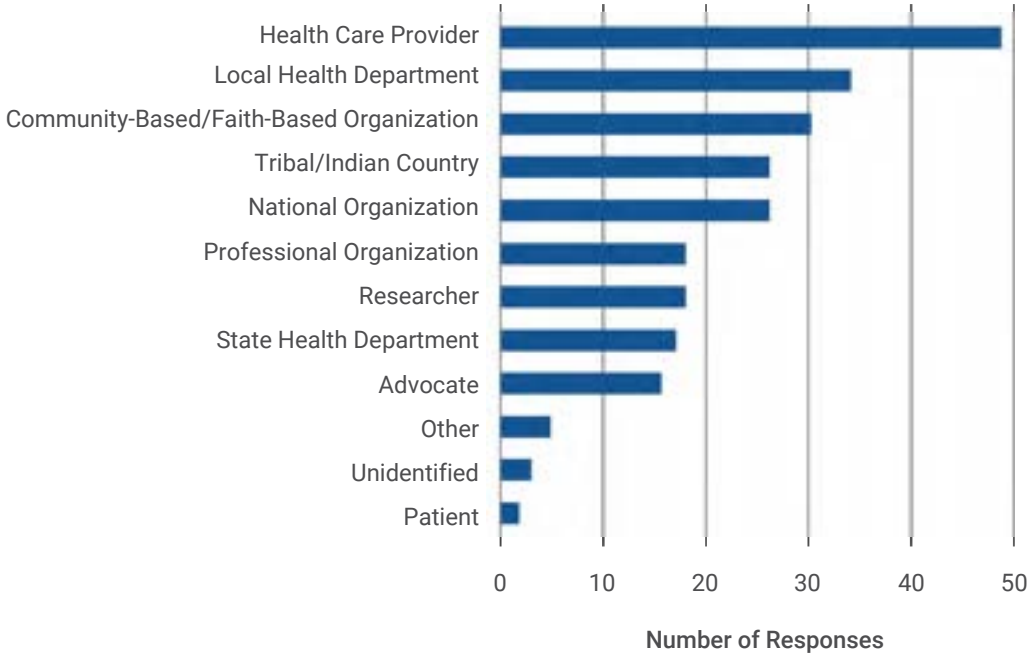


Figure A.1. Respondent type for all public comments with available affiliation

SUMMARY OF FINDINGS

Methods used and findings from the public input, including prominent themes and sub-themes along with supporting comments, were presented to the Steering Committee and the subcommittees. Input received through public comments was extremely valuable, and comments addressed a broad range of STI-related topics that are reflected in the STI Plan's objectives and strategies, including:

- innovation and technology regarding STI diagnostics, therapeutics and vaccines, and research and surveillance;
- provider training including sensitivity training in STIs and sexual health basics;
- use of primary care settings, schools, and nontraditional health care settings for STI prevention and testing services;
- culturally appropriate and inclusive comprehensive sexual health education;
- STI-related stigma and discrimination; and
- social determinants of health.

Many comments pertained to the work or purview of specific agencies. These agency-specific comments were also compiled into individual reports and shared with those agencies for review and consideration.

DEVELOPMENT OF PRIORITY POPULATIONS

Priority populations are disproportionately affected populations, which are defined as groups of people with a higher burden of disease than others. Prevention and control interventions can focus on priority populations for the highest impact. With the understanding that the STI Plan is a national plan, the Steering Committee reviewed national STD surveillance data to select priority populations. Disproportionately impacted populations will differ by jurisdiction. Therefore, each jurisdiction should review its own data to determine its own priority populations.

As a starting point, CDC's Division of STD Prevention presented data for STDs in general and for the four STIs within the scope of the STI Plan. The data were presented by incidence and prevalence and stratified by a variety of factors, including age group, sex, race/ethnicity, gender of sex partners, urban/rural/other settings, geographic areas, and risk, using 2017 surveillance data. The Steering Committee also looked at identifying disproportionately affected populations that are socially, economically, and/or environmentally disadvantaged. Other agencies that collect STI-related data, such as the Veterans Administration and Indian Health Service, also presented the data for the populations they serve. The Steering Committee reviewed and discussed the surveillance data over several meetings and voted to adopt priority populations based on the available surveillance data. The Steering Committee was selective in the total number of priority populations so that limited resources and interventions can focus on a smaller number of populations to have the most impact on outcomes for the nation.

DEVELOPMENT OF STI INDICATORS AND TARGETS

Indicators

The Indicators Subcommittee was tasked with developing indicators and targets for the STI Plan. The subcommittee reviewed existing data sources for available STI or STI-related measures, proposed indicators for each of the STI Plan's four goals, and discussed limitations and gaps in existing STI measures and data sources. The Indicators Subcommittee, after consulting with its counterparts for the Hepatitis Plan and the HIV Plan, used the following criteria to select the indicators to recommend to the Steering Committee:

- relate to at least one of the STIs covered by the STI Plan;
- relate to at least one of the STI Plan's goals;
- reflect current STI science, policy, and medical screening practices and guidance;
- convey improvement (or lack of improvement) in STI health;
- use quantitative data from a robust nationally representative data source;
- can be stratified including by priority populations; and
- have a significant impact on the STI epidemic.

Core indicators, which measure progress on a nationwide basis, were chosen by evaluating current STI data, health services, and behavioral trends. To measure progress for priority populations and subgroups most impacted by disparity, the subcommittee also identified the core indicators that should be stratified and used as corresponding disparities indicators. These were further reviewed and refined to maximize measurement of the STI Plan's impact. The Indicators Subcommittee also recommended development of several indicator measures that do not currently have an identified data source but would help measure some high-priority issues. These were also reviewed, and three developmental indicators were chosen.

Indicator Targets

To set targets for indicators, the Indicators Subcommittee first leveraged prior year data to project the estimated 2020 baseline measures. Members calculated the current trajectory of each indicator based on the most recent years of data and then applied the estimated annual percentage change to the most recent year of available data, projecting out annually until 2020. For example, the rate of gonorrhea increased, on average, 4.6% annually during 2016–2018. Applying this annual increase to the rate in the last year of available data (179.1 per 100,000 in 2018) resulted in a projected 2020 rate of 221.9 per 100,000.

Although the STI Plan is a 5-year plan, the existence of 10-year targets makes clear to federal partners and the nation that sustained efforts are needed to address the STI epidemic. These targets will act as goals to help plan sustained efforts. For STIs with rapidly worsening trends, 5- and 10-year targets were based on smaller percentage improvements to account for the need to reverse those trends. Targets are more aggressive for indicators related to STIs with already available interventions (e.g., chlamydia and congenital syphilis). In addition, targets for the disparities indicators are more aggressive than those for the related core indicators, because greater percentage improvement in the most impacted populations will be needed to reduce the disparity.

In addition, the Indicators Subcommittee set annual targets to help federal partners gauge whether they are on course to reach the longer-term national targets and, if not, examine what course corrections are needed. The approach to setting the annual target for all indicators that monitor disease rates (e.g., rates of gonorrhea) accounted for initial ramping up efforts, which would be slower. Thus, decreases in STI rates are expected to become more pronounced as the plan is implemented. For health services indicators (e.g., chlamydia screening), the rate of improvement declines the closer you get to the target. Therefore, the targets in the final years reflect this expected slowdown in the rate of improvement. HPV vaccination targets are aligned with HHS' initiative to reach 80% coverage in 5 years.

Development of indicators and targets for the STI Plan were also coordinated with *Healthy People* 2030 (HP2030) STD measures. For the indicators that are included in both the STI Plan and HP2030,[††] HP2030 targets will be updated to align with the STI Plan once the STI Plan is released.

The STI indicators were reviewed and approved by the Steering Committee. To ensure feasibility and sustainability of data collection and monitoring, the targets were vetted by leadership of the agencies involved in the funding, surveillance, data collection, and database management associated with the STI indicators.

The indicator targets were developed and approved prior to the COVID-19 pandemic. Progress toward the targets will likely be impacted by the pandemic for a number of reasons, including resources being diverted from screening for STIs to aid the pandemic. As federal partners monitor implementation of the STI Plan, the factors that affect progress toward its quantitative targets will be considered and used to inform any course corrections that may be needed.

[††] STI Plan indicators 1, 3, 5, 6, and 8 mirror HP2030 objective measures IID-08, STI-04, STI-01, STI--07, and STI-05.

APPENDIX B: INDICATORS AND TARGETS

For each indicator, the STI Plan records baseline measurements and establishes 5- and 10-year targets, as well as annual targets to monitor efforts to meet targets. Data sources are based on nationally representative samples. Data sources provide regular and consistent estimated data to enable cross-year comparisons and stratification by age, geographic region, race/ethnicity, and sex, and, when available, sex of sex partners. The data sources are described following the tables of core indicators and disparities indicators and their targets.

CORE INDICATORS

Table B.1 presents the baseline measurements, annual targets, and data sources for each core indicator. Five- and 10-year targets are bolded and underlined.

Table B.1. STI Plan Core Indicators

Core Indicator	Baseline[a]	2021	2022	2023	2024	**2025**	2026	2027	2028	2029	**2030**	Data Source[b]
1. Increase the percentage of adolescents aged 13–17 years who receive the routinely recommended doses of HPV vaccine												
Percent	51	57	63	69	75	**80**	81	82	83	84	**85**	NIS-Teen
2. Reduce rates of P&S syphilis[c]												
Rate per 100,000	13.6	13.5	13.4	13.3	13.3	**13.2**	13.0	12.8	12.6	12.4	**12.2**	NNDSS
3. Reduce rates of congenital syphilis[c]												
Rate per 100,000	67.7	66.0	64.3	62.3	60.3	**57.6**	54.2	50.1	45.4	40.0	**33.9**	NNDSS
4. Reduce gonorrhea rates[c]												
Rate per 100,000	221.9	220.8	219.7	218.4	217.1	**215.3**	213.1	210.4	207.3	203.7	**199.7**	NNDSS
5. Increase chlamydia screening in sexually active females aged 16–24 years												
Percent	58.8	59.7	60.6	62.2	64.1	**66.4**	68.0	71.1	73.3	75.0	**76.5**	HEDIS
6. Reduce PID in females aged 15–24 years[c]												
Rate per 100,000	171.6	169.9	168.2	166.1	164.0	**161.3**	157.9	153.8	149.0	143.5	**137.3**	HCUP NEDS
7. Increase condom use at last sex among sexually active high school students[c]												
Percent	51.3	51.6	51.8	52.3	52.9	**53.5**	54.2	54.9	55.5	56.0	**56.5**	YRBSS

[a] Baseline is 2020, except for Indicator 1, which uses a 2018 baseline. 2020 data points are projected based on trajectory in recent years.
[b] HCUP NEDS = Healthcare Cost and Utilization Project Nationwide Emergency Department Sample; HEDIS = Healthcare Effectiveness Data and Information Set; NIS-Teen = National Immunization Survey-Teen; NNDSS = National Notifiable Diseases Surveillance System; YRBSS = Youth Risk Behavior Surveillance System. See Data Sources section below for a description of each data source.
[c] This core indicator has a corresponding disparities indicator(s).

DISPARITIES INDICATORS

Disparities indicators were identified by evaluating current STI data trends and selecting priority populations and subgroups most vulnerable. Table B.2 presents the baseline measurements and annual targets for each disparities indicator. Five- and 10-year targets are bolded. Each disparities indicator uses the same data source as its corresponding core indicator.

Table B.2. STI Plan Disparities Indicators

Disparities Indicator	Baseline[a]	2021	2022	2023	2024	**2025**	2026	2027	2028	2029	**2030**
8. Reduce P&S syphilis rate among MSM											
Cases/100,000	461.2	457.7	454.3	450.1	446.0	**440.4**	433.5	425.2	415.5	404.5	**392.0**
9. Reduce congenital syphilis rate among African Americans/Blacks											
Rate/100,000	167.5	162.9	158.3	152.8	147.3	**139.9**	130.7	199.6	106.7	92.0	**75.4**
10. Reduce congenital syphilis rate among AI/ANs											
Rate/100,000	207.6	201.9	196.2	189.3	182.5	**173.3**	161.9	148.2	132.2	113.9	**93.4**
11. Reduce congenital syphilis rate in the West											
Rate/100,000	89.7	87.2	84.7	81.8	78.8	**74.9**	69.9	64.0	57.1	49.2	**40.3**
12. Reduce gonorrhea rate among African Americans/Blacks											
Rate/100,000	632.9	628.2	623.5	617.8	612.1	**604.5**	595.0	583.6	570.3	555.1	**538.0**
13. Reduce gonorrhea rate in the South											
Rate/100,000	211.3	209.6	207.9	205.8	203.7	**201.0**	197.5	193.4	188.5	183.0	**179.6**
14. Increase condom use at last sexual intercourse among sexually active MSM high school students											
Percentage	53.8	53.8	54.2	54.9	55.8	**56.9**	58.0	59.1	60.0	60.8	**61.9**

[a] Baseline is 2020 for all of the disparities indicators. 2020 data points are projected based on trajectory in recent years.

DATA SOURCES

The Healthcare Cost and Utilization Project Nationwide Emergency Department Sample (HCUP NEDS) is the nation's most comprehensive source of hospital care data, including information on in-patient stays, ambulatory surgery and services visits, and emergency department (ED) encounters. HCUP is a family of databases, software tools, and related products developed through a federal-state-industry partnership and sponsored by the HHS Agency for Health Research and Quality. The database consists of administrative claims data from roughly 30 million ED visits at 950 hospitals that approximate a 20% stratified sample of U.S. hospital-based EDs with records at the ED visit level. HCUP NEDS data are collected annually, but usually with a 3-year delay in reporting.

The Health Effectiveness Data and Information Set (HEDIS) is a widely used performance improvement tool in the health care field. HEDIS is sponsored by the National Committee for Quality Assurance (NCQA) and contains data on 190 million people who are enrolled in plans that report HEDIS results. NCQA collects HEDIS data annually.

The National Immunization Survey-Teen (NIS-Teen) is a phone survey sponsored by CDC's National Center for Immunization and Respiratory Diseases (NCIRD) and used to monitor vaccination coverage among teens aged 13–17, including for the HPV vaccine. Data are collected annually.

The National Notifiable Diseases Surveillance System (NNDSS) is managed by CDC's Center for Surveillance, Epidemiology, and Laboratory Services. The NNDSS collects, analyzes, and publishes health data for approximately 120 nationally notifiable diseases, including chlamydia, gonorrhea, and syphilis. These data, which CDC collects annually from state and local health departments, help public health officials monitor, control, and prevent disease in the United States.

The School Health Profiles is a system of surveys sponsored by CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention that assess school health policies and practices in states and large urban school districts. These surveys are conducted every other year, on even calendar years, by education and health agencies.

The Youth Risk Behavior Surveillance System (YRBSS) is sponsored and used by CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention to monitor health behaviors—including sexual behaviors related to STI, as well as tobacco, alcohol, and other drug use—that contribute to the leading causes of death, disability, and social problems in the United States. Data are representative of 9th through 12th grade students in public and private schools in the United States and collected every other year on odd calendar years.

APPENDIX C: FEDERAL STEERING COMMITTEE, SUBCOMMITTEES, AND STAFF

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APPENDIX D: ACRONYMS

ACIP	Advisory Committee on Immunization Practices
ACF	Administration for Children and Families
ACL	Administration for Community Living
AI/AN	American Indian/Alaska Native
AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
CARB	Combating Antibiotic Resistant Bacteria
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DIS	disease intervention specialist
DSTDP	Division of STD Prevention (CDC)
DoD	U.S. Department of Defense
DoE	U.S. Department of Education
DOJ	Department of Justice
ECHO	Extension for Community Healthcare Outcomes
ED	emergency department
EHE	Ending the HIV Epidemic
FDA	Food and Drug Administration
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCUP NEDS	Healthcare Cost and Utilization Project Nationwide Emergency Department Sample
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
HPV	human papillomavirus
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IHS	Indian Health Service
IOM	Institute of Medicine
MPT	multipurpose prevention technology

MSM	men who have sex with men
NAPA	National Association of Public Administration
NASEM	National Academies of Sciences, Engineering, and Medicine
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (CDC)
NCIRD	National Center for Immunizations and Respiratory Diseases (CDC)
NCSD	National Coalition of STD Directors
NIH	National Institutes of Health
NIS-Teen	National Immunization Survey-Teen
NNDSS	National Notifiable Diseases Surveillance System
OASH	Office of the Assistant Secretary for Health
OIDP	Office of Infectious Disease and HIV/AIDS Policy
OMH	Office for Minority Health
OPA	Office of Population Affairs
OSG	Office of the Surgeon General
OWH	Office on Women's Health
P&S	primary and secondary syphilis
PEP	post-exposure prophylaxis
PID	pelvic inflammatory disease
POC	point of care
PrEP	pre-exposure prophylaxis
RFI	Request for Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SGM	sexual and gender minority
STD	sexually transmitted disease
STI	sexually transmitted infection
SUD	substance use disorder
TAG	Treatment Action Group
U.S.	United States
USPSTF	United States Preventive Services Task Force
VA	U.S. Department of Veterans Affairs
WHO	World Health Organization
YRBSS	Youth Risk Behavior Surveillance Survey

APPENDIX E: REFERENCES

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Exhibit 5

Sexually Transmitted Infections Prevalence, Incidence, and Cost Estimates in the United States

Public Health
APRIL 3, 2024

AT A GLANCE

A CDC analysis provides the clearest picture to date of STIs in the United States. CDC estimates indicate about 20 percent of the U.S. population – approximately one in five people in the U.S. – had an STI on any given day in 2018, and STIs acquired that year will cost the American healthcare system nearly $16 billion in healthcare costs alone.

Format: PNG
Dimensions: 2000 x 586 pixels
Language: English (US)
Size: 46 KB

View PNG

Additional Information

The analysis included eight common STIs: chlamydia, gonorrhea, hepatitis B virus (HBV), herpes simplex virus type 2 (HSV-2), human immunodeficiency virus (HIV), human papillomavirus (HPV), syphilis, and trichomoniasis. Chlamydia, trichomoniasis, genital herpes, and HPV accounted for 98% of all prevalent STIs and 93% of all new STIs in 2018.

Given the serious health consequences of untreated STIs, and that many infections go undetected and unreported to CDC, these estimates are critical to better understanding the vast scope of the STI epidemic and who is most affected.

Additional graphic - Prevalence vs Incidence PNG

STIs cost the U.S. healthcare system billions each year. In 2018, the new infections totaled nearly $16 billion in direct lifetime medical costs alone. The total cost of STIs far exceeds the medical cost burden estimated in this study, which did not include costs associated with lost productivity, other non-medical costs, and STI prevention.

Additional graphic - Cost Estimates PNG

CDC's new estimates are based on modeling approaches that are more rigorous, robust, and comprehensive than ever before. However, the findings also highlight gaps in the scientific literature and the ongoing need for more data. Many assumptions were made due to no, missing, or limited data on crucial measures such as natural clearance rates and the percentage of asymptomatic infections. Population-based STI screening estimates are also greatly needed. Better data means more precise estimates and the ability to strengthen prevention and allocation efforts.

SOURCES

CONTENT SOURCE:
National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention; About Division of STD Prevention

Exhibit 6

Congressional Research Service
Informing the legislative debate since 1914

Teen Pregnancy Prevention: Background and Proposals in the 111th Congress

Updated April 25, 2011

Congressional Research Service
https://crsreports.congress.gov
R40618

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The birth rate for teenagers (ages 15 through 19) in the United States increased in 2006 and 2007 after a steady decline since 1991. In 2008 and 2009, the teen birth rate dropped below the 2007 teen birth rate, reversing the two-year upward trend. In 2009, teen births accounted for 10.1% of all U.S. births and 21.4% of all nonmarital births. In recognition of the negative, long-term consequences associated with teenage pregnancy and births, teen pregnancy prevention is a major goal of this nation.

President Obama's FY2010 and FY2011 budgets supported state, community-based, and faith-based efforts to reduce teen pregnancy using models that have been rigorously evaluated. The Administration's new discretionary Teen Pregnancy Prevention (TPP) program funds models that stress the importance of abstinence while providing medically accurate and age-appropriate information to youth who have already become sexually active. The Obama Administration's FY2010 and FY2011 budgets did not provide any funding in FY2010 or FY2011 for the Title V Abstinence Education Block Grant to states (which was a mandatory program) or the Community-Based Abstinence Education (CBAE) program (a discretionary program); nor did they continue to provide funding in FY2010 or FY2011 for abstinence-only demonstration grants through the Adolescent Family Life (AFL) program.

Nonetheless, P.L. 111-148, the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, by President Obama included the two teen pregnancy prevention provisions that were in the Senate version of the bill (H.R. 3590). P.L. 111-148 established a new state formula grant program and appropriated $75 million annually for each of FY2010-FY2014 to enable states to operate a new Personal Responsibility Education Program. P.L. 111-148 also restored funding to the Title V Abstinence Education formula block grant to states at the previous annual level of $50 million for each of FY2010-FY2014.

P.L. 111-117, the Consolidated Appropriations for FY2010 (enacted December 16, 2009), included a new discretionary Teen Pregnancy Prevention (TPP) program that provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. The TPP program was funded at $110 million for FY2010. P.L. 111-117 also provided a separate $4.5 million to carry out evaluations of teenage pregnancy prevention approaches. After several temporary funding measures were enacted, P.L. 112-10, the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011) included funding of $109.5 million for the TPP program for FY2011 ($105 million for the grant program and $4.455 million for program evaluation). P.L. 112-10 also included a 0.2% across-the-board rescission that is not reflected in $109.5 million funding total.

This report provides a brief discussion of the debate on comprehensive sex education and abstinence education, highlights evaluations of both types of programs, describes youth programs that address teen pregnancy, and examines the new teen pregnancy prevention program established by P.L. 111-117 that was included in the Obama Administration's FY2010 budget and again in his FY2011 budget. It also describes the teen pregnancy prevention initiatives included in PPACA. In addition, it identifies teen pregnancy prevention legislation introduced during the 111th Congress (H.R. 463/S. 21, H.R. 1551/S. 611, H.R. 3288, H.R. 3293, H.R. 3312, H.R. 3590, H.R. 3962, H.R. 6283/S. 3878, and S. 1796).

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Introduction

In 2009, teen births (for women ages 15 through 19) accounted for 10.1% of all births in the United States and 21.4% of all nonmarital births. The birth rate for U.S. teenagers increased in 2006 and 2007 after a steady decline since 1991. Recent data indicate that the teen birth rate dropped in 2008 and 2009, reversing the two-year increase. Although the birth rate for U.S. teens has dropped in 16 of the last 18 years (for which data are available), it remains higher than the teenage birth rate of most industrialized nations. In recognition of the negative, long-term consequences associated with teenage pregnancy and births, the prevention of pregnancy among teenagers is a major public policy goal of this nation.

Although there are many federally funded programs that provide pregnancy prevention information and/or services to teens, from 1981 to 1996, the Adolescent Family Life (AFL) program was the only federal program that was required to use all of its funding directly (and exclusively) on the issues of adolescent sexuality, pregnancy, and parenting. From 1996 to 2009, federal teen pregnancy prevention efforts relied heavily on using abstinence-only education as its primary tool; and several programs received federal funding that was to be used solely for teaching and promoting an abstinence-only approach.

President Obama's FY2010 budget proposed a new teen pregnancy prevention program and also proposed to eliminate both mandatory and discretionary funding for the abstinence-only education programs.
Administration's FY2010 budget proposal would have replaced that spending

P.L. 111-117, the Consolidated Appropriations for FY2010 (enacted December 16, 2009), included a new discretionary teenage pregnancy prevention program, identical to the one proposed in the President's FY2010 budget, that provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. P.L. 111-117 appropriated funding of $110 million for FY2010 for the new Teen Pregnancy Prevention (TPP) program, from a discretionary funding account, and an additional $4.5 million for program evaluations for FY2010. P.L. 111-117 does not provide for a $50 million per year mandatory teen pregnancy prevention block grant to states nor does it stipulate that a certain amount ($13.1 million) of that Adolescent Family Life (AFL) funding must

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Stephanie J. Ventura, "Births: Preliminary Data for 200 ," National Vital

teen pregnancy prevention from the Administration's FY2010 budget proposal includes

be used for new teen pregnancy prevention activities. President Obama's FY2011 budget proposed to increase funding for the new discretionary teen pregnancy prevention (TPP) program to $129 million for FY2011 (from $110 million for FY2010 enacted by P.L. 111-117). After several temporary funding measures were enacted, P.L. 112-10, the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011) included funding of $109.5 million for the TPP program for FY2011 ($105 million for the grant program plus $4.455 million for program evaluation). P.L. 112-10 also included a 0.2% across-the-board rescission that is not reflected in the $109.5 million funding total.

Although mandatory block grant funding for teen pregnancy prevention programs was not included in P.L. 111-117, such funding was included in the health care reform bills. Both the House and Senate health care reform bills (H.R. 3962 and H.R. 3590, respectively) included a provision that would have established a mandatory block grant to states for teen pregnancy prevention activities. In the House bill (H.R. 3962), it was funded at $50 million per year for five years and was called the Healthy Teen Initiative to Prevent Teen Pregnancy. In the Senate bill (H.R. 3590), it was funded at $75 million per year for five years and was called the Personal Responsibility Education program. The Senate bill (H.R. 3590) also included a provision that would have appropriated $50 million annually for five years for the previously authorized Title V Abstinence Education block grant. P.L. 111-148 (the Patient Protection and Affordable Care Act (PPACA)), signed into law on March 23, 2010, includes the teen pregnancy prevention provisions that were included in the Senate version of the bill (H.R. 3590).

This report provides a brief discussion of the debate on comprehensive sex education and abstinence education, highlights evaluations of both types of programs, describes youth programs that address teen pregnancy, and examines the new Teen Pregnancy Prevention program established by P.L. 111-117 (which was first proposed in the Obama Administration's FY2010 budget and then again in its FY2011 budget). It also describes the teen pregnancy prevention programs authorized and established in PPACA (P.L. 111-148). In addition, it identifies teen pregnancy prevention legislation that was introduced in the 111th Congress.

Background[6]

When the idea of abstinence-only education was being discussed during the 1994-1996 welfare reform debate it was in the context of providing equal funding for abstinence education as was then provided for teen sexual education programs that included information about contraception and sexually transmitted diseases. It appears that a consensus is now growing around the viewpoint that success in the teen pregnancy prevention arena does not necessarily have to be an "either or" proposition in which abstinence-only education programs are pitted against comprehensive sex education programs. This section discusses three approaches to reducing teen pregnancy: comprehensive sex education, abstinence-only education, and youth programs that address teen pregnancy.

Comprehensive Sex Education

Advocates of a comprehensive approach to sex education argue that today's youth need information and decision-making skills to make realistic, practical decisions about whether to engage in sexual activities. They contend that such an approach allows young people to make

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Nonmarital Childbearing: Trends, Reasons, and Public Policy Interventions

informed decisions regarding abstinence, gives them the information they need to set relationship limits and to resist peer pressure, and also provides them with information on the use of contraceptives and the prevention of sexually transmitted diseases. Given that about 50% of high school students have experienced sexual intercourse, advocates argue that abstinence-only messages provide no protection against the risks of pregnancy and disease for these youth. They further point out that according to one study, teens who break their virginity pledges were less likely to use contraception the first time than teens who had never made such a promise. In addition, the high number of females under age 25 with sexually transmitted diseases (STDs) has re-energized efforts to persuade girls and young women to abstain from sexual activity or to use condoms (along with other forms of contraceptives) to prevent or reduce pregnancy as well as reduce their risk of getting STDs.

Comprehensive sexuality education programs generally include one or more of the following components: (1) information about the benefits of abstinence, (2) information on the use of condoms and other contraceptive devices or methods for those who are sexually active, (3) information on the importance of early identification and treatment of sexually transmitted diseases, (4) information on how to resist negative peer pressure, and (5) information on how to improve communication skills (e.g., how to say no).

Until recent legislation (P.L. 111-117 and P.L. 111-148), there were no federal funding streams that were exclusively for comprehensive sex education in schools. In other words, there was no federal appropriation specifically for comprehensive sex education. Although there was not a federal comprehensive sex education program per se, there were many federal programs that provided information about contraceptives, provided contraceptive services to teens, and provided referral and counseling services related to reproductive health. These programs still provide such services, they include Medicaid Family Planning, Title X Family Planning, and Adolescent Family Life "care" demonstration grants . Also, funds from the Maternal and Child Health block grant, the Title XX Social Services block grant, the TANF block grant, and several other

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Data Bank, "New Indicator on Oral Sex," September 15, 2005, at

Reducing Teen Pregnancy: dolescent amily i e and bstinence ducation Programs

Peter S. Bearman and Hannah Bruckner, "Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse," American Journal of Sociology, January 2001.

each year, almost half of them among young people ages 15 to 24. Source: "Trends in Reportable Sexually Transmitted Disease in the United States, 2006," November 13, 2007.

contraceptive methods (sometimes referred to as the AFL "care" component) as well as abstinence imes referred to as the AFL "prevention" component).

Department of Health and Human Services (HHS) programs can be used to provide contraceptive services to teens.

The following two programs, established in the 111th Congress, provide exclusive funding for comprehensive teen pregnancy prevention initiatives: (1) the Teen Pregnancy Prevention (TPP) program (funded at $110 million in FY2010) and (2) the Personal Responsibility Education Program (PREP; funded at $75 million in FY2010).

P.L. 111-117, the Consolidated Appropriations for FY2010, included a new discretionary TPP program that provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. Of the $110 million appropriated for the TPP program for FY2010, $75 million is for replicating programs that are proven through rigorous evaluation to be effective in reducing teenage pregnancy, behavioral factors underlying teen pregnancy, or other related risk factors; $25 million is for research and demonstration grants; and $10 million for training and technical assistance, outreach, and other program support. The TPP program is administered by the new Office of Adolescent Health within HHS. P.L. 111-117 also provides a separate $4.5 million (within the Public Health Service Act program evaluation funding) to carry out evaluations of teenage pregnancy prevention approaches. After several temporary funding measures were enacted, P.L. 112-10 (enacted April 15, 2011) included funding of $109.5 million for the TPP program for FY2011 ($105 million for the grant program and $4.455 million for program evaluation). P.L. 112-10 also included a 0.2% across-the-board rescission that is not reflected in the $109.5 million funding total.

P.L. 111-148 (the Patient Protection and Affordable Care Act, PPACA) established a new state formula grant program and appropriated $375 million at $75 million per year for five years (FY2010-FY2014) to enable states to operate a new Personal Responsibility Education program, which is a comprehensive approach to teen pregnancy prevention that educates adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted diseases. It also provides youth with information on several adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, and healthy life skills). The new Personal Responsibility Education program is mandated to provide programs that are evidence-based, medically accurate, and age-appropriate.

Also, the AFL program, which has been in existence since 1981, was funded at $16.7 million for FY2010. The FY2010 appropriation for the AFL program (P.L. 111-117) stipulated that the funds were to be exclusively used for comprehensive sex education-type programs. P.L. 112-10 included funding of $12.5 million for the AFL program for FY2011 to be used for comprehensive sex education-type programs. (Note: the $12.5 million figure does not account for the 0.2% across-the-board rescission that was also included in P.L. 112-10).

For example, the mission of the CDC's Division of Adolescent and School Health (DASH) is to

U.S. General Accounting Office, "Teen Pregnancy: State and Federal Efforts to Implement Prevention Programs and

Evaluation of Comprehensive Sex Education Programs

There have been numerous evaluations of comprehensive sex education programs, but most of them did not use a scientific approach with experimental and control groups—an approach that most analysts agree provides more reliable, valid, and objective information than other types of evaluations. A recent report by the National Campaign to Prevent Teen Pregnancy, however, highlighted five teen pregnancy prevention programs that were subjected to a random assignment, experimentally designed study. These five comprehensive sex education programs were found to be effective in delaying sexual activity, improving contraceptive use among sexually active teenagers, or preventing teen pregnancy.

Many analysts and researchers agree that effective pregnancy prevention programs (1) convince teens that not having sex or that using contraception consistently and carefully is the right thing to do; (2) last a sufficient length of time (i.e., more than a few weeks); (3) are operated by leaders who believe in their programs and who are adequately trained; (4) actively engage participants and personalize the program information; (5) address peer pressure issues; (6) teach communication skills; and (7) reflect the age, sexual experience, and culture of young persons in the programs.

Abstinence Education

Many argue that sexual activity in and of itself is wrong if the individuals are not married. Advocates of the abstinence education approach argue that teenagers need to hear a single, unambiguous message that sex outside of marriage is wrong and harmful to their physical and emotional health. These advocates contend that youth can and should be empowered to say no to sex. They argue that supporting both abstinence and birth control is hypocritical and undermines the strength of an abstinence-only message. They also cite research that indicates that teens who take virginity pledges to refrain from sex until marriage appear to delay having sex longer than those teens who do not make such a commitment. (One study found that teens who publicly promise to postpone sex until marriage refrain from intercourse for about a year and a half longer than teens who did not make such a pledge.) They further argue that abstinence is the most effective (100%) means of preventing unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS.

The National Campaign to Prevent Teen Pregnancy, “Putting What Works To Work: Curriculum Prevent Teen Pregnancy,” 2007

Peter S. Bearman and Hannah Bruckner, “Promising the Future: Virginity Pledges as They Affect the Transition to First Intercourse,” Americ

Until FY2010, three federal programs included funding that was exclusively for abstinence education: the Title V Abstinence Education Block Grant to states, the Community-Based Abstinence Education (CBAE) program, and the "prevention" component of the Adolescent Family Life (AFL) demonstration program. All of these programs were carried out by HHS. For FY2009, federal abstinence education funding totals $149.8 million: $37.5 million for the Title V Abstinence Education Block Grant to states; $94.7 million for the CBAE program (up to $10 million of which could be used for a national abstinence education campaign) and $4.5 million for an evaluation of the CBAE program; and $13.1 million for AFL abstinence education "prevention" demonstration projects.

The Title V Abstinence Education Block Grant to states was authorized under P.L. 104-193 (the 1996 welfare reform law). The law provided $50 million per year for five years (FY1998-FY2002) in federal funds specifically for the abstinence education program. The Title V Abstinence Education program is considered a mandatory program and is funded by mandatory spending. It is a formula grant program. State funding is based on the proportion of low-income children in the state compared to the national total. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds and must be used exclusively for teaching abstinence. To receive federal funds, a state must match every $4 in federal funds with $3 in state funds. This means that full funding (from states and the federal government) for abstinence education must total at least $87.5 million annually. The Title V Abstinence Education program was continued through a series of funding extensions. The program's funding expired on June 30, 2009, but the program was reauthorized and appropriated funding for five years (FY2010 through FY2014) pursuant to P.L. 111-148.

Additional abstinence-only education funding (discretionary funding), for the CBAE program, had been included in annual appropriations legislation. CBAE program competitive grants provided support to public and private entities for the development and implementation of abstinence-only education programs (that conform to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states) for adolescents ages 12 through 18, in communities nationwide. Funding for the CBAE program increased incrementally, from $20 million in FY2001 to $108.9 million in FY2008; in FY2009 CBAE funding dropped to $94.7 million. The CBAE program was not funded in FY2010. Moreover, from FY2004 through FY2009, $4.5 million annually (in discretionary funding) was set aside from the Public Health

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Reducing Teen Pregnancy: dolescent amily i e and bstinence ducation Programs

Service for evaluation of the CBAE program. In FY2010, $4.5 million (in discretionary funding) was set aside from the Public Health Service for evaluation of the TPP program. Similarly, in FY2011 (pursuant to P.L. 112-10) $4.5 million was included for evaluation of the TPP program. (Note: this figure does not account for the 0.2% across-the-board rescission that was also included in P.L. 112-10.)

Since 1998, the "prevention" component of the AFL demonstration program has been used to exclusively fund abstinence-only education projects that conform to the definition of abstinence education defined in the Title V Abstinence Education Block Grant to states. The "prevention" component of the AFL demonstration program was funded at $9.0 million in FY1998 and FY1999; $9.1 million in FY2000 and FY2001; $10.2 million in each of the fiscal years FY2002 through FY2004; and $13.1 million in each of the fiscal years FY2005 through FY2009. In FY2010 and FY2011, no funding was provided for the "prevention" component of the AFL program.

Evaluation of Abstinence Education Programs

A report by Mathematica Policy Research, Inc. (released in April 2007) presented the final results from a multi-year, experimentally based impact study on several abstinence-only block grant programs. The report focused on four selected Title V abstinence education programs for elementary and middle school students. Based on follow-up data collected from youth (ages 10 to 14) four to six years after study enrollment, the report, among other things, presented the estimated program impacts on sexual abstinence and risks of pregnancy and STDs. According to the report

The AFL program authorizes grants for two types of demonstrations: (1) projects which provide "care" services (i.e.,

"prevention" services (i.e., services to promote abstinence from premarital sexual relations) to develop, test, and

cienti ic valuations o roaches to Prevent Teen Pregnancy

Christopher Trenholm, Barbara Devaney, Ken Fortson, Lisa Quay, Justin Wheeler, and Melissa Clark, "Impacts of

In response to the report, HHS (under the Bush Administration) stated that the Mathematica study showcased programs that were among the first funded by the 1996 welfare reform law. It stated that its recent directives to states encouraged states to focus abstinence-only education programs on youth most likely to bear children outside of marriage (i.e., high school students) rather than elementary or middle-school students. It also mentioned that programs need to extend the peer support for abstinence from the pre-teen years through the high school years.

In contrast, a recently released study of the abstinence-only strategy found positive results. The scientifically based study assigned African-American students in the 6th and 7th grades to (1) an eight-hour abstinence-only intervention to reduce sexual intercourse; (2) an eight-hour safer sex intervention to increase condom use; (3) eight-hour and 12-hour comprehensive intervention to reduce sexual intercourse and/or increase condom use; or (4) a control group wherein an 8-hour health promotion intervention was used to improve healthy behaviors unrelated to sexual behavior (i.e., informed students about behaviors associated with heart disease, hypertension, stoke, diabetes, and certain cancers). The study found that only about 34% of the student participants in the abstinence-only intervention said that they had engaged in sexual intercourse, whereas about 49% of the students in the control group reported (during the two-year follow-up interview) that they had engaged in sexual intercourse. The authors also reported that among the participants in the abstinence-only intervention who had engaged in sexual activity during the demonstration, there was no significant difference between the abstinence-only intervention participants and the control group participants regarding consistent condom use. The authors further noted that none of the interventions had significant effects on consistent condom use.

Youth Programs

Youth programs incorporate elements of the other two approaches, and generally include one or more of the following components to address teen sexual activity: sex education, mentoring and counseling, health care, academic support, career counseling, crisis intervention, sports and arts activities, and community volunteer experiences. Youth programs receive funding from a wide array of sources, including the federal government, state and local governments, community organizations, private agencies, nonprofit organizations, and faith-based organizations.

Four Title V, Section 510 Abstinence Education Programs (final report)," Mathematica

U.S. Department of Health and Human Services (HHS), "Report Released on Four Title V Abstinence Education Programs," HHS Press Office, April 13, 2007,

Fong, "Efficacy of a Theory Intervention Over 24 Months," *rchives o Pediatrics and dolescent edicine*

Note:

Fong, "Efficacy of a Theory Intervention Over 24 Months," *rchives o Pediatrics and dolescent edicine*

The sex education component of many youth programs usually includes an abstinence message (which is intended to enable teens to avoid pregnancy) along with discussions about the correct and consistent use of contraception (which is intended to reduce the risk of pregnancy for sexually active teens). There is a significant difference between abstinence as a *message* and abstinence-only *interventions*. While some child advocates continue to support an abstinence-only program intervention (with some modifications), others argue that an abstinence message integrated into a comprehensive sex education program that includes information on the use of contraceptives and that enhances decision-making skills is a more effective method to prevent teen pregnancy. A recent nationally representative survey found that 90% of adults and teens agree that young people should get a strong message that they should not have sex until they are at least out of high school, and that a majority of adults (73%) and teens (56%) want teens to get more information about both abstinence and contraception. The American public—both adults and teens—supports encouraging teens to delay sexual activity *and* providing young people with information about contraception.

Some youth programs seek to delay the first time teens have sex. Others have an underlying goal of trying to decipher the root reasons behind teen pregnancy and childbearing. Is it loneliness or trying to find love or a sense of family? Is it carelessness—not bothering with birth control or using it improperly—or shame—not wanting to go to the doctor to ask about birth control or not wanting to be seen in a pharmacy purchasing birth control? Is it a need to meet the sexual expectations of a partner? Is it trying to find individual independence or is it defiance (a mentality of you can't boss me or control me—"I'm grown")? Is it trying to validate and/or provide purpose to one's life? Is it realistically facing the probability that the entry-level job she can get at the age of 18 is the same or similar to the one she will likely have when she is 30, thus why should she wait to have a child?

In addition, many youth programs also want to prevent second or additional births to teens and they realize that a different approach may be needed to prevent secondary births as compared to first births. Research has indicated that youth programs that include mentoring components, enhanced case management, home visits by trained nurses and/or program personnel, and parenting classes have been effective in reducing subsequent childbearing by teens.

Evaluation of Youth Programs

A study that evaluated youth programs that sought to delay the first time teens have sex partly summarized the research by highlighting some characteristics or activities associated with teenagers who delayed sexual activity. The study reported that (1) teens who do well in school and attend religious services are more likely to delay sexual initiation; (2) girls who participate in sports also delay sex longer than those who do not; and (3) teens whose friends have high educational aspirations, who avoid such risky behavior as drinking or using drugs, and who

Bill Albert, "With One Voice 2007— erica's Adults and Teens Sound Off About Teen Pregnancy," National

Erin Schelar, Kerry Franzetta, and Jennifer Manlove, "Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity," Child Trends, Research Brief no. 2007

perform well in school are less likely to have sex at an early age than teens whose friends do not.

Proposals in the 111th Congress

Although the birth rate for U.S. teens has dropped in 16 of the last 18 years (for which program data are available), it remains higher than the teenage birth rate of most industrialized nations. As mentioned earlier, the birth rate for U.S. teenagers increased in 2006 and 2007, but dropped in 2008 and 2009. According to a recent report on children and youth, in 2007, one-third of 9th graders reported having experienced sexual intercourse. The corresponding figures for older teens were 44% of 10th graders, 56% of 11th graders, and 65% of 12th graders.

teenagers get pregnant: (1) social and economic changes; (2) teens' relationships with parents,

Some commentators suggest that the 14-year reduction in teen birth rates brought on a mild complacency among policymakers and that the recent upswing in teen births has renewed public attention to the need to implement proven strategies and find new ways to reduce teen pregnancy. According to recent data, the birth rate for U.S. teenagers dropped in 2008 and 2009. This decline reverses two consecutive years of increase, as mentioned above.

President's Budget Proposal

FY2010 Budget

The Obama Administration switched the focus of teen pregnancy prevention from using abstinence-only education as its primary tool to using approaches that rely on teaching abstinence along with information on contraception. According to HHS budget documents for FY2010, funds from the discretionary CBAE program, the mandatory Title V Abstinence Education Block Grant, and the "prevention" component of the AFL program would be redirected in FY2010 to

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Jennifer Manlove, Angela Romano Papillio, and Erum Ikramullah, "Not Yet: Program To Delay First Sex Among Teens," The National Campaign to Prevent Teen Pregnancy and Child Trends, September 2004, p. 4.

R outh Ris ehavior urveillance— nited tates,

erson Moore, "Teen Births: Examining the Recent Increase," *Child Trends Research rie*

the proposed teen pregnancy prevention programs because the HHS-sponsored scientific evaluation of abstinence-only education programs indicated that such programs were not effective in reducing teenagers' likelihood of engaging in sexual activity.

As mentioned earlier, although many federal programs allow their funds to be used for teen pregnancy prevention, until enactment of P.L. 111-117, there was not a separate funding source specifically for the purpose of providing comprehensive sex education in schools. President Obama's FY2010 budget included funding for a new teen pregnancy prevention initiative. The President's proposed teen pregnancy prevention initiative would fund programs based on successful models that provide medically accurate and age-appropriate resources to reduce the risks of pregnancy and sexually transmitted diseases. These funds would be used to support both the replication of evidence-based models and demonstration programs to identify new effective approaches to reduce teenage pregnancy. The proposed teen pregnancy initiative has multiple components, and would total $164.5 million in FY2010. In addition, the FY2010 budget proposed that $13.1 million that is to be expended on the "prevention" component of the AFL demonstration program be redirected from funding abstinence-only education demonstration programs to funding broader teen pregnancy prevention programs that replicate successful program models or

According to budget documents, approximately 20 curriculum-based models have been evaluated using a rigorous experimental design and were shown to reduce teen pregnancy rates, increase contraception use, or delay the onset of sexual activity. Many of these programs have a strong emphasis on abstinence and encourage teens to wait to have sex, but also provide information on contraception and comprehensive sex education. Although some of the most successful programs usually include a youth development component, such as service learning (e.g., volunteering, community service), academic support, or opportunities to participate in sports and the arts, research on teen pregnancy prevention is still emerging.

The proposed FY2010 budget provided $110 million in *discretionary* funds for a competitive teen pregnancy prevention grant program for community and faith-based organizations as well as outreach, training, technical assistance, and evaluation. The proposed teen pregnancy prevention budget initiative would direct most of its funds towards programs that have been shown to be effective, but also provides some funding for grantees to identify new approaches for reducing teen pregnancy. The HHS Secretary would be authorized to award grants to non-profit faith-based and community organizations for teen pregnancy prevention programs for youth ages 12 to 19. Grants would last three to five years and provide an average of $350,000 to the grantee with a 25% match requirement. All applicants for teen pregnancy prevention grants would have to agree

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group. The term "medically accurate," with respect to information, usually means information that is

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to randomly assign participants to control and experimental groups if selected for a national evaluation.

According to HHS budget documents, not less than $75 million of the proposed $110 million in discretionary funds would be used to fund grants for programs to replicate curriculum-based models that have been shown through strong evaluation (defined as an experimental or quasi-experimental study) to be effective in reducing teen pregnancy, delaying sexual activity, or improving contraception use (without increasing sexual activity). Moreover, not less than $25 million (of the proposed discretionary $110 million) would be used to fund grants for demonstration programs to develop, replicate, refine, and test additional models and innovative strategies for preventing teen pregnancy. All grantees would be required to use a curriculum that is both age appropriate and medically accurate. In addition, the Obama Administration's FY2010 budget would fund activities to support parents in communicating with their children about teen pregnancy and other high-risk behaviors. These funds would be used for an interactive website and other outreach activities for parents, youth, teachers, and community members (the budget documents do not specify a specific dollar amount for these activities).

The Administration's FY2010 budget also provided $4.5 million in Public Health Service Act evaluation funds for a rigorous evaluation of the proposed pregnancy prevention initiatives.

In addition, the Obama Administration's FY2010 budget sought authorization for a new $50 million *mandatory* teen pregnancy prevention grant to states, tribes, and territories. Budget documents indicated that funding for the mandatory Title V Abstinence Education Block Grant program would not be requested; instead, $50 million in mandatory funds would be used to fund a broader teen pregnancy prevention initiative using scientifically based models and promising practices.

Moreover, the Obama Administration's FY2010 budget sought to redirect in FY2010 $13.1 million in funds from the "prevention" component of the AFL program that were previously used exclusively for abstinence-only education program to the proposed teen pregnancy initiative. According to the FY2010 Budget Appendix, o

To summarize, under the Obama Administration's FY2010 budget, the proposed teen pregnancy prevention initiative would have received funding totaling $177.6 million for FY2010. That

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The term "rigorous" in this context usually means an evaluation using a

U.S. Department of Health and Human Services, Administration for Children and Families, "Children and Families Services Programs," Justification of Estimates

The Obama Administration's FY2010 budget would fund the entire AFL demonstration program at FY2010. It stipulates that funding for the "prevention" component of the AFL demonstration program would amount to

initiative. The remaining AFL demonstration funds ($16.7 million) would be for the "care" and research components of

he Obama Administration's Teen Pregnancy Prevention (TPP) program

total includes $110 million to fund approximately 275 discretionary grants; $50 million in mandatory funds for states, tribes, and territories; $13.1 million for the "prevention" component of the AFL program (which was being used to exclusively fund abstinence-only education programs), and $4.5 million in Public Health Service Act evaluation funds for a rigorous evaluation of the pregnancy prevention initiatives.

As noted earlier, the $110 million discretionary TPP program and its evaluation ($4.5 million) were included in P.L. 111-117.

FY2011 Budget

President Obama's FY2011 budget proposed to increase funding for the new discretionary teen pregnancy prevention (TPP) program to $129 million for FY2011 (from $110 million for FY2010 enacted by P.L. 111-117). The funding for the TPP program would include (1) $85 million to replicate teen pregnancy prevention approaches that have been proven (through rigorous evaluation) to be effective; (2) $28 million for research and demonstration grants to develop, replicate, refine, and test additional strategies for reducing and preventing teenage pregnancy; (3) $4 million for program evaluation; and (4) $12 million for training and technical assistance, outreach, and other program support. The Obama Administration has also requested an additional $50 million in mandatory funds for a new formula grant to support teen pregnancy prevention efforts by states, tribes, and the territories. Also, the FY2011 budget documents indicate that funding of $17 million is to be used to support AFL "care" demonstration projects and research. Further, according to budget documents, an additional $4 million from Public Health Service (PHS) evaluation funds is to be used for evaluating TPP programs.

To summarize, funding for teen pregnancy prevention initiatives included in the Administration's FY2011 budget request would have totaled $200 million in FY2011.

H.R. 463/S. 21

The proposed Prevention First Act, H.R. 463, was introduced by Representative Slaughter (et al.) on January 13, 2009. Its companion bill, S. 21, was introduced by Senator Reid (et al.) on January 6, 2009. The bills included provisions that would have established two new grants.

The bills would have given the HHS Secretary the authority to award grants on a competitive basis to public and private entities to establish or expand teenage pregnancy prevention programs (with priority given to programs that would benefit at-risk or underserved communities). The bills stipulated that the proposed teenage pregnancy prevention grant funds could only be used to replicate or substantially incorporate elements of one or more teenage pregnancy prevention programs that have been proven (on the basis of rigorous scientific research) to delay sexual intercourse or activity, increase condom or contraceptive use without increasing sexual activity, or reduce teenage pregnancy. The bills required that any information concerning the use of contraception provided through specified federally funded education programs be age-appropriate and medically accurate. The teenage pregnancy prevention grant program would have been funded by "such sums as may be necessary" for FY2010 and each subsequent fiscal year. The bills would have required that the HHS Secretary conduct or provide an evaluation of at least 10% of the individual grant programs.

Under the Administration's FY2011 budget proposal, the $129 million would continue funding for the 275 TPP

The bills would have required the HHS Secretary via the Director of the Centers for Disease Control and Prevention to award grants to public or nonprofit entities to conduct, support, and coordinate teenage pregnancy prevention research. The research would have been funded by "such sums as may be necessary" for each of the fiscal years FY2010 through FY2014.

The bills would have allowed the HHS Secretary to make grants to states for family life education programs, including programs that provide education on both abstinence and contraception to prevent teenage pregnancy and sexually transmitted diseases. The bills would have required a national evaluation and individual state evaluations of the family life programs. The family life grant program would have been funded by "such sums as may be necessary" for each of the fiscal years FY2010 through FY2014. The bills stipulated that no more than 7% of family life grant funds could be used for administrative expenses, that no more than 10% of grant funds could be used for a national evaluation of the program, and that no more than 10% of grant funds could be used for the evaluation of individual state program evaluations.

Among other things, the bills also would have (1) stipulated that any information concerning the use of a contraceptive provided through specified federally funded education programs be age-appropriate and medically accurate and include health benefits and failure rates relating to the use of such contraceptive; (2) amended title XIX (Medicaid) of the Social Security Act to expand Medicaid's coverage of family planning services; and (3) expanded Medicaid rebates to manufacturers for the sale of covered outpatient drugs at nominal prices to include sales to student health care facilities and entities offering family planning services.

H.R. 1551/S. 611

The proposed Responsible Education About Life Act, H.R. 1551, was introduced by Representative Lee (et al.) on March 17, 2009. Its companion bill, S. 611, was introduced by Senator Lautenberg (et al.) on March 17, 2009. The bills would have permitted the HHS Secretary to award to eligible states a grant to conduct sex education programs that include both abstinence and contraception information for the purpose of preventing teenage pregnancy and sexually transmitted diseases, including HIV/AIDS. The information in the programs was required to be age appropriate and medically accurate. The bills also required individual state program evaluations as well as a national evaluation of the state programs. The grant program would have been funded at $50 million for each of the fiscal years 2010 through 2014. The bills stipulated that no more than 7% of grant funds could be used for administrative expenses and that no more than 10% of grant funds could be used for a national evaluation of the program. Also, a state would have been prohibited from using more than 10% of its funds for an evaluation of its individual program (conducted by an external, independent entity).

H.R. 3288

H.R. 3288, the Consolidated Appropriations for FY2010, was introduced in the House on July 22, 2009. It was passed by the House on July 23, 2009, and by the Senate, amended, on September 17, 2009. The conference agreement (H.Rept. 111-366) was passed by the House on December 10, 2009, and by the Senate on December 13, 2009. The bill was signed into law as P.L. 111-117 on December 16, 2009.

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define "s " to mean the 50 s

P.L. 111-117, the Consolidated Appropriations for FY2010 (H.R. 3288), does not fund the Community-Based Abstinence Education (CBAE) program, but it does include a new Teenage Pregnancy Prevention program under the HHS Office of the Secretary that would receive $110 million for FY2010. The program, identical to the discretionary teenage pregnancy prevention program proposed in the President's FY2010 budget (discussed earlier), provides grants and contracts, on a competitive basis, to public and private entities to fund "medically accurate and age appropriate" programs that reduce teen pregnancy. Of the amount appropriated, $75 million is for replicating programs that are proven effective through rigorous evaluation as reducing teenage pregnancy, behavioral factors underlying teen pregnancy, and related risk factors; while $25 million is for research and demonstration grants. P.L. 111-117 also appropriated $16.7 million to the AFL *care* program for FY2010. Moreover, P.L. 111-117 provided a separate $4.5 million within Public Health Service Act program evaluation funding to carry out evaluations of teenage pregnancy prevention approaches.

H.R. 3293

The Labor, HHS, and Education appropriations bill was introduced by Representative Obey (et al.) on July 22, 2009. The bill included the provisions outlined in the President's FY2010 budget with regard to teen pregnancy prevention programs (see earlier description). H.R. 3293 was passed by the House on July 24, 2009; but was not passed the Senate.

H.R. 3312

The proposed Preventing Unintended Pregnancies, Reducing the Need for Abortion, and Supporting Parents Act, H.R. 3312, was introduced by Representative Ryan (et al.) on July 23, 2009. H.R. 3312 would have required the HHS Secretary to provide grants to local educational agencies, state and local public health agencies, and nonprofit private entities to operate projects that offer comprehensive education on preventing teen pregnancies. H.R. 3312 would have required that the proposed teenage pregnancy prevention grant funds could only be used to replicate or substantially incorporate elements of one or more teenage pregnancy prevention programs that have been proven (on the basis of rigorous scientific research) to delay sexual intercourse or activity, improve contraceptive use, reduce the number of partners for those who are sexually active, or reduce teenage pregnancy. H.R. 3312 would have required that any information concerning the use of contraception provided through specified federally funded education programs be age-appropriate and medically accurate. The teenage pregnancy prevention grant program would have been funded by "such sums as may be necessary" for each of the years FY2010 through FY2015. H.R. 3312 would have required that the HHS Secretary commission an evaluation of the programs of a few of the selected grantees.

H.R. 3312 also would have provided incentive grants ($30 million for each of the years FY2010 through FY2014) for certain states or Indian tribes to implement teen pregnancy prevention strategies. It also required the HHS Secretary to establish a national goal to prevent teen pregnancy. The bill also would have authorized the HHS Secretary to provide grants to several public or nonprofit private entities for innovative approaches to prevent teen pregnancies. In addition, H.R. 3312 would have required the HHS Secretary to provide competitive grants for (1) a national center to support parents of adolescents in their efforts to prevent teen pregnancy, (2) media campaigns that provide messages to parents about how they can help prevent teen pregnancy, and (3) challenge grants to states and tribes to promote parent education and

involvement. H.R. 3312 also included many other provisions related to pregnant or parenting women.

H.R. 3590

H.R. 3590 was the Senate vehicle for the health care reform legislation. It was introduced in the House on September 17, 2009. It passed the House on October 8, 2009, and the Senate, amended, on December 24, 2009. The House agreed to the Senate amendments on March 21, 2010. It became P.L. 111-148 on March 23, 2010.

H.R. 3590 included a provision that authorized and appropriated funding for a new Personal Responsibility Education state block grant program. The program is funded at $75 million per year for five years (FY2010-FY2014) for grants to states to support "Personal Responsibility Education" programs for adolescents. Each Personal Responsibility Education program is required to address prevention of pregnancy (through both abstinence and contraception), prevention of sexually transmitted diseases, and at least three of the "adulthood preparation subjects" (i.e., healthy relationships, adolescent development, financial literacy, parent-child communication, education and career success, and healthy life skills). H.R. 3590 also included a provision that appropriated $50 million annually for five years (FY2010-FY2014) for previously authorized Title V Abstinence-only Education block grants.

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). PPACA included the two teen pregnancy prevention provisions that were in the Senate version of the bill (H.R. 3590). It established a new state formula grant program and appropriates $75 million annually for each of FY2010-FY2014 to enable states to operate a new Personal Responsibility Education program ($375 million over five years). PPACA also restored funding to the Title V Abstinence Education formula block grant to states at the previous annual level of $50 million for each FY2010-FY2014 ($250 million over five years).

H.R. 3962

H.R. 3962, the Affordable Health Care for America Act, was introduced on October 29, 2009. It was passed by the House on November 7, 2009 and the Senate, amended, on June 18, 2010. The House agreed to the Senate amendments on June 24, 2010. It became P.L. 111-192 on June 25, 2010.

H.R. 3962, as passed by the House, included a provision that would have authorized and appropriated funding for a new Healthy Teen Initiative to Prevent Teen Pregnancy block grant to states. The block grant would have been funded at $50 million per year for five years (FY2011-2015) for evidence-based education programs to reduce teen pregnancy or sexually transmitted diseases. However, the Senate-passed bill did not include the Healthy Teen Initiative.

H.R. 6283/S. 3878

H.R. 6283 was introduced by Representative Barbara Lee (et al.) on September 29, 2010. S. 3878 was introduced by Senator Frank Lautenberg (et al.) on September 29, 2010.

H.R. 6283 and S. 3878 would have amended Title V (Maternal and Child Health Services) of the Social Security Act to: (1) eliminate the abstinence-only education program; (2) rescind unobligated FY2010 program appropriations; and (3) reprogram such rescinded appropriations for the personal responsibility education program (PREP) for FY2011-FY2014.

S. 1796

The proposed America's Healthy Future Act of 2009, S. 1796, was introduced by Senator Baucus on October 19, 2009. It authorized and appropriated funding for a new Personal Responsibility Education state block grant program. The program would have been funded at $75 million per year for five years (FY2010-FY2014) for grants to states to support "Personal Responsibility Education" programs for adolescents. It also reauthorized and appropriated funding for the Title V Abstinence Education block grant to states ($50 million annually for five years (FY2010-FY2014). It included teen pregnancy prevention provisions identical to those in H.R. 3590.

Author Information

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Exhibit 7

An official website of the United States government Here's how you know

State Personal Responsibility Education Program

Listen

Through the **State Personal Responsibility Education Program (PREP),** FYSB awards grants to state agencies to educate young people on both abstinence and contraception. With efforts toward preventing pregnancy and sexually transmitted infections, **PREP** targets young people who are:

- Homeless
- In foster care
- Living in rural areas or areas with high teen birth rates
- From minority groups (including sexual minorities)

PREP also supports pregnant youth and mothers under the age of 21.

For more info, please see the **PREP Fact Sheet** and navigate through the **PREP Home Page.**

Exhibit 8

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501WAPREP
FAIN# 2501WAPREP
Federal Award Date: December 27, 2024

Recipient Information

1. Recipient Name
HEALTH, WASHINGTON STATE DEPARTMENT OF
PO Box 47880

OLYMPIA, WASHINGTON 98504 7880

2. Congressional District of Recipient
*See Remarks

3. Payment Account Number and Type
*See Remarks

4. Employer Identification Number (EIN)
1911444603A1

5. Data Universal Numbering System (DUNS)
808883128

6. Recipient's Unique Entity Identifier
C16SP2HBR123

7. Project Director or Principal Investigator
Mary Clark

Mary.Clark@doh.Wa.Gov
360-236-3940

8. Authorized Official
*See Remarks

Federal Agency Information

9. Awarding Agency Contact Information
David Lee
Grants Management Officer
david.lee@acf.hhs.gov
202-401-5461

10. Program Official Contact Information
Jerry Milner
Program Authorizing Official
ACYF - Family and Youth Services Bureau
Milner.Jerry@acf.hhs.gov
111-111-1111

Federal Award Information

11. Award Number
2501WAPREP

12. Unique Federal Award Identification Number (FAIN)
2501WAPREP

13. Statutory Authority
Section 513 of the Social Security Act

14. Federal Award Project Title
*See Remarks

15. Catalog of Federal Domestic Assistance (CFDA) Number
93.092

16. CFDA Program Title
Personal Responsibility Education Program

17. Award Action Type
New

18. Is the Award R&D?
*See Remarks

Summary Federal Award	Financial Information
19. Budget Period Start Date 10-01-2024	**End Date** 09-30-2027
20. Total Amount of Federal Funds Obligated by this Action	$420,717.00
20a. Direct Cost Amount	*See Remarks
20b. Indirect Cost Amount Administrative Offset	*See Remarks
21. Authorized Carryover	*See Remarks
22. Offset	*See Remarks
23. Total Amount of Federal Funds Obligated this budget period	$420,717.00
24. Total Approved Cost Sharing or Matching, where applicable	*See Remarks
25. Total Federal and Non-Federal Approved	*See Remarks
26. Project Period Start Date 10-01-2024 -	**End Date** 09-30-2027
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching	*See Remarks

28. Authorized Treatment of Program Income
*See Remarks

29. Grants Management Officer – Signature

Esign
David Lee
Grants Management Officer

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501WAPREP
FAIN# 2501WAPREP
Federal Award Date: December 27, 2024

Recipient Information
HEALTH, WASHINGTON STATE DEPARTMENT OF
PO Box 47880
OLYMPIA, WASHINGTON 98504 7880
Employer Identification Number (EIN): 1911444603A1
Data Universal Numbering System (DUNS): 808883128
Recipient's Unique Entity Identifier: C16SP2HBR123
Object Class: 41.15

Financial Information

Appropriation	CAN	Allotment	Award this action	Cumulative Grant Award to Date	Document Number	Funding Type
75-X-1512	2025,G99SU25	$1,133,232.00	$420,717.00	$420,717.00	2501WAPREP	Formula

Terms and Conditions

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501WAPREP
FAIN# 2501WAPREP
Federal Award Date: December 27, 2024

Standard Terms and Conditions
Except as noted otherwise, these Terms and Conditions (T&Cs) apply to Federal financial assistance awards, i.e., grant and cooperative agreement programs, administered by the Administration for Children and Families (ACF). Please see the Award Terms and Conditions page.
Precedence
Applicable statutory or regulatory provisions supersede conflicting or inconsistent provisions in this Standard T&C.
Department of Health and Human Services (HHS) to Adopt 2 CFR Part 200 in Phases
Per Federal Register (FR), 89 FR 80055, HHS describes the intended phases of formally adopting 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (UAR) as modified by Office of Management and Budget (OMB), 89 FR 30136, April 22, 2024). As a result, the content herein will identify both 45 CFR Part 75 and respectively, by effective date, 2 CFR Part 200 and 2 CFR Part 300 HHS-specific regulations.
Effective 10/1/2024 – Increasing Thresholds / Flexibilities for Recipients in 45 CFR Part 75 (to align with similar provisions in 2 CFR 200)

Provisions (Regulations) CFR Part 75	Before 10/1/2024 Threshold under 45	On and After 10/1/2024 New Threshold
Modified Total Direct Cost Definition (45 CFR §75.2 / 2 CFR §200.1)	$25,000	$50,000
Equipment (45 CFR §75.320(e) / 2 CFR §§200.1, 200.313(e), 200.439(b)(2))	$5,000	$10,000
Unused Supplies (45 CFR §75.321(a) / 2 CFR §§200.1, 200.314(a))	$5,000	$10,000
Micro-purchase Threshold1 (45 CFR §75.329(a) / 2 CFR §200.320)	$10,000	$50,000
Fixed Amount Awards Subawards (45 CFR §75.353 / 2 CFR §200.333)	$250,000	$500,000
Closeout2 (45 CFR §75.381 / 2 CFR §200.344)	90 days	120 days

1 This provision was adopted on December 12, 2017 under Public Law 115-91 and OMB Memorandum 18-18.
2 This provision was adopted on September 15, 2023 under 88 FR 63591.

Provisions (Regulations) CFR Part 75	Before 10/1/2024 Threshold under 45	On and After 10/1/2024 New Threshold
De Minimis Indirect Rate3 (45 CFR §75.414(f) / 2 CFR §200.414(f))	10%	15%
Single Audit (45 CFR §75.501 / 2 CFR §200.501)	$750,000	$1,000,000

Effective 10/1/2025 – 2 CFR 200 and HHS Specific Modifications Implementation
- Adopt 2 CFR Part 200.
- Repeal 45 CFR Part 75 in its entirety and update existing citations in HHS regulations.
- Relocate HHS-specific modifications from 45 CFR Part 75 to 2 CFR Part 300:

Modification	Before 10/1/2025	On and After 10/1/2025
45 CFR Part 75	2 CFR Part 300	
Adoption of 2 CFR Part 200	75.106	300.106
Conflict of Interest	75.112	300.112
Special Provisions for awards to For-Profit Organizations as Recipients	75.216	300.218
Special Provisions for awards to Federal agencies	75.217	300.219
Non-discrimination language	75.300	300.300
Federal Payment	75.305(a)	300.305
Revision of budget and program plans (specific to research care cost prior Approval)	75.308(c)(1)(ix)	300.308
Intangible Property (patents and inventions)	75.307(c)(2)	300.315

Indirect Cost (Training and Foreign cap and allowing rates for American U, Beirut, and WHO)		75.414(c)(1)		300.414
Independent research and development costs	75.476		300.477	
Shared responsibility payments		75.477		300.478
Cost Principles for Research & Development Grant Activities with Hospitals		Appendix IX		Appendix IX

Federal Financial Assistance Award Acceptance
State, local, tribal and other laws and regulations may apply and affect expenditures of Federal funds provided that they conform to applicable federal statutes and regulations. The first draw down or request for award funds from HHS Division of Payment Management Services (PMS) constitutes acceptance of the T&Cs under the Federal award.
A Federal assistance award is subject to T&Cs set forth in the award, these standard T&Cs, and those T&Cs cited and incorporated by reference. A recipient is the entity that receives a Federal award directly from ACF, per 45 CFR §75.2 (effective 10/1/2025: 2 CFR §200.1). By acceptance of an award, the recipient agrees to comply with these T&Cs. Unless indicated otherwise, per 45 CFR §75.101(b)(1) (effective 10/1/2025: 2 CFR §200.101(b)(2)), the T&Cs of Federal awards flow down to subrecipients and to contractors (when applicable) as described in 45 CFR §§75.351 – 75.353 (effective 10/1/2024: 2 CFR §200.333; effective 10/1/2025: 2 CFR §200.331 – 200.332).
Recipients must comply with all T&Cs of their awards, including:
a) The T&Cs in effect at the time of the award, including the requirements of applicable HHS uniform administrative regulations.
• Discretionary: Any T&Cs in effect at the time of the original award, or any non- competing continuation, post-award action or renewal award related thereto are applicable. Discretionary awards are subject to the requirements set forth in the Notice of Funding Opportunity (NOFO); Notice of Award (NoA) including remarks and/or specific award conditions (e.g., restricted drawdown); these Standard T&Cs; and the U.S. Department of Health and Human Services (HHS) Grants Policy Statement.

3 Note this does not apply to HHS Training or Foreign awards, for which HHS retains the de minimis cap at 8%.

• Non-Discretionary: Non-discretionary awards are subject to these Standard T&Cs, the individual program-specific supplemental T&Cs, and NoA including remarks and/or specific award conditions.
b) Requirements of statutes and regulations applicable to the program under which the award is funded, including authorizing statutes, appropriations statutes, generally applicable statutes, and any regulations related thereto.

Enforcement
Failure to comply with the T&Cs of the award may result in disallowances, restricted drawdown, withholding of future awards, deferral of claims for Federal Financial Participation (FFP), or termination of the award. Some programs may have more specific termination provisions that will be referenced in the NOFO, the program-specific supplemental T&Cs, NOA, and/or in the specific award conditions (as applicable).
ALL FEDERAL FINANCIAL ASSISTANCE PROGRAMS
APPLICABLE LEGISLATION, STATUTES, REGULATIONS
Recipients must follow Federal, State, and local laws applicable to HHS awards. This includes, but is not limited to statutory and regulatory requirements, even if not directly mentioned in these terms and conditions. This award is subject, at the minimum, to the following requirements:

1. The statutory requirements as identified in the NOFO or program-specific supplemental terms and conditions, and any requirements in the authorization and appropriations acts related to the program and award.
2. The HHS specific implementing regulations of 45 CFR Part 75 or 2 CFR Part 200 as codified at 2 CFR Part 300, as they are applicable in effect or implemented during the period of the award. See "Department of Health and Human Services (HHS) to Adopt 2 CFR Part 200 in Phases" in these T&Cs for effective dates and changes.
a. Discretionary: Unless otherwise stated in the NOFO, all provisions under the UAR apply. Please note discretionary recipients are required to report deviations from budget or program scope or objective, and must request prior written approval from ACF for budget and program plan revisions. See the NoA for any expanded authorities authorized under the award.

b. Non-Discretionary: Please refer to the program-specific supplemental T&Cs, which may also cite to or contain budget or program prior approval requirements.

3. Other Code of Federal Regulations: Unless otherwise provided by law, the following apply:

a. 2 CFR Part 25 – Universal Identifier and System for Award Management

b. 2 CFR Part 170 – Reporting Subaward and Executive Compensation Information

c. 2 CFR Part 175 – Award Term for Trafficking in Persons

d. 2 CFR Part 176 – Award Terms for Assistance Agreements that include Funds under the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5

e. 2 CFR Part 180 – OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Non-Procurement)

f. 2 CFR Part 182 – Government-wide Requirements for Drug-Free Workplace (Financial Assistance) (including Smoking Prohibitions (20 U.S.C §§7971 – 7974, previously §§7181 – 7184)

g. 2 CFR Part 183 – Never Contract with the Enemy

h. 2 CFR Part 376 – Non procurement Debarment and Suspension

i. 2 CFR Part 382 – Requirements for Drug-Free Workplace (Financial Assistance)

j. 31 CFR Part 205 – Rules and Procedures for Efficient Federal-State Funds Transfers – Cash Management Improvement Act (see also 31 U.S.C. §§3335, 6501, and 6503)

k. 45 CFR Part 16 – Procedures of the Departmental Grant Appeals Board

l. 45 CFR Part 30 – Claims Collection

m. 45 CFR Part 46 – Protection of Human Subjects

n. 45 CFR Part 80 – Nondiscrimination Under Programs Receiving Federal Assistance through the Department of Health and Human Services, Effectuation of Title VI of the Civil Rights Act of 1964
o. 45 CFR Part 81 – Practice and Procedure for Hearings Under Part 80 of this Title
p. 45 CFR Part 84 – Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving Federal Financial Assistance
q. 45 CFR Part 86 – Nondiscrimination on the Basis of Sex in Education Programs and Activities Receiving or Benefiting from Federal Financial Assistance
r. 45 CFR Part 87 – Equal Treatment for Faith-Based Organizations
s. 45 CFR Part 91 – Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance from HHS
t. 45 CFR Part 93 – New Restrictions on Lobbying
u. 45 CFR Part 95 – General Administration – Grant Programs
v. 45 CFR Part 100 – Intergovernmental Review of Department of Health and Human Services Programs and Activities

4. Administrative and National Policy Requirements, including HHS Policy Directives (identified with an asterisks (*) and Annual Appropriation Limitations (identified with two asterisks (**)): Unless otherwise noted in the program-specific supplemental T&Cs, the NOFO, the administrative and national policy requirements, HHS policy directives, and annual appropriations limitations apply to all programs. Public policy requirements are requirements with a broader national purpose and are imposed by statute. The non- exhaustive list is located under the Administrative and National Policy Requirements page.

5. Build America, Buy America (BABA) Applicability: The BABA is not applicable to HHS programs; therefore, the following does not apply to ACF awards:
a. 2 CFR Part 184 – Buy America Preferences for Infrastructure Projects
b. 2 CFR §200.322 – Domestic Preference for Procurements provision

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

6. Some Federal financial assistance programs require the recipient to provide a portion of program funding, as specified in Federal law. Please see the NOFO or program-specific supplemental T&Cs for the requirements.

7. Insular Areas. For any program that (a) requires a non-Federal share of program funding and (b) is available to several identified recipients, under the provisions of 48 U.S.C.§1469a(d), as amended, the Insular Areas, defined as American Samoa, Guam, the Northern Mariana Islands and the U.S. Virgin Islands, these recipients are not required to provide up to $200,000 of the non-Federal share of program funding. If, in any fiscal year, the non-Federal share exceeds $200,000, the statutory Federal/non-Federal funding rates for that program will apply to all expenditures that exceed that threshold.

PROGRAM INCOME

8. Default Method. Please refer to the NOFO, program-specific supplemental T&Cs, and NoA to verify if program income is permitted, and if so, how it is to be used. When the regulations or the T&Cs are silent, the default is the deduction method as described under 45 CFR §75.307(e) (effective 10/1/2025: 2 CFR §200.307(e)(1)). ("Ordinarily program income must be deducted from total allowable costs to determine the net allowable costs. Program income must be used for current costs unless the HHS awarding agency authorizes otherwise. Program income that the non-Federal entity did not anticipate at the time of the Federal award must be used to reduce the Federal award and non-Federal entity contributions rather than to increase the funds committed to the project.")

9. Property. Proceeds from the sale of real property, equipment, or supplies, are not program income; such proceeds will be handled in accordance with the relevant property standards at 45 CFR §§75.318 – 75.322 (effective 10/1/2025: 2 CFR §§200.311 – 200.315), or as specifically identified in Federal statutes, regulations, or T&Cs of the Federal award. For more information about real property and tangible personal property, please see the subheading contained in this Standard T&C.

10. Applicable Credit. Unless provided in statutes, regulations, or T&Cs of the award, program income does not include rebates, credits, discounts, and interest earned on any of them. When those sources are silent, to the extent that such credits accruing to or received by the recipient relate to allowable costs, they must be credited to the award either as a cost reduction or cash refund as described under 45 CFR §75.406 (effective 10/1/2025: 2 CFR §200.406).

MONITORING AND REPORTING

Except in unusual circumstances, ACF recipients are required to use OMB-approved data collection forms and file these forms in intervals identified by the Federal award. (45 CFR §75.341-75.343; effective 10/1/2025: 2 CFR §§200.328 – 200.330) For more information, see the NOFO, program-specific supplemental T&Cs, NoA, or specific award conditions.

11. Electronic Submissions.
Reports must be submitted electronically. Paper copies will not be accepted. ACF recipients must submit reports through designated online reporting systems, as identified in the NOFO, program-specific supplemental T&Cs, NoA, and/or the specific award conditions. Each system is secured and requires individuals to use a PIN, username, and password.
a. GrantSolutions On-Line Data Collection (OLDC) system is the online reporting mechanism and is located at https://grantsolutions.gov. The GrantSolutions Help Desk is open on Monday through Friday from 7:00 am to 8:00 pm ET (except for Federal Holidays). You may reach the Help Desk at 1-866-577-0771, 202-401- 5282, or help@grantsolutions.gov.

b. HHS Payment Management System (PMS) is the online payment management mechanism and is located at https://pms.psc.gov. The PMS Help Desk is open Monday through Friday from 7:00 am to 9:00 pm ET (except Federal Holidays). You may reach the Help Desk at 1-877-614-5533 or PMSSupport@psc.gov.

FINANCIAL REPORTING

12. Federal funds must be expended for the purposes which they were awarded and within the time period allotted. (45 CFR §75.302; effective 10/1/2025: 2 CFR §200.302)
13. Obligation Period.
a. Discretionary: Recipients may charge to the award "only allowable costs incurred during the period of performance." (45 CFR §75.309; effective 10/1/2025: 2 CFR §200.309) See the NoA for the approved start and end dates of the period of performance and, if applicable, the budget period for the award. Costs incurred within a specific budget period may only be charged to the award within the dates specified for that budget period. Recipients may not charge costs incurred in a previous budget period to the next or any subsequent budget period.

b. Non-Discretionary: The program-specific supplemental T&Cs will set forth the deadline for obligation.

14. Liquidation Period.
Unless superseded by program specific statute or regulations, the deadline for liquidating all financial obligations incurred under the Federal award is not later than 120 calendar days after the end of the period of performance (or as specified in a program regulation). (effective 9/15/2023: 2 CFR §200.344) See NoA.

PROGRAM REPORTING

15. Discretionary: Please see the NOFO, NoA, as well as Reporting Requirements.
16. Non-Discretionary: Please see the program-specific supplemental T&Cs for the program reporting requirements.

PROPERTY REPORTING

Real property (requires specific authority and prior approval, see limitation under item 16 within this T&C), tangible personal property, and intangible property, that is acquired or improved with a Federal award must be held in trust by the recipient as trustee for the beneficiaries of the project or program under which the property was acquired or improved. ACF requires the recipient to record liens or other appropriate notice of record to indicate that personal or real property has been acquired or improved with a Federal award and that use and disposition conditions apply to the property. Unless program regulations, program-specific supplemental T&Cs, or other program guidance say otherwise, recipients are required to follow the property standards outlined under 45 CFR §§75.316 – 75.323 (effective 10/1/2025: 2 CFR §§200.310 – 200.316). States must follow their own property standards. The following are the real property and tangible personal property guidance and reporting requirements. For additional information, please see the ACF Property Guidance pages.

REAL PROPERTY REPORTING

17. Real Property Reports (SF-429s), OMB Control No. 4040-0016. ACF programs must have specific statutory authority to allow recipients to provide support for acquisition, construction, and/or major renovation of real property. Absent statutory authority and approval, costs are considered unallowable under the Federal award. Only a few ACF programs have authority, please see the Applicable ACF Programs with Real Property Authority list. When Federal funds are allowed and used for these purposes, a Federal interest is established. A Notice of Federal Interest (NFI) must be recorded in the jurisdiction where the real property is located. Federal interest does not expire unless program statute says otherwise. So long as a Federal interest remains, property requirements and reporting apply. Recipients (and on behalf of subrecipients) are responsible for submitting the request and report forms. Only forms submitted in GrantSolutions OLDC are considered official real property submissions.
The collection of SF-429 forms must be used for awards that establish a Federal interest on real property. Overview of forms are as follows:

c. SF-429. The Cover Page must be submitted along with the other SF-429 Attachments (A, B, and C). GrantSolutions OLDC automatically adds the cover page to the Attachment.

d. SF-429 Attachment A. The General Report form is due annually and follows the same reporting cycle as the annual Federal Financial Report or program specific Expenditure Report.

e. SF-429 Attachment B. The Acquire or Improve Request form may be submitted at any time to request prior approval to use federal funds to acquire or improve property. The submission of this form, with supporting documentation, in GrantSolutions OLDC is the official starting point for any prior approval request to purchase, construct, and/or major renovation project for real property.
f. SF-429 Attachment C. The Disposition or Encumbrance Request form may be submitted at any time to request disposition instructions. The submission of this form, with supporting documentation, in GrantSolutions OLDC is the official starting point for any prior approval disposition or encumbrance requests. When the property is no longer needed, the recipient (when applicable, on behalf of subrecipients) must submit in GrantSolutions OLDC a request for disposition instructions. OGM must be consulted and confirm the percentage of participation (federal interest) before any payment is remitted on a real property. ACF will review and make a decision on one of the three standard OMB disposition options described under 45 CFR §75.318(c) to eliminate the Federal interest. The recipient (when applicable, on behalf of subrecipient) is required to compensate ACF for its share by remitting payment when real property is sold or retained. Payment must be received and confirmed before ACF can release the federal interest on the property. For more information, see Remit Payment guidance.

Please note that for the SF-429 Attachment B and C, the appraised value is the current fair market value based on the appraisal (no more than three years old) conducted by an independent certified appraiser.
For more information, please see program-specific supplemental T&Cs, the ACF Real Property Guidance, and the Applicable ACF Programs with Real Property Authority list.

TANGIBLE PERSONAL PROPERTY REPORTING

18. Tangible Property Report (SF-428s), OMB Control No. 4040-0018. The SF-428 is a standard form used to collect information related to tangible personal property purchased under a Federal award. Unless otherwise directed in the program-specific supplemental T&Cs, Federal assistance programs are required to use the SF-428s. Recipients (and on behalf of subrecipients) are required to submit the forms. States must use, manage and dispose of equipment acquired under a Federal award by the state in accordance with state laws and procedures. Overview of the forms are as follows:

g. SF-428. The Cover Page must be submitted along with the other SF-428 Attachments (B, C, and S).
h. SF-428 Attachment A. The Federally Owned Property Annual Report is not applicable to ACF programs.
i. SF-428 Attachment B. The Final/Award Closeout form on Acquired Equipment purchased with Federal Funds is due at the end of a Federal Assistance Award.
This form may not apply to some non-discretionary programs. Please see program-specific supplemental T&Cs for applicability and exceptions.

j. SF-428 Attachment C. The Disposition Request form on Acquired Equipment is due at any time other than award closeout. The submission of this form, with the SF-428 cover page and supporting documentation, to OGM is the official starting point for any prior approval disposition request. OGM must be consulted and confirm the percentage of participation (federal interest) before any payment is remitted on the property. Recipients (and on behalf of subrecipients) are required to compensate ACF for its share by remitting payment when equipment is sold or retained. Payment must be received and confirmed before ACF can release the federal interest on the property. For more information, see Remit Payment guidance.

k. SF-428 Attachment S. The Supplemental Sheet may be submitted with the SF- 428 Attachment B or C to provide additional information.

For more information, please see the ACF Tangible Personal Property Guidance.

AWARD PAYMENTS

19. Payment. All Federal financial assistance program payments will be made available through the HHS PMS. Questions pertaining to payments should be directed to: HHS Division of Payment Management, P.O. Box 6021, Rockville, MD, 20852, or PMS Help Desk at 877-614-5533, or PMSSupport@psc.gov. Other questions should be directed to the ACF contact listed on the NOA or program-specific supplemental T&Cs.

20. Returning Funds/Interest. Unless otherwise directed in the financial or program specific expenditure report, the HHS Program Support Center (PSC) serves as a centralized point for returning award interest and funds according to established federal law, policies, procedures, and regulations. PMS prefers that repayment be completed as an electronic transfer or by check. Please refer to the Returning Funds/Interest instructions under the Recipients drop-down on the PMS website.

SUBRECIPIENTS AND SUBCONTRACT MONITORING AND MANAGEMENT

21. All Federal assistance programs must comply with the Subrecipient Monitoring and Management requirements described in subpart D, 45 CFR §§75.351 – 75.353 (effective 10/1/2025: 2 CFR §§200.331 – 200.333). Discretionary awards are also subject to the ACF Term and Condition on Subawards located on the Administrative and National Policy Requirements page, see item 4 herein.

22. Debarred or Suspended. No entity may participate in these programs in any capacity or be a recipient or subrecipient of Federal funds designated for these programs if the organization has been debarred or suspended or otherwise found to be ineligible for participation in Federal financial assistance programs or activities. Please see Executive

Orders 12549 and 12689, as well as 2 CFR Parts 180 and 376 for debarment and suspension provisions. Recipients must include a similar T&C for all subawards and contracts awarded under these programs. Prior to issuing subawards and contracts under the Federal award, the recipient (pass-through) must review information available through the System for Award Management (SAM), https://www.sam.gov, to determine whether an entity is ineligible.

23. Determinations. Recipients are required to make case-by-case subrecipient and contractor determinations on whether the substance of an agreement creates a Federal assistance relationship (subaward) or a procurement relationship (contract) in accordance with 45 CFR §75.351 (effective 10/1/2025: 2 CFR §200.331). The presence of one or more characteristics may not be present in all cases; as such, the recipient must use judgment as the substance of the relationship is more important than the form of the agreement. ACF may also supply and require recipients to comply with additional guidance to support these determinations.

Please note for subrecipients: There is a long standing ACF OGM policy that any State, local, Tribal, or Territorial governments providing a service for a pass- through entity must be considered a subrecipient.

24. Fixed amount subawards. A fixed amount award cannot be used in programs which require mandatory cost sharing or matching in accordance with 45 CFR §75.201(b)(2) (effective 10/1/2025: 2 CFR §200.201(b)(2)). Many Federal assistance programs require the recipient to provide a portion of program funding, as specified in Federal law. Please see the NOFO or program-specific supplemental T&Cs for the cost sharing or matching (non-Federal share) requirement.

25. Indirect Cost. In accordance with 45 CFR §75.352(a)(4) (effective 10/1/2025: 2 CFR§200.332(a)(4)), pass-throughs must recognize the approved federally recognized indirect cost rate negotiated between the subrecipient and the Federal Government, or if no such rate exists, either a rate negotiated between the recipients and subrecipient or provide a percent de minimis indirect cost rate (10% under 45 CFR §75.414(f) prior to 10/1/2024; effective date 10/1/2024: 15% under 45 CFR 75.320(f); effective date 10/1/2025: 15% under 2 CFR §200.414) Please direct indirect cost questions to the HHS PSC Division of Cost Allocation Services (CAS), see CAS Contact Us.

26. Monitoring:

a. Contract. Recipients are responsible for ensuring that contracts contain the applicable provisions described in Appendix II of 45 CFR Part 75 (effective 10/1/2025: 2 CFR Part 200). The recipient is responsible for oversight to ensure that contractors perform in accordance with the terms, conditions, and specifications of the contract or purchase order. Records must be maintained by the recipient and be sufficiently detailed for compliance.

b. Subrecipient. Recipients are required to advise subrecipients of requirements imposed on them by Federal laws, regulations, and the provisions of award as well as any supplemental requirements imposed by the recipient. These include administrative and audit requirements (where applicable) under 45 CFR Part 75 (effective 10/1/2025: 2 CFR Part 200). The recipient must conduct a risk assessment of subrecipient(s) in accordance with 45 CFR §75.352(b) (effective 10/1/2025: 2 CFR §200.332(b)). Additionally, all subrecipient(s) must obtain a Unique Entity Identifier number assigned by the SAM, if they do not already have one. Recipients are required to check the SAM to verify that the subrecipient(s) is/are not debarred, suspended, or ineligible. Recipients are responsible for monitoring the activities of the subrecipient to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the T&Cs of the subaward, and that subaward performance goals are achieved. "Monitoring by the non-Federal entity must cover each program, function and activity." See 45 CFR §§75.342 and 75.352 (effective 10/1/2015: 2 CFR§§200.329(a) and 200.332). Records must be maintained by the recipient and be sufficiently detailed for compliance. For more information, see item 4.k. Salary Limitation – Federal Executive Level II within this Standard T&C.

Should a subrecipient perform unsatisfactorily, the recipient is responsible for remedying subrecipient issues. Recipients of an award will be legally accountable to ACF for performance of the project or program. Recipients will be held solely responsible in the event of non-compliance by a subrecipient. The recipient will be held accountable for cost disallowances regarding subawarded funds. If requirements of the program cannot be met due to subrecipient issues, ACF may take one or more of the actions listed under 45 CFR § 75.371 – 75.375 (effective 10/1/2015: 2 CFR §§200.339 – 200.343).

NON-COMPETING CONTINUATIONS

27. Most ACF discretionary awards are funded in increments. These increments are referred to as "non-competing continuations." If the award has multiple budget periods, recipients will be expected to submit non-competing continuation applications for each budget period. If not referenced in the NOA, the ACF Program Office or Grants Office will provide additional information on what documentation to submit and deadlines for non- competing continuation applications. Deadlines are typically in advance of the start date of the next budget period to allow ACF sufficient time to process the applications.

AUDITS

28. Recipients must arrange for the conduct of audits as required by 45 CFR Part 75, Subpart F – Audit Requirements (effective 10/1/2025: 2 CFR Part 200 Subpart F). For more information, also see ACF Oversight and Monitoring: Audit Reports page.

29. Recipients and pass-through entities, per 45 CFR §§75.352(f) and 75.501(effective 10/1/2025: 2 CFR §200.501), must verify that subrecipients also comply with the audit requirements.

l. For-profit subrecipients. Unless stated otherwise in regulation, guidance, the NOFO, or program-specific supplemental T&Cs, the Subpart F does not apply to for-profit subrecipients. (45 CFR §75.501(h) – (k); effective 10/1/2025: 2 CFR§200.501(h)) However, at a minimum, the recipient and pass-through entity are responsible for establishing requirements to ensure compliance by for-profit subrecipients. The agreement must describe applicable compliance requirements and the for-profit subrecipient's compliance responsibility.

EFFECTIVE PERIOD

The Standard T&C and each of the program-specific supplemental T&Cs are effective on the date shown in the footer at the bottom of the respective pages. Each T&C supersedes all previous similar T&Cs and will remain in effect until updated. All T&Cs will be updated and reissued as needed.

POINTS OF CONTACT

Points of contact for additional information or questions concerning either the operation of the program or related financial or Federal assistance award matters may be found on the NoA. The Program Office contact handles the programmatic specific needs such as program intent, goals and objectives; whereas, the OGM contact typically handles any business, financial, and administrative activities such as budget revisions, prior approval requests, and closeouts.

IMPORTANT ADDRESSES

Administration for Children and Families Office of Grants Management
330 C Street, SW. Mailstop 3127
Washington, DC 20201

OIG HOTLINE

The OIG of HHS maintains the OIG Hotline, a system for reporting allegations of fraud, waste, abuse and mismanagement in Department of Health and Human Services' programs. Your information will be reviewed by a professional staff member and will remain confidential; you need not provide your name. Information provided through the website is secure and all information is safeguarded against unauthorized disclosure. Report the possible misuse of federal funds by phone or online. Please provide as much detailed information as possible in your report.

Online: https://oig.hhs.gov/report-fraud Phone: 800-HHS-TIPS (800-447-8477)
TTY: 800-377-4950
Fax: 800-223-8164

If you are a provider, HHS contractor, HHS recipient or subrecipient and want to self-disclose potential fraud in HHS programs, please visit the self-disclosure webpage at: https://oig.hhs.gov/compliance/self-disclosure-info/index.asp.

IMPORTANT WEBSITES

- Welcome To ACF website.
- ACF Award Terms and Conditions.
- HHS Grants website.
- Congress.gov Congressional Research Service: Appropriations.
- General and Permanent Laws: United States Code (U.S.C.).
- Federal Regulations: Electronic Code of Federal Regulations (e-CFR).
- Congress.gov: U.S. Federal Legislative Information.

SUPPLEMENTAL TERMS and CONDITIONS

The General Terms and Conditions apply to all non-discretionary programs. These Supplemental Terms and Conditions are additional requirements applicable to the program named below.

By acceptance of awards for this program, the recipient agrees to comply with the requirements included in both the General and Supplemental Terms and Conditions for this program.

Administration on Children, Youth, and Families (ACYF)
Family and Youth Services Bureau (FYSB)
State Personal Responsibility Education Program (PREP)
Assistance Listing No. 93.092

APPLICABLE LEGISLATION, STATUTE, REGULATIONS

1. The administration of this program is authorized under Title V, Section 510, of the Social Security Act (the Act).
2. The program is codified at 42 U.S.C. §710.
3. There are no implementing program regulations for this program.
4. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (UAR) are located under 45 CFR Part 75 (effective 10/1/2025: 2 CFR Parts 200 and 300). In accordance with 45 CFR §75.101 (effective 10/1/2025: 2 CFR §200.101) and program regulation 45 CFR §93.235 the following Subparts:

a. Apply to all awards:

i. Subpart A – Acronyms and Definitions
ii. Subpart B – General Provisions
iii. Subpart C – Pre-Federal Award Requirements and Contents of Federal Awards: Only 45 CFR §75.202 Requirement to Provide Notice of Federal Financial Assistance programs (effective 10/1/2025: 2 CFR §200.203).
iv. Subpart D – Post Federal Award Requirements: Only 45 CFR §§75.351 – 75.353 Subrecipient Monitoring and Management (effective 10/1/2025: 2 CFR §§200.331 – 200.333).
v. Subpart F – Audit Requirements

b. Apply to this award in its entirety:

i. Subpart C – Pre-Federal Award Requirements and Contents of Federal Awards
ii. Subpart D – Post Federal Award Requirements
iii. Subpart E – Cost Principles

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

5. This program has a Maintenance of Effort (MOE) requirement per Section 513(a)(5) of the Act (42 U.S.C. § 713(a)(5)). No payment shall be made from the allotment awarded under 513(a)(4), if the non-federal expenditure is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2023 (or the fiscal year amended by subsequent Public Laws).

6. MOE is a statutory requirement where the State, local organization, or entities awarded under this program is required, as a condition of eligibility for federal funding, to maintain its financial contribution to the program. MOE must be used to supplement not supplant federal funds with existing non-federal funds. State, local organizations or entities under this award may not replace or supplant federal funds to meet program requirements.

FINANCIAL REPORTING

7. Federal funds awarded under this grant must be expended for the purposes for which they were awarded and within the time period allotted.
8. The OMB approved Financial Reporting form for this program is the Federal Financial Report SF-425. The SF-425 is due annually and no later than December 30, which is 90 days after the end of each reporting period.
a. Submission Methodology: All periodic SF-425 financial reports for all grant programs must be submitted electronically through the Payment Management System (PMS). Recipients must not submit duplicate copies either by mail, by fax or as an email attachment of any reports submitted.
b. Submission Schedule: Annual. Each annual financial report must be submitted within 90 days (i.e., no later than December 30) following the end of each Federal Fiscal Year (FFY).
i. An interim financial report (covering Year 1 of the project period) is due 90 days following the end of Federal Fiscal Year 1.
ii. An interim financial report (covering Year 2 of the project period) is due 90 days following the end of the Federal Fiscal Year 2.
iii. A final financial report (cumulative, covering the entire 3-year project period) is due 120 days following the end of Federal Fiscal Year 3.

9. Obligation Deadline:
a. In accordance with Section 503(b) of the Act (42 U.S.C. § 703(b)), the State Personal Responsibility Education program has a 3-year project/obligation period starting from the first day of the FFY for which these funds were awarded through the last day of the next FFY. (i.e., October 1, Federal Fiscal Year 1 through September 30, Federal Fiscal Year 3.) Any Federal funds not obligated by the end of the obligation period will be recouped by this Department.
10. Liquidation Deadline:
a. In accordance with 2 CFR § 200.344(b), a recipient must liquidate all obligations incurred under the award no later than 120 days after the end of the funding/obligation period (i.e., December 30 following the end of Federal Fiscal Year 3). Any Federal funds from this award not liquidated by this date will be recouped by this Department.

PROGRAM REPORTING AND REQUIREMENTS
11. The OMB approved Program Report form for this program is the Performance Progress Report (PPR). Semi-annual narrative program performance reports must describe the program activities carried out, including an assessment of the effectiveness of those activities in achieving the purposes of this award. Each report covers the preceding 6-month period and is due 30 days following the end of the 2nd and 4th quarters (i.e., no later than April 30 and October 30, respectively). Please refer to the general terms and conditions for electronic submission guidance.
12. All recipients and subrecipient(s), including their implementation sites, will be required to collect and report information on program implementation and program outcomes through a common set of performance measures. This requirement applies to any community partners who agree to host a site or recruit program participants (e.g., school districts, non-profits. Recipients must collect and report on these measures twice a year.
13. Recipients will be expected to check local and state laws, policies, and procedures to ensure that the collection of performance measures data is feasible and obtain any necessary permissions (e.g., formal agreements with partners, Institutional Review Board (IRB) approval, copies of school district approvals) to collect these data. Recipients are responsible for ensuring all subrecipients and implementation sites collect and submit the PREP performance measures. Recipients may develop additional indicators of program performance, as needed, including adding items to the entry or exit surveys. However, all FYSB OMB-approved items must be administered first, in the order presented in the approved survey, before any additional items are added. Any additional survey items should be added at the end of the OMB-approved survey and should not be submitted to ACF.
14. Additional program conditions:

a. Have the project fully functioning and serving youth within at least 90 days following the issuance of the Notice of Award.
b. Formally train facilitators/educators in the evidence-based effective program model or elements of the effective program model by professionals who can provide follow-up technical assistance to facilitators.
c. Provide PREP programming to youth populations that are the most high-risk or vulnerable for pregnancies and sexually transmitted infections, including HIV/AIDS, or have other special circumstances including culturally underrepresented youth populations such as Hispanic, African American, or Native American youth; youth in or aging out of foster care or adjudication systems; youth who are victims of trafficking; youth who have runaway or left home without permission; youth experiencing homelessness; youth who identify as lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ+), and other vulnerable or underserved youth populations.
d. Send at least two key staff persons to the 3-day Adolescent Pregnancy Prevention (APP) Program Grantee Conference held in the Louisville, KT, on August 5-7, 2025. A minimum of two staff persons are to attend at least one of two topical training sessions offered each year of the project in areas such as Washington, DC; Phoenix, AZ; and Boston, Massachusetts.
e. Collect and report on all OMB cleared federal PREP performance measures (recipient, partners and subrecipients). PREP Performance Measures are currently approved under OMB # 0970-0497, expiration date 07/31/2026.
f. For states and subrecipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.

g. Submit curricula and programmatic materials to FYSB, as requested, for a medical accuracy review and provide a plan to comply with making any required modifications.

PROPERTY REPORTING

15. The OMB approved property reporting forms are the following:
h. Real Property Reports (SF-429s). The SF-429 Real Property forms are not applicable to this program. Purchase, construction, and major renovation are not an allowable activity or expenditure under this program.
i. Tangible Property Report (SF-428s). The SF-428 Tangible Personal Property forms must be submitted as described in the General Terms and Conditions.

EFFECTIVE PERIOD

16. These program-specific Supplemental Terms and Conditions are effective on the date shown in the footer at the bottom of the page and will remain in effect until updated. They will be updated and reissued only as needed whenever a new program-specific statute, regulation or other requirement is enacted or whenever any of the applicable existing Federal statutes, regulations, policies, procedures, or restrictions is amended, revised, altered, or repealed.

POINTS OF CONTACT
17. Points of contact for additional information or questions concerning either the operation of the program or related financial matters can be found on the Notice of Award.

a. Program Office:
Sierra Baker
Program Specialist
330 C St., SW.
Washington, DC 20201
Sierra.Baker@acf.hhs.gov
202-401-4663

b. Office Grants Management:
Girma Araya
Grants Management Specialist
330 C St., SW.
Washington, DC. 20201
Girma.Araya@acf.hhs.gov
202-205-8643

Remarks

* This field is intended to be included in the standardized Notice of Award and will be displayed in subsequent quarters.

This award represents the 1st quarter funding for the total approved FY 2025 State Personal Responsibility Education Program budget. The remaining balance will be awarded at a later date, subject to the availability of funds.

Exhibit 9

Administration for Children and Families

Administration on Children, Youth and Families – Family and Youth Services Bureau

Standing Notice of Funding Opportunity for Title V State Sexual Risk Avoidance Education

HHS-2024-ACF-ACYF-SRAE-0044

Application Due Date for FY 2024: **June 3, 2024**

Application Due Date for FY 2025: **October 1, 2024**

Kimberly A. Waller -S

Digitally signed by Kimberly A. Waller -S
Date: 2024.04.09 09:09:31 -04'00'

Signature

Standing Announcement for Title V State Sexual Risk Avoidance Education

HHS-2024-ACF-ACYF-SRAE-0044

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

Program Office:	**Family and Youth Services Bureau, Administration on Children, Youth and Families**
Funding Opportunity Title:	**Standing Notice of Funding Opportunity for Title V State Sexual Risk Avoidance Education**
Announcement Type:	**Mandatory**
Funding Opportunity Number:	**HHS-2024-ACF-ACYF-SRAE-0044**
Assistance Listing Number:	**93.235**
Due Date for Applications:	**June 3, 2024**

Executive Summary:

The Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF), Family and Youth Services Bureau (FYSB) is accepting mandatory formula grant applications from states and territories for the development and implementation of the Title V State Sexual Risk Avoidance Education (SRAE) Program. The purpose of the Title V State SRAE program is to fund states/territories to implement education exclusively on sexual risk avoidance that teaches participants to voluntarily refrain from non-marital sexual activity and other risky behaviors. This announcement sets forth the application requirements, the application process, and other administrative and fiscal requirements on how to apply for funding in fiscal year (FY) 2024 and FY 2025.

To qualify for funding in FY 2024, states must submit an application and state plan for review and approval prior to the award of funds. Applications for FY 2024 may be awarded with restrictions on the drawdown of awarded funds until the post-award state plans have been approved by FYSB.

States are expected to submit program plans that are medically accurate; complete; age-appropriate based on adolescent learning and developmental theories for the age group receiving the education; and be culturally appropriate, recognizing the experiences of youth from diverse communities, backgrounds, and experiences.

All programs incorporated by a state must ensure that sexual risk avoidance education has a holistic approach and demonstrate societal benefits with the focus being on the future. These projects must focus on the social, psychological, and health gains to be realized by refraining from non-marital sexual activity and engaging in healthy relationships.

I. PROGRAM DESCRIPTION

A. Statutory Authority

The Title V SRAE program is authorized and funded by section 510 of the Social Security Act (42 U.S.C. 710) as amended by the Consolidated Appropriations Act of 2022 (Public Law 117-103) and extended by division B, title I, section 142 of the Further Additional Continuing Appropriations and Other Extensions Act, 2024 (Public Law No 118-35), and the Further Consolidated Appropriations Act, 2024.

B. Background

Congress amended section 510 of the Social Security Act (42 U.S.C. 710) in FY 2018 to enable states, territories, or other entities to implement education exclusively on sexual risk avoidance (SRA). Title V State SRAE supports funding to states and territories to provide education to youth that normalizes the optimal health behavior of avoiding non-marital sexual activity. The program is designed to teach youth personal responsibility, self-regulation, goal setting, healthy decision-making, a focus on the future, and the prevention of youth risk behaviors, such as drug and alcohol usage, without normalizing teen sexual activity.

According to the Centers for Disease Control and Prevention (CDC) data collected in 2021, the proportion of high school students who had ever had sexual intercourse significantly decreased for all youth, from 2011 through 2021 [1]. There were also decreased reports of those who had ever had sex among each racial and ethnic group [1].

In 2022, the birth rate for youth ages 15-19 declined by 3 percent to 13.5 births per 1,000 females from 13.9 births per 1,000 females in 2021 [2]. Additionally, the birth rate for teenagers declined for both younger (aged 15–17) and older (aged 18–19) teenagers 5.5 and 25.6 births per 1,000 females, respectively [2]. Although there has been a significant decline in the teen birth rate for all groups, disparities still exist. The latest CDC data indicate that young people ages 15 to 24 account for over half of new sexually transmitted diseases reported annually [3]. Adolescents who are at greatest risk of sexually transmitted infections (STI) and unintended pregnancies are a complex and dynamic group. Thus, a targeted and holistic approach is essential to preventing teen pregnancy and other risk behaviors.

C. Title V State SRAE Program Overview

SRAE Goal and Objectives

The goal of the Title V State SRAE program is to provide messages to youth that normalize the behavior of avoiding non-marital sexual activity. The objectives of the Title V State SRAE program are to:

1. Implement curricula and/or strategies that include medically accurate and complete information based on adolescent learning and developmental theories for the age group receiving the education.
2. Select SRA curricula and/or strategies that are culturally and linguistically appropriate; inclusive; and recognize the experiences of youth from diverse communities, backgrounds, and experiences.
3. Teach SRA skills through methods that do not normalize teen sexual activity.
4. Target youth ages 10 to 19.

Title V State SRAE Program Requirements

States are expected to design SRAE projects that address the following requirements:

1. Goals and Logic Model(s)
2. Medically Accurate and Culturally and Age-Appropriate Approaches
3. Evidence-Based Strategies
4. Positive Youth Development (PYD) Framework including Leading in Partnership with Youth and Young Adults/Meaningful Youth Engagement
5. Equity
6. Youth Populations Served
7. Linkages and Referrals to Health care and Other Services
8. Local Evaluation (optional)
9. National Evaluation
10. Performance Measures
11. Sustainability Plan

Goal(s) and Logic Models

States should submit the goal(s) and logic models for all state-led programs or subrecipient programs in their post-award state plans. Logic models demonstrate how the process (specified inputs, activities, and outputs) will lead to the enumerated outcomes, and ultimately, the achievement of the goal(s). Where possible, applicants should specify short- and long-term goals and provide the following:

- Up to six outcomes that clearly state expected results or benefits of the intervention proposed and link with the goal(s).
- A logic model demonstrating how proposed inputs and activities will lead to the outputs, outcomes, and the ultimate achievement of the goal(s).

- Proposed outcomes that are specific, measurable, achievable, realistic, time-framed, inclusive, and equitable (S.M.A.R.T.I.E.).

Further information on sources available for developing programs and logic models is provided in *Appendix B.*

Medically Accurate and Culturally and Age-Appropriate Approach

Title V State SRAE projects must provide information that is medically accurate and complete. Medical information must be verified or supported by the weight of research. The research must be conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable, or comprise information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete. Program materials, such as texts, supplements, workbooks, videos, flyers, handouts, posters, and flash cards, should be in accordance with the latest, scientifically supported information.

For states that provide information on contraception, the information must be medically accurate and complete and ensure that youth understand that contraception offers physical risk reduction, but not risk elimination; the education cannot include demonstrations, simulations, or distribution of contraceptive devices.

States must use culturally sensitive interventions that incorporate the norms, beliefs, and values of the target population into the intervention [5]. The proposed project should demonstrate competence in providing socially, linguistically, and culturally appropriate interventions with the population served. Youth participation in the Title V State SRAE programs must be voluntary.

States must ensure that SRAE projects are inclusive of youth who identify as lesbian, gay, bisexual, transgender, and/or questioning, intersex, asexual, and two-spirit (LGBTQIA2S+). Proposed projects should have inclusive programming and environments that create equitable access to resources and opportunities for such youth. These programs help youth who identify as LGBTQIA2S+ feel safe, respected, engaged, and valued for who they are and enables grant recipients to be more sensitive and responsive to their needs. Project materials, practices, and services should not discriminate, alienate, exclude, or stigmatize LGBTQIA2S+ youth and their families.

Title V State SRAE projects must provide age-appropriate information and activities. The topics, messages, and teaching methods implemented by the project must be consistent with the developmental and social maturity of the program participants and emphasize sexual delay until marriage as normative behavior.

States will be required to take appropriate action to correct any medically inaccurate or age-inappropriate information discovered by FYSB during the grant project period. As requested, states must submit curricula for FYSB to conduct a medical accuracy review and respond to requests to make modifications to ensure curricula and other program implementation materials are medically accurate and complete.

Evidence-Based Strategies

States are not required to choose from a prescribed list, as there is no mandated list of curricula required by FYSB for Title V State SRAE. All curricula used by funded recipients, as well as their subrecipient(s), must be compliant with the Title V State SRAE statute (https://www.ssa.gov/OP_Home/ssact/title05/0510.htm) and use an evidence-informed approach and/or effective strategies to educate youth on how to avoid risks that could lead to non-marital sexual activity.

To ensure effective programming, the Title V State SRAE program must, at a minimum, implement evidence-informed programming that complies with the following requirements:

- Provide data that demonstrate how the selected intervention and overall proposal systematically applies core curriculum components that have been found to be effective in positive youth behavior change that leads to preventing and reducing teen pregnancies, STIs, and sexual activity.
- Teach the benefits associated with personal responsibility, self-regulation, goal setting, healthy decision making, healthy relationships, avoiding poverty through self-sufficiency and emotional maturity, resisting sexual coercion and dating violence, and other youth risk behaviors, such as drug and alcohol usage.
- Provide formal training for facilitators/educators on the program strategies, approaches, and interventions. This training must be delivered by professionals who can provide follow-up technical assistance (TA) to facilitators.
- Link program participants to services with local community partners and other agencies that support the health, safety, and well-being of program participants.
- Ensure that all education and research in sexual risk avoidance must be the exclusive purpose of the grant.
- Demonstrate that interventions and/or strategies selected must be medically accurate; age-appropriate with regard to the developmental stage of the intended audience; and inclusive and culturally and linguistically appropriate, recognizing the experiences of youth from diverse communities, backgrounds, and experiences.

Many of these required components have been identified in assessment tools, such as the CDC Health Education Curriculum Assessment Tool, that provide critical elements for success in implementing programs to positively change youth behavior. There may be other tools and resources available to assess curricula.

FYSB encourages states to review evidence-informed or evidence-based programs to determine whether the interventions can be adapted, subject to copyright restrictions; implemented with fidelity; and adhere to the core curriculum components to meet the requirements of programs designed for this grant. More information on evidence-based programs may be found on the Teen Pregnancy Prevention Evidence Review website. The selected interventions must be evidence-informed or have evidence of effectiveness with the populations served and adhere to the following requirements:

In accordance with the Title V State SRAE legislation (42 U.S.C. 710)(b)(3)), interventions must address the following topics:

a) The holistic, individual, and societal benefits associated with personal responsibility, self-regulation, goal setting, healthy decision-making, and a focus on the future.
b) The advantage of refraining from non-marital sexual activity to improve the future prospects and physical and emotional health of youth.
c) The increased likelihood of avoiding poverty when youth attain self-sufficiency and emotional maturity before engaging in sexual activity.
d) The foundational components of healthy relationships and their impact on the formation of healthy marriages and safe and stable families.
e) The effect of other youth risk behaviors, such as drug and alcohol usage, on increasing the risk for teen sex.
f) The Strategies on how to resist and avoid, and receive help regarding, sexual coercion and dating violence, recognizing that—even with consent—teen sex remains a youth risk behavior.

For programs that provide information on contraception, the information must be medically accurate and complete, and ensure students understand that contraception offers physical risk reduction, but not risk elimination. Education involving contraception cannot include demonstrations, simulations, or distribution of contraceptive devices.

Curricula and any related materials must be in accordance with 45 CFR § 87.3, Equal Treatment for Faith Based Organizations. For more information, please reference the Administrative and National Policy Requirements, which can be found on the ACF website at: https://www.acf.hhs.gov/administrative-and-national-policy-requirements#chapter-2.

PYD Framework including Leading in Partnership with Youth and Young Adults/Meaningful Youth Engagement

States must demonstrate in their state plan the incorporation of PYD as part of any risk avoidance strategies to help participants build healthy life skills and protective factors that mitigate the impact of past and future negative factors, empower participants to make healthy decisions, provide tools and resources to prevent pregnancy and STIs, and prevent youth engagement in other risky behaviors. The program approach should also include service linkages to local community partners that support the safety and well-being of the population served. For more information on the key principles of PYD, please see: Key Principles of Positive Youth Development | Youth.gov or https://aspe.hhs.gov/execsum/positive-youth-development-united-states-research-findings-evaluations-positive-youth-development-programs. For information on integrating PYD into programs, please see: Integrating Positive Youth Development into Programs | Youth.gov.

Leading in partnership with youth and young adults with lived experience or meaningful youth engagement is an important component of the overarching PYD strategy. Meaningful youth engagement views youth as equal partners with adults in the decision-making process rather than mere beneficiaries of programs [6]. Programs and activities are developed with youth, rather than

for youth [6]. This kind of equal partnership is based on a shared unified vision for a partnership in which both adults and young people are fully engaged and are open to change in how things are done. Programs that are developed in partnership with youth are more likely to be effective at engaging the population and, therefore, to have a greater impact [6]. Involving youth as partners in making decisions that affect them increases the likelihood that the decisions will be accepted, adopted, and become part of their everyday lives. For additional information on youth partnership, please see: Involving Youth in Positive Youth Development | Youth.gov.

States should demonstrate in their state plan ways in which they plan to incorporate meaningful youth engagement as part of their larger PYD approach. This online assessment tool (1|youth.gov) can assist state organizations and community partnerships in determining how they engage youth in programs, whether youth are becoming more engaged in the community, and if certain strategies are helping to retain youth.

Equity

According to CDC data, a disproportionate number of Hispanic, non-Hispanic Black, and American Indian/Alaska Native teens have significantly higher than the national average of teen birth rates. Although teen birth rates have declined between 1991 and 2020, teen birth rates for White non-Hispanic teens were 10.4, Hispanic teens were 23.5, non-Hispanic Black teens were 24.4, and American Indian/Alaska were 25.7 in 2020 [7]. Certain geographic areas of the United States have disproportionate rates of teen births, such as rural areas, Southern States and counties, and territories.

To address these disproportionate rates, SRAE recipients should include at least some of these populations. Advancing equity in SRAE programs requires a concerted, multi-pronged, multi-level effort assessing whether there are disparities in access to programs for different populations, and collaboration with young people and communities including people with lived experiences.

Programs must provide services to youth populations between the ages of 10 and 19. Programs may target services to youth populations who are vulnerable, including, but not limited to, the following groups:

- Youth living in under-resourced regions and areas with high rates of teen births and STIs
- Youth populations who are historically and culturally underrepresented and underserved, especially Hispanic, non-Hispanic Black, and American Indian/Alaska Native teens; and teens from rural areas and territories
- Youth in, or aging out of, foster care or adjudication systems
- Youth who are victims of trafficking
- Youth who have run away or left home without permission
- Youth experiencing homelessness
- Youth who identify as LGBTQIA2S+

Applicants must describe how their program plans coordinate, communicate, and engage with community-based organizations whose mission is to reach such populations. Applicants must also describe staff development and training opportunities to increase knowledge of the communities most impacted by teen births, including by geography, gender, race, and equity.

Youth Populations Served

Title V State SRAE programs must provide services to youth populations between the ages of 10 and 19. In addition, SRAE programs may target services to youth populations who are vulnerable to include, but not limited to, the following: youth living in under-resourced regions and areas with high rates of teen births and STIs; youth populations that are culturally underrepresented, especially Hispanic, African American, or Native American teenagers; youth in, or aging out of foster care, or adjudication systems; youth who are victims of trafficking; youth who have runaway or left home without permission; youth experiencing homelessness; youth who identify as LGBTQIA2S+; and other youth populations that are vulnerable or underserved.

Linkages and Referrals to Health care and Other Services

Linkages and referrals to health care and other services are important components of supporting youth holistically. Such services may include healthcare; educational services (e.g., tuition for formal K-12/ General Educational Development classes); career development; counseling services (e.g., substance abuse including alcohol, tobacco cessation, mental health issues, and intimate partner violence); public benefits, including Supplemental Nutrition Assistance Program and other relevant benefit programs; and should be youth-friendly. As needs are identified, recipients should provide referrals for necessary services but may not pay for the services themselves with FYSB funding. Title V State SRAE programs may only provide education to youth on SRA. Funds may not be used to provide separate services such as those mentioned above.

Local Evaluation

States have the option to conduct a local evaluation of their Title V State SRAE projects. States that choose to conduct local evaluations must provide a description of the plan to conduct recipient-specific evaluations, also called "local evaluations." The purpose of local evaluations is to contribute to the evidence base for SRAE programming and provide an opportunity for recipients to learn whether desired outcomes are being achieved; target areas for improved program quality; and/or examine whether the program(s) being implemented is effective. States may only propose one local evaluation. The evaluation plan must answer one or more specific research question(s) related to the programming implemented and funded by the grant. The research question(s) should drive the local evaluation, including its design, methods, data collection, and analyses.

ACF is interested in supporting high-quality, well-designed local evaluations from which programs will learn and expand the evidence base. ACF will work in collaboration with states to disseminate information about the evaluation findings. In accordance with legislation, any

SRAE evaluation conducted or supported must be:

- Rigorous;
- Evidence-based; and
- Designed and conducted by independent researchers who have experience in conducting and publishing research or evaluation studies in peer-reviewed outlets.

(See *Section E. Glossary Terms* for definitions.)

States that propose to conduct a local evaluation should ensure that the evaluation:

- Answers important questions of interest to the state and to the larger field of SRA education;
- Includes an appropriate evaluation design;
- Addresses SRA outcomes; specifically, sexual activity or other sexual risk behaviors, or reducing pregnancy among youth;
- Addresses relevant positive youth development outcomes, including self-regulation;
- Meets expectations of rigor that ACF provides through a system of TA for recipients and their local evaluators;
- Establishes scientific methods for measuring the impact of an intervention or program model in changing behavior (specifically, sexual activity or other sexual risk behaviors, or reducing pregnancy among youth); or
- Adheres to other evidence-based methodologies established by the U.S. Department of Health and Human Services (HHS) Secretary.

Three types of methodologies are permitted for local evaluations:

- Impact evaluations: (a) efficacy/effectiveness studies that have a control/comparison group that either receives no services or services distinct from the intervention group, and (b) measure behavioral outcomes beyond the period directly following the end of programming, when feasible;
- Comprehensive needs assessments: scientific/systematic investigations that identify needs and challenges around a given issue, determine root causes, identify current barriers to addressing the need, and set priorities for future actions; and
- Descriptive studies: studies that both document and link program implementation (i.e., activities/components/program delivery) and participant outcomes.

Well-conducted evaluations require time for planning, implementation, analysis, reporting, and dissemination activities. States are advised to develop evaluation timelines that are sufficient for conducting impact studies, comprehensive needs assessments, or descriptive studies that document and link program implementation and participant outcomes. FYSB also recommends applicants review current SRAE evaluation resources to inform the evaluation plan, including research questions and evaluation design. These resources can be found at: https://sraene.com/search-resources.

Local evaluations should be designed and conducted by independent researchers, called "local evaluators", who have experience in conducting evaluations of youth-focused programs in the community and publishing research in peer-reviewed outlets. The expertise of the evaluator should match the methodology for the proposed local evaluation. Examples of independent evaluators may be universities, research organizations, evaluation consultants, or other institutions with experience in conducting high-quality evaluations of community programs.

In order to maximize learning from these projects, ACF will provide TA and/or training on evaluation planning, implementation, analysis, reporting, and dissemination to states conducting local evaluations, and to their local evaluators. As part of the TA, recipients may also be asked to complete standardized forms and templates describing their evaluation plans and submit evaluation updates. These forms and templates are subject to Office of Management and Budget (OMB) approval under the Paperwork Reduction Act (PRA). ACF will obtain OMB approval prior to requiring states to complete the forms and/or templates. ACF will review and provide suggestions to states to improve plans prior to the initiation of local evaluation activities. Improvements may include reconsiderations of evaluation design and funding.

Upon completion of local evaluations, states are required to submit a final report to ACF. The final report template is subject to OMB approval under PRA, which ACF will obtain prior to use. Although ACF may provide technical support to states that propose local evaluations, the states will ultimately decide what data are to be collected and maintain oversight of the entity conducting the evaluation, as well as the subrecipient(s) that they select to participate in the evaluation.

Applicant funding levels will not be affected if a local evaluation is not proposed. Applicants should carefully assess whether they have the capacity and sufficient funding allocated to conduct a local evaluation within the short project period.

If the applicant chooses to conduct a local evaluation, describe the amount of funding that will be allocated towards conducting an evaluation, within the allowable amount (up to 20 percent of total budget).

Performance Measurement

All grant recipients and sub-recipient(s), including their implementation sites, will be required to collect and submit information on program implementation through a common set of performance measures. This requirement applies to any community partners that agree to host a site or recruit program participants (e.g., school districts, non-profits). The purpose of the performance measures is to monitor and provide feedback about whether recipients are implementing SRAE programs as intended and to demonstrate progress towards expected objectives. Performance measures also create a foundation for program improvement efforts, prompted by federal, recipient, and program providers' examination of the data. Performance measures provide information based upon the three categories of data collection listed below, while rigorous evaluations assess program effectiveness and impact.

SRAE performance measures will be distributed to funded grant recipients who will be required to collect and submit the measures twice a year. FYSB has defined measures at the recipient, provider, and program levels. For some performance measures, grant recipients provide data about activities they undertake directly at the recipient level. For other measures, data are based on information about each separate provider that serves youth directly (i.e., provider level) or each program model that a provider is implementing (i.e., program level). A program model is defined as the core curriculum plus other lessons or activities that may be integrated with the core curriculum to meet the SRAE requirements. In addition, data are also collected directly from the youth through participant entry and exit surveys. Ultimately, grant recipients are responsible for submitting performance measures from the recipient, provider, and program levels to ACF/FYSB.

The following are the three categories of SRAE performance measures for data collection and submission:

1. Structure, cost, and support for program implementation;
2. Attendance, reach, and dosage; and
3. Participants' characteristics, behaviors, program experiences, and perceptions of effects (through participant entry and exit surveys).

Applicants applying for funds must indicate their agreement to collect the SRAE performance measures and submit the data to FYSB. Recipients will be expected to check local and state laws, policies, and procedures to ensure the feasible collection of performance measures data and obtain any necessary permissions (e.g., formal agreements with partners, Institutional Review Board (IRB) approval, copies of school district approvals) to collect these data. In some jurisdictions, IRB approval is not required for performance measures data collection. If an IRB determines approval is not required for performance measures data collection, the grant recipient must obtain a Letter of Determination from IRB. The letter should be submitted to the grant recipient's Federal Project Officer for their records.

Grant recipients are responsible for ensuring all subrecipients and implementation sites collect and submit the SRAE performance measures. FYSB will provide training on how to conduct performance measures data collection and submission. Grant recipients may develop additional indicators of program performance, as needed, including adding items to the participants' entry or exit surveys. However, all FYSB OMB-approved items must be administered first, in the order presented in the approved survey before any additional items are added. Any additional survey items should be added at the end of the OMB-approved survey and should not be submitted to ACF/FYSB.

For more information about the SRAE performance measures, including definitions, survey instruments, and data collection tools, please see www.sraepas.com.

NOTE: Consistent with the PRA of 1995, (44 U.S.C. 3501-3521), under this NOFO, ACF will not conduct or sponsor, and a person is not required to respond to, a collection of information covered by such Act, unless it displays a currently valid OMB control number. ACF has obtained OMB approval (OMB Control Number 0970-0536; Expiration Date January 31, 2025) under PRA to request and collect performance measures.

National Evaluation

FYSB may select a subset of projects, such as state-led programs or subrecipient programs, funded under this NOFO to participate in one or more rigorous federal evaluations. All states and subrecipients will be required to participate, if selected, and must give their assurance that they will participate. As part of these national evaluation efforts, recipients and subrecipients may also be required to complete surveys, standardized forms, and templates. These instruments are subject to OMB approval under the PRA. FYSB will obtain OMB approval prior to launching any evaluations.

Sustainability Plan

States are to develop a sustainability plan that includes their subrecipients and collaborating partners. The plan should detail how the proposed project activities will continue after federal funding ends. States are encouraged to have their funded providers develop a plan to sustain key elements of their grant-supported projects (e.g., strategies, or services and interventions) that have been effective in improving practices and outcomes for youth and families.

D. SRAE Post Award Requirements

The acceptance of federal funds under this NOFO will signify agreement by the recipient that it will include in their application/state plan the following assurances:

- Have the project fully functioning within 90 days following the Notice of Award (NOA) for the grant.
- Formally train facilitators/educators in the selected program components and strategies by professionals who can provide follow-up TA to facilitators/educators.
- FYSB requires all grant recipients to prepare the Disparity Impact Statement (DIS) as part of a data-driven, quality improvement approach to advance equity using grant programs. The DIS helps grant recipients identify populations that are underserved who are at risk of experiencing health disparities related to adolescent pregnancy. The aim is to increase inclusion of such populations in FYSB-funded grants, achieve health equity for populations that are vulnerable to disparities, and help systems better meet the needs of these populations. Guidance for preparing a DIS statement may be found here.
- Provide diversity, equity, and inclusion trainings for facilitators/educators.
- Provide SRAE programming to youth populations who are vulnerable to include, but not limited to, the following: youth living in under-resourced regions and areas with high rates of teen births and STIs; youth who are culturally underrepresented, especially Hispanic, African American, or Native American teenagers; youth in, or aging out of, foster care or adjudication systems; youth who are victims of trafficking; youth who have runaway or left home without permission; youth experiencing homelessness; youth who identify as LGBTQIA2S+; and other vulnerable or underserved youth populations.
- Budget the annual costs of sending at least two key staff persons to attend the 3-day Annual Adolescent Pregnancy Prevention Program Grantee Conference to be held in San Francisco, California in 2024. The 2025 location is not determined.

- Budget the annual costs for at least two staff to attend a minimum of one of two topical training sessions offered each year of the project in areas such as Washington, DC; Portland, Oregon; and Boston, Massachusetts, or through a virtual platform.
- Collect and report on OMB-approved federal SRAE performance measures (recipient, partners, and subrecipient(s).
- For states and subrecipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.
- Participate in a recipient orientation webinar. The webinar will be held shortly after the official award date.
- Develop a sustainability plan with any proposed subrecipients and collaborating partners to create self-sufficiency and continue program activities after federal funding ends.
- Agree to participate in the national evaluation, if selected.
- Participate in a medical accuracy review of selected curricula sponsored by FYSB.

E. Glossary of Terms

The terms Age-Appropriate, Medically Accurate and Complete, Rigorous, and Youth are defined according to the legislation at 42 U.S.C. 710(e). All other terms are defined by applicable research for the purposes of this NOFO unless a citation or source is shown.

Activities–All the actions needed to prepare for and carry out the program. This includes program and financial management, intervention activities, training activities, and staff debriefings.

Age-Appropriate–Information that is suitable (in terms of topics, messages, and teaching methods) to the developmental and social maturity of the particular age or age group of children or adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group [Section 510(e)(1) of the Social Security Act (42 U.S.C. 710(e)(1)].

Comprehensive Needs Assessment–Scientific/systematic investigations that identify needs and challenges in an area, determine root causes, identify current barriers to addressing the needs, and set priorities for future actions.

Dating Violence–Violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim and where the existence of such a relationship shall be determined based on a consideration of the following factors: the length of the relationship; the type of relationship; and the frequency of interaction between the persons involved in the relationship [Section 40002 of the Violence Against Women Act of 1994 (34 U.S.C. 12291)].

Effectiveness–The impact of a program under conditions that are likely to occur in a real-world implementation.

Equity–The consistent and systematic treatment of all individuals in a fair, just, and impartial manner, including individuals who belong to communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American, Asian American, Native Hawaiian, and Pacific Islander persons and other persons of color; members of religious minorities; women and

girls; LGBTQIA+ persons; persons with disabilities; persons who live in rural areas; persons who live in U.S. territories; persons otherwise adversely affected by persistent poverty or inequality; and individuals who belong to multiple such communities (Executive Order on Further Advancing Racial Equity and Support for Underserved Communities Through the Federal Government).

Evidence-Based–Interventions, strategies, approaches, and/or program models that have been evaluated using rigorous evaluation design, such as randomized controlled or high-quality quasi-experimental trials, and that have demonstrated positive impacts for youth, families, and communities. Examples of evidence-based programs can be found at https://youth.gov/evidence-innovation/tpper.

Evidence-Informed–Interventions, strategies, approaches, and/or program models that bring together the best available research, professional expertise, and input from youth and families to identify and deliver services that have promise to achieve positive outcomes for youth, families, and communities.

Goal Setting–The process of deciding what to accomplish and devising a plan to achieve the desired result(s).

Healthy Relationships–Peer, romantic, marriage, family, and other interactions that are based on trust, honesty, and respect and allow adolescents to feel supported, connected, and independent. In healthy relationships, key elements are communication, appropriate boundaries, empathy, effective conflict resolution, and resistance of peer pressure.

Impact Evaluation–Efficacy/effectiveness study with a control/comparison group receiving no services or distinct services from the intervention group.

Implementation–The process of introducing and using interventions in real-world service settings, including how interventions or programs are adopted, sustained, and taken to scale.

Inclusivity–Celebrating and amplifying perspectives, voices, and values of such youth who have been historically underserved, marginalized, and adversely affected by persistent inequities.

Meaningful Youth Engagement–Engaging youth as equal partners meaningfully and authentically in the discovery, planning, implementation, and evaluation stages of youth-serving programs.

Medically Accurate and Complete–Medical information that is verified or supported by the weight of research conducted in compliance with accepted scientific methods and (a) published in peer-reviewed journals, where applicable, or (b) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete [Section 510(e)(2) of the Social Security Act (42 U.S.C. 710(e)(2)].

Objectives–The specific and measurable actions that support the expected result of the program.

OPDIV–An operating Division or an HHS administrative unit led by an Assistant Secretary and reporting directly to the Secretary.

Outcomes–The intended effects of the implemented program or program elements, such as an increase in knowledge, development of skills, and behavior changes.

Performance Measures–Indicators that are designed to collect data for program monitoring, improvement, and reporting purposes.

PYD–PYD is an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.

Rigorous–With respect to research or evaluation, using established scientific methods for measuring the impact of an intervention or program model in changing behavior (specifically sexual activity or other sexual risk behaviors) or reducing pregnancy among youth, or other evidence-based methodologies established by the Secretary [Section 510(e)(3) of the Social Security Act (42 U.S.C. 710(e)(3)].

Self-Regulation–The act of managing thoughts and feelings to enable goal-directed actions, including a variety of actions necessary for success in school, relationships, and the workplace.

Youth–One or more individuals who have attained age 10 but not age 20 [Section 510(e)(4) of the Social Security Act (42 U.S.C. 710(e)(4)].

F. REFERENCES

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II. FEDERAL AWARD INFORMATION

A. Expenditure Period

Each FY allocation will remain available for expenditure by the state through the end of the succeeding FY. For example, FY 2024 allocations through this announcement would remain available for expenditure by the state until September 30, 2025. FY 2025 allocations through this announcement will remain available for expenditure by the state through September 30, 2026.

Recipients cannot request to carry over funds beyond the grant award expenditure period**.** The chart below provides a timeline of the budget periods for FY 2024 and FY 2025 awards.

FY	**Applicant/Recipient Action Required**	**Project Period End Date for Obligation**	**Fund Expenditure**
2024	Submit application to receive FYSB approval.	September 30, 2025	All obligated funds must be expended by December 30, 2025.
2025	Recipient will submit Letter of Intent and applicant will submit an application to receive ACF approval.	September 30, 2026	All obligated funds must be expended by December 30, 2026.

The process for fulfilling requirements necessary to use FY 2024 or FY 2025 Title V State SRAE funding requires the submission of an application for funding, which will include the

federally required standard application documents, assurances, and other documents as outlined in *Section IV.D. Forms, Assurances, and Certifications* of this NOFO**.** The application also includes the implementation plan as outlined in *Section IV. E. Application and Submission Information, The Project Description.*

States are eligible to apply for FY 2024 and FY 2025 funding under this announcement. States will not be required to submit full applications after the initial funding year, unless there are material changes made to the program. Instead, states receiving funding in FY 2024 will be required to submit a written letter of intent and updated state plan to receive funding for FY 2025. ACF will provide states with guidance for submitting any updates to their applications and state plans. States planning to conduct a local evaluation must include with their letter of intent, an updated evaluation plan as part of the request for FY 2024 and FY 2025 funding.

States that do not submit an application in FY 2024 are eligible to apply for funding in FY 2025 and will be required to submit both an application and state plan on the due date found on the cover page of this announcement.

In states where Title V State SRAE awards were not made in FY 2024 or FY 2025, unexpended annual state allotments for FY 2024 and FY 2025 will be utilized to award competitive grants to local organizations and entities for the same purpose and in the same state in FY 2024 and FY 2025. A separate NOFO will be published regarding these discretionary grants, per the Title V SRAE legislation.

Anticipated Total Funding

A total of $60 million is available for FY 2024 awards, and it is anticipated that $60 million will be available for awards in FY 2025.

Allocations

Grants awarded to each state are determined by a formula using the state's proportion of low-income children compared to the total number of low-income children in the U.S., based on the most recent Census data for children in poverty. For each FY, the estimated allotment for each state or territory will be updated based on the most current available census data and will be communicated to states by October of the preceding FY. Census data are unavailable for the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau. Thus, the allocations for these three entities are based on the amounts allocated to them by HHS in prior FYs. **See *Appendix A* for FY 2024 and FY 2025 allotments.**

Approved Application

States that apply for FY 2024 are anticipated to receive grant awards by July 19, 2024

Funding Restrictions

Funds under this announcement cannot be used for the following purposes:

- To supplant or replace current public or private funding;
- To supplant ongoing or usual activities of any organization involved in the project;
- To purchase or improve land, or to purchase, construct, or make permanent improvements to any building;
- To reimburse pre-award costs;
- To support planning efforts and other activities associated with the development of the application; or
- For fundraising, political education, or lobbying activities.

Approval Status

Upon completion of the review of the application, ACF will make notification to the recipient on the approval status. The NOA will be issued by the ACF Office of Grants Management.

B. Terms and Conditions

General Terms and Conditions applicable to mandatory award programs and additional financial requirements specific to this program can be found at:
https://www.acf.hhs.gov/sites/default/files/documents/main/Non-discretionary%20General%20Terms%20and%20Conditions%202023%20update.pdf

III. ELIGIBILITY INFORMATION

A. Eligible States/Territories

For purposes of this announcement, 59 entities are eligible, including all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

The authorized representative, established under state law, shall apply for, and administer the Title V State SRAE Program. A signed letter from the authorized representative must accompany each application; it should include documentation or a citation establishing the authorized representative's authority to apply for and administer Title V State SRAE Program funds on behalf of the state.

Sub-awards

States are allowed to use awarded funding to make sub-awards. Sub-awards should be clearly identified to a subrecipient that meets the requirement as outlined under Part 75 (45 CFR § 75.352). States are required to verify the medical accuracy of all materials used by subrecipients.

B. Additional Information on Eligibility

Unique Entity Identifier (UEI) and System for Award Management (SAM)

All applicants must have a UEI and an active registration with SAM (https://www.sam.gov) prior to applying to a funding opportunity.

HHS requires all entities that plan to apply for, and ultimately receive, federal funds from any HHS Agency to:

- Be registered in SAM prior to submitting an application or plan;
- Maintain an active SAM registration with current information until the process is complete. If you receive an award, your SAM registration must be active throughout the life of the award. It must be renewed every 365 days to keep it active;
- Provide its UEI in each application or plan it submits; and
- Ensure any proposed subrecipient(s) have obtained and provided to the recipient their UEI(s) prior to making any subawards (**Note:** Subrecipients are not required to complete full SAM registration).

ACF is prohibited from making an award until an applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, ACF:

- May determine that the applicant is not qualified to receive an award; and
- May use that determination as a basis for making an award to another applicant.

IV. APPLICATION AND SUBMISSION INFORMATION

A. Application Submission Requirements

Mandatory grant recipients are required to use the Online Data Collection System (OLDC) within GrantSolutions, to submit the Application for Federal Assistance Standard Form (SF)-424 Mandatory Form (SF-424M) and upload all required documents. The form is available to applicants and recipients at https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family. ACF will not accept paper applications or those submitted via email or facsimile, without an exemption.

Application and State Plan Checklist

FY 2024 Title V State Sexual Risk Avoidance Education Program **Application for Funding and State Plan Checklist** **FY 2024– June 3, 2024** **FY2025– October 1, 2024**	
1.	Application for Federal Assistance SF-424M–Mandatory
2.	Project/Performance Site Location(s) SF-P/PSL
3.	Budget Information–SF-424A Non-Construction Programs
4.	Assurances–SF-424B Mandatory Non-Construction Programs
5.	Letter from the Authorized Representative (Transmittal Letter)
6.	Table of Contents
7.	State Plan Abstract
8.	State Plan/Program Narrative
9.	Budget Narrative/Justification
10.	Appendices
11.	Certification Regarding Lobbying
12.	Protection of Human Subjects Assurance Identification/IRB
13.	SF-LLL – Disclosure of Lobbying Activities, if applicable

FY 2024 and FY 2025 applicants are to submit all documents in the order listed in the checklist.

B. Request an Exemption from Required Electronic Submission

To request an exemption from required electronic submission, please refer to ACF's "Policy for Requesting an Exemption from Required Electronic Application Submission" for complete guidance.

C. Formatting Requirements for Paper Format Applications Only

All application materials must be submitted on 8.5- inch by 11-inch white paper with 1-inch margins.

All elements of the application submission must be in double-spaced format in 12-point Times New Roman or Courier font.

- The Project Description (Section IV. E.) must not exceed 65 pages.
- Tables and/or charts are permitted throughout the application.
- Clearly number all pages (including forms, project description, and appendices) in one serial number set, handwritten if necessary.
- Include a table of contents.
- Submit an original and one copy.
- Submit all documents in the order listed in the Application for Funding and State Application Checklist.
- Mail application to the Program Office contact listed in this announcement.

D. Forms, Assurances, and Certifications

Applicants seeking financial assistance under this announcement must submit the listed Standard Forms (SFs), assurances, and certifications. All required Standard Forms, assurances, and certifications are available at the Grants.gov Forms Repository.

Forms/Certifications	Description	Where Found
SF-424M (Mandatory Form)	This is a required Standard Form. Application for Federal Assistance– Mandatory	Available at https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family
Certification Regarding Lobbying (Grants.gov Lobbying Form)	Required of all applicants at the time of their application. If not available at the time of the application, it must be submitted prior to the award of the grant.	Available at https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family
SF-LLL-Disclosure of Lobbying Activities	If any funds have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to	"Disclosure Form to Report Lobbying" is available at https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family

	insure or guarantee a loan, the applicant shall complete and submit the SF-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Applicants must furnish an executed copy of the Certification Regarding Lobbying prior to award.	
SF-Project/Performance Site Location(s) (SF-P/PSL)	Referenced in *Section IV Application and Submission Information*	Form is available at https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family
Protection of Human Subjects Assurance Identification/IRB Certification/ Declaration of Exemption (Common Rule)	Submission of the required information and forms is due with the application package by the date	Form is available at http://www.hhs.gov/ohrp/assurances/forms/index.html. General information about HHS Protection of Human Subjects regulations can be obtained at http://www.hhs.gov/ohrp/. Applicants may also contact OHRP by email (ohrp@csophs.dhhs.gov).
Letter from the Authorized Representative (Transmittal Letter)	The transmittal letter signed by the Authorized Representative must include the Code of Federal Domestic Assistance Number 93.235 and "State Sexual Risk Avoidance Education" as the program to which the application is responding. The letter should also include the Payment Management System (PMS) EIN associated with the applicant organization's account; ex. 1-123456789-	Must be submitted with the application package by the due date found on the cover page of this announcement.

	A1. Documentation or a citation of the authority of the authorized representative to apply for and administer funds on behalf of the state should also be included in the letter. The transmittal letter should be included with all copies of the application. If states are proposing a local evaluation, the letter should also identify the type or method of evaluation that is proposed.	
Budget Information–Non-Construction Programs–SF-424A		https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family
Assurances for Non–Construction Programs (SF-424B Mandatory)		https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family

E. The Project Description

The project description provides the majority of information by which the state plan addresses the activity for which federal funds are being requested and must be consistent with the goals and objectives of the program as described in *Section I. Program Description*. Supporting documents must be included to provide clear and succinct details on planned program activities.

Project Abstract

States will include an abstract of no more than 600 words of the post-award state plan. The abstract will provide an overview of the plan and will form the basis for the application summary in grants management documents. The abstract may also be distributed to provide information to the public and Congress and represents a high-level summary of the project. As a result, applicants must prepare a clear, accurate, concise abstract that can be understood without reference to other parts of the state plan and that provides a description of the proposed project, including the following: brief statement of the project; whether it is a local, county-wide, or

state-wide project; mechanism for delivering services (e.g., sub-awards to local organizations through a competitive bid process); geographic area to be served (urban, rural, suburban); description of population served and number of youths to be served; a short description of the intervention to be implemented; overarching goal(s); any evaluation plans; and monitoring strategies. States should include the following information on the first page of the project abstract (this information is not included in the 600-word maximum).

Include the following information in the abstract:

Contact and Grant Request Information

State:

Fiscal Year:

Grant allocation amount:

	Prefix	First and Last Name	Suffix	Title	Telephone	Email Address
Contact Person						
Project Director						
Authorized Representative						

Description of Problem and Need

This section requires the applicant to establish a simple needs assessment of problems related to non-marital sexual activity and other risky behaviors as identified in the Title V SRAE legislation. The state must clearly identify the physical, economic, social, financial, institutional, and/or other problem(s) requiring a solution. The need for assistance, including the nature and scope of the problem, must be demonstrated, and the principal and subordinate objectives of the project must be clearly and concisely stated. Any relevant data based on planning studies should be included or referred to in the endnotes/footnotes. Incorporate demographic data and participant/beneficiary information, as well as data describing the needs of the population served and the proposed service area. The discussion may also include brief descriptions of existing programs and/or gaps therein to address the problem. However, the applicant should avoid detailed descriptions of these programs. The goal is not to describe all programs and activities in the state, but rather to demonstrate that the applicant has assessed how best to use the available grant funds.

Goal(s)

As outlined in the *Section I. C. Program Description, Title V State SRAE Program Overview, Goals(s) and Logic Models*, describe the goal(s) and outcomes of all planned activities. FYSB encourages the use of logic models and the inclusion in the proposal of any logic models that have been developed that support the implementation plan.

Logic Model

Applicants are expected to submit a logic model for designing and managing their project. A logic model is a one-page diagram that presents the conceptual framework for a proposed project and explains the links between program elements. While there are many versions of logic models, for the purposes of this announcement the logic model must summarize the following:

- Goals of the project (e.g., objectives, reasons for proposing the interventions, if applicable);
- Assumptions (e.g., beliefs about how the program will work and its supporting resources. Assumptions should be based on research, best practices, and experience);
- Inputs (e.g., organizational profile, collaborative partners, key staff, budget);
- Population served (e.g., the individuals to be served);
- Activities (e.g., approach, listing key interventions, if applicable);
- Outputs (i.e., the direct products or deliverables of program activities); and
- Outcomes (i.e., the results of a program, typically describing a change in people or systems).

Implementation Plan

The implementation plan is a critical part of the program narrative and, therefore, of the state plan. States must demonstrate in their state plan that the implementation plan is based on the problem and the need for reaching the proposed population(s). They should also develop and identify goals, activities, mechanisms, and a short set of broad steps that will be used to implement the activities. For each step, include the responsible party, the expected outputs, and the start and end dates.

States should involve service recipients in this process and describe how they were involved. Also, they should describe how the state proposes to involve service recipients in the actual implementation of the proposed plan.

A state's plan should include any potential barriers to the implementation plan, including any state and local laws restricting implementation, and how the state proposes to overcome those barriers.

If the state plans to develop formal partnerships, describe the mechanisms that will be used and the types of services the partners will provide. Formal partners are those with whom the state will establish legal agreements such as grants, contracts, interagency agreements, memoranda of agreement, or memoranda of understanding. States should also include a plan for monitoring the

effective management and coordination of activities with subrecipients, partners, and other stakeholders to ensure program integrity to the proposed plan and the priorities of the state and of FYSB.

Description of Programmatic Assurances

Educational materials used by awardees and subrecipients must be reviewed for medical accuracy. Education must be based on adolescent learning and developmental theories for the age group receiving the education and be culturally appropriate, recognizing the experiences of youth from diverse communities and backgrounds.

For each of the requirements related to legislative priorities, states must describe measures (i.e., contract language, report requirements, and site visits) that the state will use to ensure compliance.

States will be required to take appropriate action to correct any inaccurate information discovered by FYSB during the state plan review process or at any time during the grant project period(s).

Medically Appropriate Materials and Culturally and Age-Appropriate Approaches

States should describe how interventions will address the trauma needs of vulnerable youth and will ensure all curricula, services, and materials are inclusive; medically accurate; culturally, linguistically, and age appropriate; and voluntary.

Evidence-Based Strategies

The program model should incorporate an evidence-based or evidence-informed approach that has demonstrated impacts on youth refraining from sexual activity. These selected interventions must have evidence of effectiveness with populations served and address each topic outlined in *Section I.C. Program Description, Title V State SRAE Program Overview, Evidence-Informed Interventions and Strategies*. Applicants must identify all methods utilized that will ensure facilitators/educators who will deliver the program(s) have been or will be formally trained in the proposed SRA program model and/or strategies.

PYD Framework including Leading in Partnership with Youth and Young Adults/Meaningful Youth Engagement

States should describe a plan for incorporating a PYD approach, including targeting risk and protective factors in young people's lives that are known to influence sexual activity, and address the trauma needs of vulnerable youth. States should demonstrate in their state plan ways in which they plan to incorporate meaningful youth engagement as part of their larger PYD approach.

Equity

Describe how the project will recruit and retain populations who are vulnerable. The applicant must describe how they will coordinate, communicate, and engage with community-based organizations whose mission is to reach vulnerable populations, including people with lived experience. Applicants must also describe staff development and training opportunities to increase knowledge of the communities most impacted by teen births, including by geography, gender, race, and equity. Provide a description of the types and frequency of diversity, equity, and inclusion training that will be conducted throughout the project period.

Youth Populations Served

State plans must identify how they will target SRAE to youth ages 10 to 19. The plan must include a description of the proposed target groups in detail and demonstrate how and why they were chosen. In cases where groups have equal needs, the state may describe how infrastructure, systems, local support, feasibility, and service recipient participation were considered in identifying target populations.

Linkages and Referrals to Healthcare and Other Services

State plans should describe youth and family service referrals to other providers of healthcare services (e.g., substance abuse, including alcohol). For youth such linkages and referrals should be youth-friendly. Youth-friendly services are those that attract young people, respond to their needs, and retain young people for continuing care [4]. Youth-friendly services are based on a comprehensive understanding of what young people want and need (rather than being based only on what providers believe youth need) [4]. The description should identify referral resources, include information about how referrals will be made to other services and programs, and how follow up and tracking will take place to ensure linkage to identified services. Referral resources should include, but not be limited to, substance use and abuse and mental health services. Referrals cannot be made to family planning organizations that provide abortions. For additional information on linkages and referrals, please see: Referrals and Linkages to Youth-Friendly Health Care Services.

Local Evaluation (Optional)

States may use up to 20 percent of their allotment to build the evidence-base for SRAE by conducting or supporting a local evaluation. *See Section I.C., Program Description, Title V SRAE Program Overview, Local Evaluation* for details on funding allotment requirements for evaluation.

States that plan to conduct a local evaluation must describe a brief plan to implement the evaluation. The plan must include the proposed research questions, the planned rigorous evaluation design, how an independent evaluator will be procured (including the types of experience of the independent evaluator), and the proposed evaluation infrastructure. Plans should be clearly described with an understanding that modifications may be required after an evaluator is officially hired and/or federal government-sponsored TA is provided. See *Section I.C. Program Description, Title V State SRAE Program Overview, Local Evaluation* to assist

with the development of the evaluation plan. Recipients proposing to complete a local evaluation must indicate their agreement to submit a final report to ACF.

National Evaluation:

Applicants must clearly state their assurance/agreement that the state and subrecipient will participate, if selected for national evaluation(s). Plans must discuss the recipients' willingness to participate, if selected, and authorized representatives must affirm this understanding in their plan.

Performance Measurement

FYSB plans to use OMB-approved performance measures data to monitor the extent to which the programs are being implemented according to the SRAE legislation. Recipients applying for funds must indicate their agreement to collect information related to the performance measures and submit the data to FYSB. FYSB will only collect data that have received OMB approval under PRA from recipients. Recipients are encouraged to develop additional indicators of program performance for their internal data collection needs, as desired. See *Section I. Program Description, Performance Measurement*.

Objective Performance Measures

Describe at least two program-related, objective outcome measures that the state proposes to use to measure its success in reaching key goals. Outcome measures are those designed to measure behaviors, attitudes, knowledge, beliefs, attendance, reach, and dosage of service recipients served. The outcome measures must take into consideration how education on SRAE is a means of preventing teen pregnancy, STIs, and other risky behavior. SRAE primarily teaches the benefits associated with delaying sexual activity until marriage, including personal responsibility; self-regulation; goal setting; healthy decision-making; healthy relationships; avoiding poverty; and resisting sexual coercion, dating violence, and other youth risk behaviors, such as drug and alcohol usage.

States may develop additional performance measures, including both outcome and output measures. Output measures are those designed to measure the success of the program staff in implementing activities, such as the number of program recipients or communities served.

Sustainability Plan

States are encouraged to develop a sustainability plan that includes their subrecipient and collaborating partners. The plan must detail how the proposed project activities will continue after federal funding ends. States should have their funded providers develop and plan to sustain

key elements of their grant-supported projects (e.g., strategies or services and interventions that have been effective in improving practices and outcomes for youth and families).

Service Recipient Involvement

Briefly describe how the state proposes to make the plan public within the state, after its transmittal to FYSB, in such a manner as to facilitate comment from the public (including service recipients and any federal or other public agency). For example, the state may post the proposed plan on the web, hold listening sessions or town hall meetings, establish or continue an advisory board for the program, or send the plan to interested groups.

Budget Information–Non-Construction Projects–SF-424A

States will submit one budget information form with this application, which will be reviewed in light of their proposed activities for the budget period. For section B of the Budget Information Form (SF-424A), applicants must submit a *detailed* budget justification for each line item within the object class categories (6a-j) on a supplemental sheet(s) of paper. The budget justification should include detailed sub-categories of section 6a-j. The budget narrative must thoroughly describe how the proposed categorical costs are derived. For in-kind contributions, the source of the contribution and how the valuation of that contribution was determined must also be described.

Whether direct or indirect, all costs must be allowable, allocable, reasonable, and necessary under the new applicable uniform administrative requirements, cost principles, and audit requirements for HHS awards. Awards issued under this announcement are subject to 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. The Code of Federal Regulations is available at www.gpo.gov. Any fees as program income must be used toward the goals and objectives of the project. The budget narrative must also include a breakdown of the allocation of federal funding. For further information on Budget guidance, see *Appendix C.*

Complete sections A (Budget Summary) through F (Other Budget Information) of the SF-424A. The SF-424A is available at the: Grants.gov Forms Repository web site.

F. Paperwork Reduction Disclaimer

As required by the Paperwork Reduction Act, 44 U.S.C. 3501-3521, the public reporting burden for the Application, State Plan, and Performance Progress Report is estimated to average 80 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. The Application, State Plan, and Performance Progress Report are approved under OMB Control Number 0970-0551, which expires on November 30, 2026. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

G. Funding Restrictions

Special Note: *Annual appropriations legislation for the HHS limits the salary amount that may be awarded and charged to ACF grants and cooperative agreements. Award funds issued under this funding opportunity may not be used to pay the salary of an individual at a rate in excess of Executive Level II. For the Executive Level II salary, please see "Executive & Senior Level Employee Pay Tables" under https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/. The salary limitation reflects an individual's base salary exclusive of fringe benefits, indirect costs, and any income that an individual may be permitted to earn outside of the duties of the applicant organization. This salary limitation also applies to subawards and subcontracts under an ACF grant or cooperative agreement.*

V. AWARD ADMINISTRATION INFORMATION

A. Administrative and National Policy Requirements

For the terms and conditions that apply to all mandatory grants, as well as ACF program-specific terms and conditions, go to: https://www.acf.hhs.gov/grants/mandatory-formula-block-and-entitlement-grants.

An application funded with the release of federal funds through a grant award does not constitute or imply compliance with federal regulations. Funded organizations are responsible for ensuring that their activities comply with all applicable federal regulations. SRA grants are subject to requirements at Sections 503 (relating to payment), 507 (relating to criminal penalties for false statements), and 508 (relating to nondiscrimination) of the Social Security Act (42 U.S.C. 703, 707, and 708).

B. Reporting

Recipients are required to submit post-award performance progress reports and financial reports. Program reporting forms for mandatory grant programs must be submitted electronically through the OLDC at: https://home.grantsolutions.gov/home/.

Please see *Section IV. Application and Submission Information* for more information on required electronic submission, as well as exemption from this requirement.

Financial reporting forms must be submitted electronically to the Division of Payment Management through the Payment Management System. Paper copies will not be accepted.

C. Performance Progress Reports (PPR)

State SRAE recipients will be required to submit progress reports semi-annually. Reports will be due 30 days after the conclusion of the reporting period. Recipients **must** submit their reports online through the OLDC at: https://home.grantsolutions.gov/home/.

Failure to submit reports on time may be a basis for withholding grant funds, suspension, or termination of the grant. In addition, all funds reported after the obligation period will be recouped.

PPR requirements are approved under OMB control number 0970-0551, which expires November 30, 2026.

D. Federal Financial Reports (FFR)

Recipients must submit FFR for each grant award using the Standard Form 425 (SF-425). The following table lists the due dates for the first and final FFR for FY 2024 and FY 2025 grant awards.

Fiscal Year	Project and Expenditure Period	Report Period End Date	FFR Due Date First Report	FFR Due Date Final Report
FY 2024	10/01/2023-09/30/2025	09/30/2025	12/30/2024	01/30/2026
FY 2025	10/01/2024-09/30/2026	09/30/2026	12/30/2025	01/30/2027

F. Property Reporting

ACF has implemented the use of the SF-428 *Tangible Property Report* and the SF-429 *Real Property Status Report* for all recipients. Both standard forms are available at: https://www.grants.gov/forms/forms-repository/sf-424-mandatory-family.

VI. AGENCY CONTACT

Program Office Contact

MeGan Hill
U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Family and Youth Services Bureau
330 C Street, SW
Washington, DC 20201
Tel: (301) 348-3565
Email: megan.hill@acf.hhs.gov

Grants Management Contact

Trang Le
Grants Management Specialist
Administration for Children and Families
Office of Grants Management
Division of Mandatory Grants
330 C Street, SW
Washington, DC 20201
Tel: (202) 690-7053
Email: trang.le@acf.hhs.gov

APPENDICES

APPENDIX A–ESTIMATED ALLOTMENTS FOR FY 2024 and FY 2025

APPENDIX B–RESOURCES FOR DEVELOPING PROGRAMS AND LOGIC MODELS

APPENDIX C–BUDGET GUIDANCE

APPENDIX A–ALLOTMENTS FOR FY 2024 & FY 2025**

States/Territories	Allocation
ALABAMA	$ 1,166,016
ALASKA	$ 103,907
ARIZONA	$ 1,309,082
ARKANSAS	$ 735,423
CALIFORNIA	$ 6,486,657
COLORADO	$ 689,521
CONNECTICUT	$ 436,737
DELAWARE	$ 164,378
DISTRICT OF COLUMBIA	$ 139,244
FLORIDA	$ 3,583,508
GEORGIA	$ 2,388,247
HAWAII	$ 192,757
IDAHO	$ 287,541
ILLINOIS	$ 2,104,804
INDIANA	$ 1,182,721
IOWA	$ 431,730
KANSAS	$ 438,859
KENTUCKY	$ 1,044,928
LOUISIANA	$ 1,367,491
MAINE	$ 175,738
MARYLAND	$ 891,806
MASSACHUSETTS	$ 805,845
MICHIGAN	$ 1,793,410
MINNESOTA	$ 659,724
MISSISSIPPI	$ 897,426
MISSOURI	$ 1,040,778
MONTANA	$ 154,369
NEBRASKA	$ 282,920
NEVADA	$ 611,703
NEW HAMPSHIRE	$ 109,885
NEW JERSEY	$ 1,352,324
NEW MEXICO	$ 529,812
NEW YORK	$ 3,553,611
NORTH CAROLINA	$ 1,953,909
NORTH DAKOTA	$ 89,873
OHIO	$ 2,260,392
OKLAHOMA	$ 946,712
ORGEON	$ 538,793

PENNSYLVANIA	$	2,120,281
RHODE ISLAND	$	144,746
SOUTH CAROLINA	$	1,050,677
SOUTH DAKOTA	$	149,500
TENNESSEE	$	1,295,176
TEXAS	$	6,858,807
UTAH	$	362,184
VERMONT	$	57,082
VIRGINIA	$	1,154,846
WASHINGTON	$	943,029
WEST VIRGINIA	$	347,526
WISCONSIN	$	798,897
WYOMING	$	82,477
AMERICAN SAMOA	$	71,778
FEDERATED STATES of MICRONESIA	$	47,492
GUAM	$	78,913
MARSHALL ISLANDS	$	13,501
NORTHERN MARIANA ISLANDS	$	44,341
PALAU	$	21,000
PUERTO RICO	$	1,415,984
VIRGIN ISLANDS	$	39,182
Total Allocation	**$**	**60,000,000**

APPENDIX B–RESOURCES FOR DEVELOPING PROGRAMS AND LOGIC MODELS

A potential resource for identifying and creating relevant programs geared toward outcomes is the CDC's *10 Steps to Promoting Science-Based Approaches to Teen Pregnancy Prevention using Getting to Outcomes* (see https://www.cdc.gov/teenpregnancy/practitioner-tools-resources/psba-gto-guide/index.html). This guide provides a clear 10-step process to assessing the needs of a community, selecting a program, implementing it, and tracking progress. States and subrecipients are encouraged to review these steps in developing their approaches and their logic models.

Another helpful resource is the CDC webpage devoted to Program Evaluation at the Office of the Associate Director for Program-Program Evaluation see (http://www.cdc.gov/eval/resources/). This federal website offers links to many online resources focused on logic model development including templates and sample documents.

These resources are intended to be used as a guide for developing logic models. The specific program examples within are not meant to be examples that meet the criteria for this NOFO.

Logic Model Format

A logic model is a diagram that shows the relationship between the program components and activities and desired process and outcome objectives. It is a visual way to present and share understanding of the relationships among the resources available to implement the proposed intervention, the strategies/activities planned for implementation, and the outputs and outcomes expected. The outputs are often expressed as S.M.A.R.T.I.E. process objectives. A potential resource for creating S.M.A.R.T.I.E. objectives is the CDC's National *Breast and Cervical Cancer Early Detection Program Writing Effective Objectives* (see https://www.cdc.gov/cancer/nbccedp/pdf/smartie-objectives-508.pdf). All states and/or subrecipients must create logic models that provide an overview of the entire program/activity for the duration in which it is expected to occur. The logic models must detail how inputs (e.g., resources) will be used to fund activities for the achievement of specific process and outcome objectives enumerated and ultimately the achievement of the goal(s) statement.

APPENDIX C-BUDGET GUIDANCE

Program Application Budget Related Documents

SF-424A Form Budget Information–Non-Construction Programs

Budget and Budget Narrative Documents

1. **Budget**–This should be in a spreadsheet or table format. Both the federal and non-federal budget items should be clearly marked. The budget should reflect the budget cost categories outlined in SF-424A (i.e., personnel, benefits, travel expenses, equipment, supplies, contractual, other, indirect costs, matching and in-kind contributions) and identify all line items within each category. Programs should provide a specific itemization of the budget.

2. **Budget Narrative**–The programs should provide a justification supporting the need to allocate funds for items in the spreadsheet or table format of the itemized budget. The justification should provide a clear description of how the budget items directly relate to the completion of project activities. In the contractual category, indicate if the sub-award was awarded competitively or non-competitively. If the sub-award is a sole-source/non-competitive award, provide a brief explanation of the rationale for the selection of the subrecipient(s).

Budget Categories

The components of the budget and budget narrative are the line-item categories and the type of funding (federal and non-federal share), as indicated below:

Personnel

Description: Costs of employee salaries and wages. See 45 CFR § 75.430 for more information on allowable personnel costs. Do not include the personnel costs of consultants, contractors and subrecipients under this category.

Justification: For each position, provide: the name of the individual (if known), their title; time commitment to the project in months; time commitment to the project as a percentage or full-time equivalent; annual salary; project salary; wage rates; etc. Identify the project director or principal investigator, if known at the time of application.

Fringe Benefits

Description: Costs of employee fringe benefits are allowances and services provided by employers to their employees in addition to regular salaries and wages. For more information on Fringe Benefits please refer to 45 CFR § 75.431. **Do not include** the fringe benefits of consultants, contractors, and subrecipients because those costs should be listed under the "Contractual" category as part of the total value of the contract or agreement.

Typically, fringe benefit amounts are determined by applying a calculated rate for a particular class of employee (full-time or part-time) to the salary and wages requested. Fringe rates are often specified in the approved indirect cost rate agreement. Fringe benefits may be treated as a direct cost or indirect cost in accordance with the applicant's accounting practices. Only fringe benefits as a direct cost should be entered under this category.

Justification: Provide a breakdown of the amounts and percentages that comprise fringe benefit costs such as health insurance, Federal Insurance Contributions Act taxes, retirement, taxes, etc.

Travel

Description: Costs of project-related travel (i.e., transportation, lodging, subsistence) by employees of the applicant organization who are in travel status on official business. Travel by non-employees such as consultants, contractors or subrecipients should be included under the Contractual line item. Local travel for employees in non-travel status should be listed on the Other line. Travel costs should be developed in accordance with the applicant's travel policies and 45 CFR § 75.474.

Justification: For each trip show: the total number of travelers; travel destination; duration of trip; per diem; mileage allowances, if privately owned vehicles will be used to travel out of town; and other transportation costs and subsistence allowances. If appropriate for this project, travel costs for key project staff to attend ACF-sponsored workshops/conferences/recipient orientations should be detailed in the budget justification.

Equipment

Description: "Equipment" means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost that equals or exceeds the lesser of: (a) the capitalization level established by the organization for the financial statement purposes, or (b) $5,000. (Note: Acquisition cost means the net invoice unit price of an item of equipment, including the cost of any modifications, attachments, accessories, or auxiliary apparatus necessary to make it usable for the purpose for which it is acquired. Ancillary charges, such as taxes, duty, protective in-transit insurance, freight, and installation, shall be included in, or excluded from, acquisition cost in accordance with the organization's regular written accounting practices.) See 45 CFR § 75.439 for more information.

Justification: For each type of equipment requested provide: a description of the equipment; the cost per unit; the number of units; the total cost; and a plan for use on the project; as well as use and/or disposition of the equipment after the project ends.

Supplies

Description: Tangible personal property other than those included under the Equipment category. A computing device is a supply if the acquisition cost is less than the lesser of $5,000, or the capitalization level established by the non-federal entity for financial statement purposes,

regardless of the length of its useful life. See 45 CFR § 75.2, 75.321, and 75.453 for more information.

Justification: Specify general categories of supplies and their costs. Show computations and provide other information that supports the amount requested.

Contractual

Description: Cost of all contracts and subawards except those that should be placed under other categories such as equipment, supplies, construction, etc. Include third-party evaluation contracts, procurement contracts, and subawards. Recipients are required to use 45 CFR §§ 75.326-.340 procurement procedures, and subawards are subject to the requirements at 45 CFR §§ 75.351-.353. Costs related to professional and consultant services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees, must be listed in the Other category. (Typically, these arrangements will take the form of a consultant agreement directly with an individual as opposed to a contract with a company that employs the consultant. The latter case must still be listed under Contractual line item).

If applicable and charged as a direct cost, include cost of third-party renting or leasing agreements for equipment; and third-party renting or leasing agreements for real property by address for each building, facility, administrative office, space, structure, land, and other real property.

Justification: Indicate whether the proposed agreement qualifies as a subaward or contract in accordance with 45 CFR § 75.351. Provide the name of the contractor/subrecipient (if known), a description of anticipated services, a justification for why they are necessary, a breakdown of estimated costs, and an explanation of the selection process. In addition, for subawards, the applicant must provide a detailed budget and budget narrative for each subaward, by entity name, along with the same justifications referred to in these budget and budget justification instructions.

For contracts, demonstrate that procurement transactions will be conducted in a manner to provide, to the maximum extent practical, open, and free competition. Applicants must justify any anticipated procurement action that is expected to be awarded without competition and exceeds the simplified acquisition threshold stated in 48 CFR § 2.101(b). Recipients may be required to make pre-award review and procurement documents, such as requests for proposals or invitations for bids, independent cost estimates, etc., available to ACF.

If applicable and charged as a direct cost, for each real property proposed or claimed for rent or lease include: the rent amount with calculation; terms of lease; maintenance and repair amounts with details on each type of expense proposed and its associated cost; minor A&R with specifics for each type of proposed expense and its associated cost; show the computation and provide other information that supports the amount requested. Only when allowable and with prior approval, describe the financing costs (including interest) including terms for the real property address. For applicable ACF programs with real property authority, see ACF Property

Guidance. **Do not include** real property owned by the recipient or arrangements considered "less-than-arms-length," "sale and lease back," "finance lease" per Financial Accounting Standards Board, "financed purchase" per Government Accounting Standards Board standards because these costs (e.g., depreciation costs) if charged as (1) a direct cost, should be listed under the "Other" category or (2) an indirect cost as with any indirect costs, as part of their indirect cost pool that is used to calculate an indirect cost rate). These costs must be treated as either direct or indirect costs, not both. For more information, see 45 CFR §75.2, 75.414, 75.430-75.431, 75.434, 75.436, 75.439, and 75.452.

Other

Description: Enter the total of all other costs. Such costs, where applicable and appropriate, may include, but are not limited to: individual consultant costs; local travel; insurance (when not included under the Fringe category); food (when allowable); medical and dental costs (non-personnel); professional service costs (e.g., audit charges); depreciation of real property and equipment (when not treated as an indirect cost), printing and publications, training costs (such as tuition and stipends), staff development costs, and administrative costs (when not treated as an indirect cost). Please note costs must be allowable per 45 CFR Part 75 Subpart E.

Justification: Provide a breakdown of costs, computations, a narrative description, and a justification for each cost under this category.

If applicable and charged as a direct cost, include depreciation by real property address for each building, facility, administrative office, structure, land, and other real property proposed for use and depreciation of equipment proposed for use. For each real property owned by the recipient or less-than-arms-length lease intended to be proposed or claimed for use provide, if applicable, and in accordance with 45 CFR §§75.436 and 75.465: the allocable percentage and total dollar amount; the depreciation amount with type of method and calculation used; tax amount; insurance amount and what it covers; maintenance and repair amounts with details on each type of expense proposed and its associated cost; minor A&R with specifics for each type of proposed expense and its associated cost; the ownership type (e.g., owned, leased, or intent to lease); show the computation and provide other information that supports the amount requested. For more information, please see ACF Property Guidance. **Do not include** costs of third-party renting or leasing real property and equipment because those costs should be under the Contractual category.

Indirect Charges

Description: Indirect or Facilities & Administration (F&A) (F&A means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved. F&A costs are generally used by institutions of higher education). Typical examples of indirect or F&A costs include but are not limited to depreciation on buildings and equipment, equipment and capital improvements, operation and maintenance expenses, and general administration and expenses, such as the salaries and expenses of personnel administration and accounting. For more information, see 45 CFR §75.2, 75.414, 75.430-75.431, 75.434, 75.436,

and 75.439. Enter the total amount of indirect costs. This category has one of two methods that an applicant can select. An applicant may only select one.

1. The applicant currently has an indirect cost rate approved by HHS or another cognizant federal agency.

   Justification: An applicant must enclose a copy of the current approved rate agreement. If the applicant is requesting a rate that is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed. Choosing to charge a lower rate will not be considered during the merit review or award selection process.

2. Per 45 CFR § 75.414(f) Indirect (F&A) costs, "any non-Federal entity [i.e., applicant] that has never received a negotiated indirect cost rate, ... may elect to charge a *de minimis* rate of 10% of modified total direct costs which may be used indefinitely. As described in Section 75.403, costs must be consistently charged as either indirect or direct costs but may not be double charged or inconsistently charged as both. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as the non-Federal entity chooses to negotiate for a rate, which the non-Federal entity may apply to do at any time."

   Justification: This method only applies to applicants that have never received an approved negotiated indirect cost rate from HHS or another cognizant federal agency. Applicants awaiting approval of their indirect cost proposal may request the 10 percent *de minimis* rate. When the applicant chooses this method, costs included in the indirect cost pool must not be charged as direct costs to the award.

Commitment of Non-Federal Resources

Description: Amounts of non-federal resources that will be used to support the project as identified in Block 18 of the SF-424. This line should be used to indicate required and/or voluntary committed cost sharing or matching, if applicable.

For all federal awards, any shared costs or matching funds and all contributions, including cash and third-party in-kind contributions, must be accepted as part of the recipient's cost sharing, or matching when such contributions meet all of the criteria listed in 45 CFR § 75.306. For awards that require matching by statute, recipients must meet the required level of cost sharing. Recipients that have voluntarily decided to contribute cost sharing when it is not required, or at a higher level than required, will be held accountable for the proposed cost-sharing, if accepted by ACF and included in the NOA. **A recipient's failure to provide cost sharing that has been accepted by ACF may result in the disallowance of federal funds.**

Justification: If an applicant is relying on cost share or match from a third-party, then a firm commitment of these resources (letter(s) or other documentation) is required to be submitted

with the application. Detailed budget information must be provided for every funding source identified in Item 18. "Estimated Funding ($)" on the SF-424.

Applicants are required to fully identify and document in their applications the specific costs or contributions they propose in order to meet a matching requirement. Applicants are also required to provide documentation in their applications on the sources of funding or contribution(s). In-kind contributions must be accompanied by a justification of how the stated valuation was determined. Matching or cost sharing must be documented by budget period (or by project period for fully funded awards).

Indirect Cost Rate Agreement

Website of contacts for assistance in obtaining an indirect cost rate agreement:
https://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html

Exhibit 10

PMAPS
PREP Studies of Performance Measures and Adulthood Preparation Subjects

Fact Sheet

OPRE Report #2023-029 February 2023

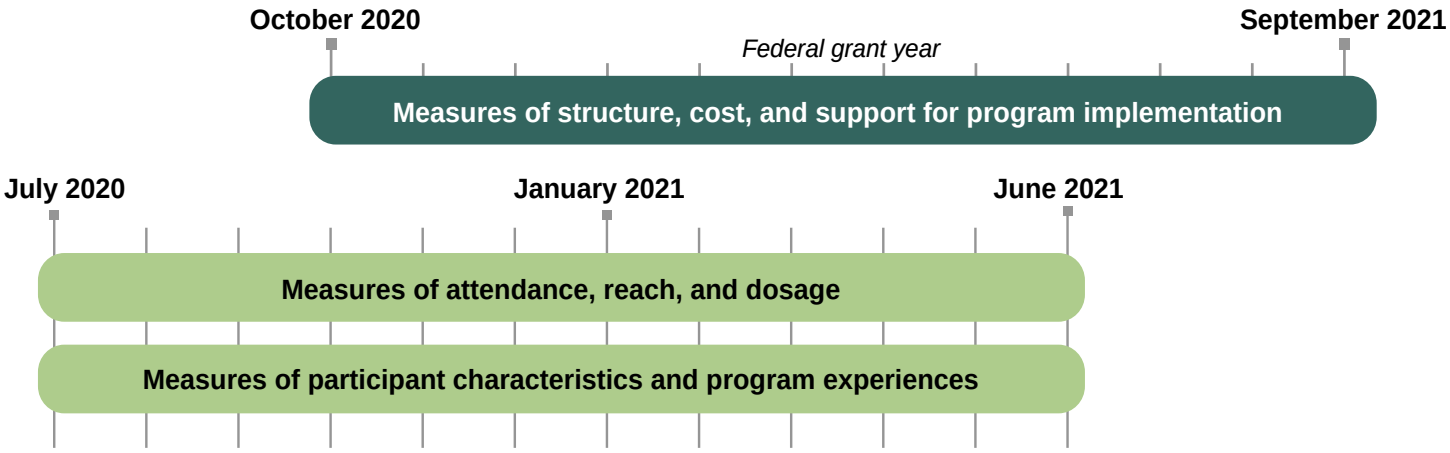
2020–2021 Performance Measures

Background

The goal of the Personal Responsibility Education Program (PREP) is to educate adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS. PREP is administered by the Family and Youth Services Bureau (FYSB) within the Administration for Children and Families of the U.S. Department of Health and Human Services. PREP operates through four different funding streams:

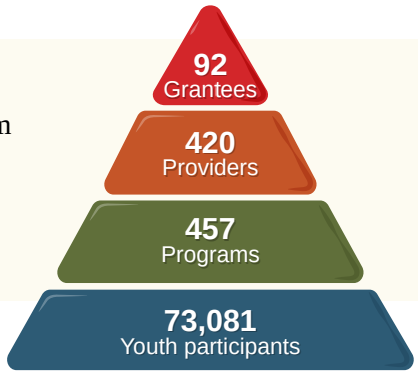
More information on these grant programs is available at https://www.acf.hhs.gov/fysb/adolescent-pregnancy-prevention.

All PREP grantees are required to submit performance measures data to FYSB twice a year. This fact sheet is based on performance measures for the 2020–2021 reporting period, including the following:



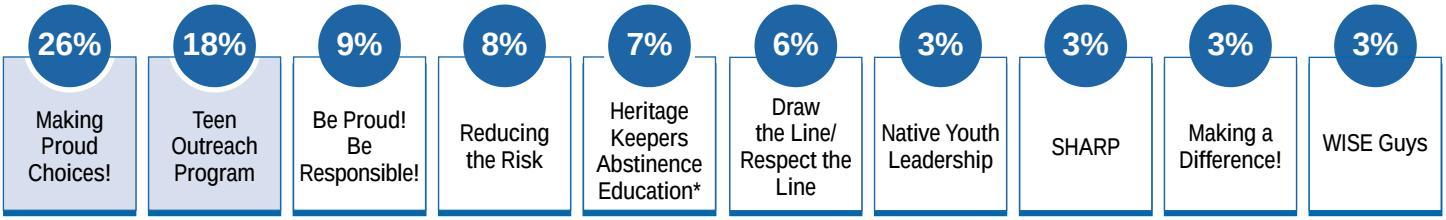
Scale

During the 2020–2021 reporting period, PREP funded 92 grantees and 420 program providers. Some program providers are PREP grantees that serve youth directly; others are subrecipients funded through a PREP grantee. Providers operated 457 programs with 1,540 facilitators, and served 73,081 youth during the period.



Program content

Providers most commonly implemented two program models: Making Proud Choices! and Teen Outreach Program.



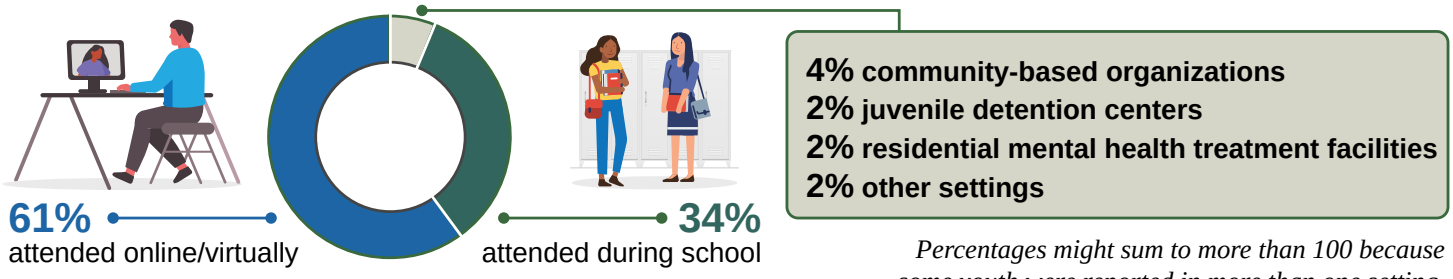
The most common program models differed by funding stream. For example, Making Proud Choices! was the most common model among State PREP programs, while Native Youth Leadership was the most common model among Tribal PREP programs.

**The PREP programs that implemented Heritage Keepers also incorporated information on contraceptives into their program model to meet PREP requirements.*

PREP grantees **must address at least three of six adulthood preparation subjects (APSs)**. Programs most commonly addressed healthy relationships, healthy life skills, and adolescent development. Fifteen percent of PREP programs addressed all six APSs.

Setting

Participants primarily received PREP programming virtually because of disruptions related to the COVID-19 pandemic. Just over one-third of participants attended PREP programming in schools during school time.

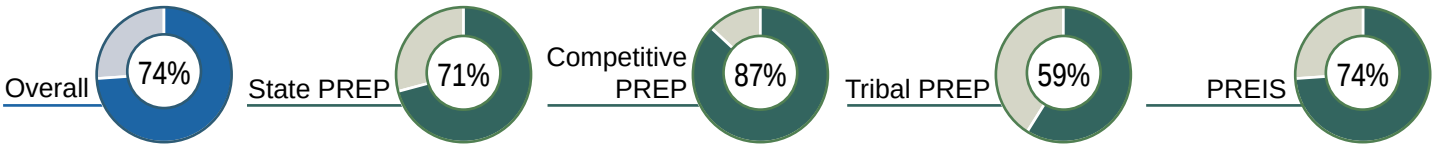


Percentages might sum to more than 100 because some youth were reported in more than one setting.

Dosage

Nearly three-quarters of youth participants completed at least 75 percent of the intended programming hours overall. This percentage was highest for Competitive PREP programs and lowest for Tribal PREP programs.

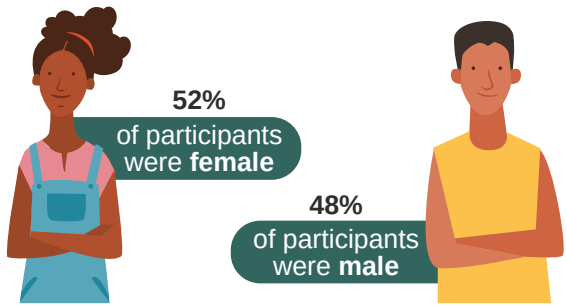
Percentage of participants receiving at least 75 percent of intended program hours



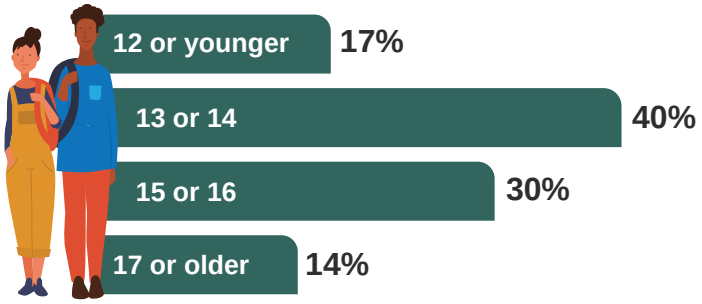
Characteristics of participants

PREP programs served diverse populations of youth.

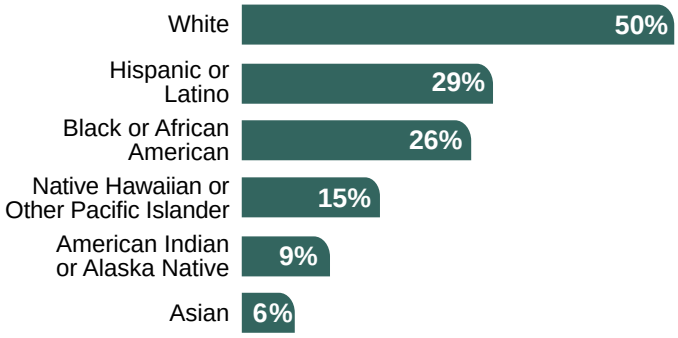
Sex



Age



Race and ethnicity

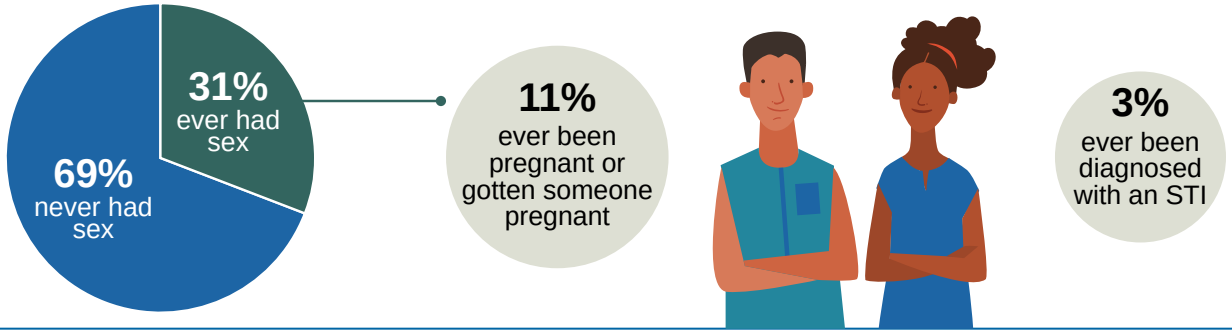


Living situation

- 5% living in foster care
- 3% in adjudication systems
- 2% homeless or runaways

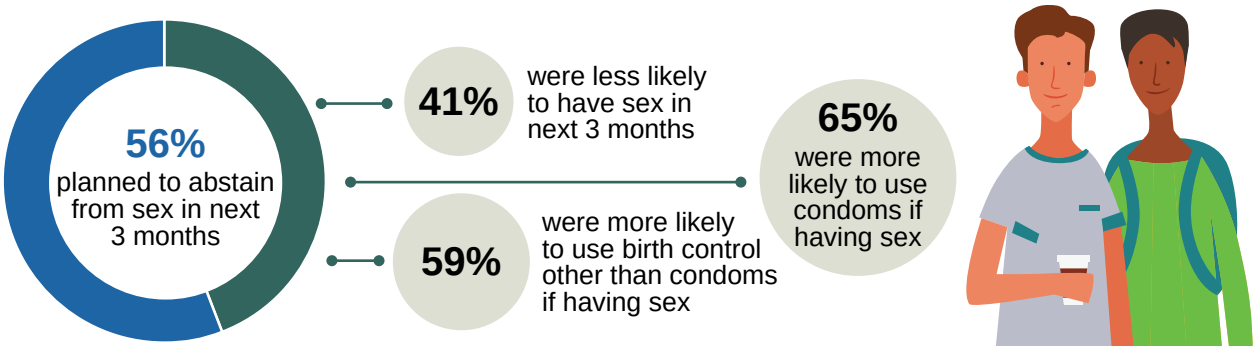
Behaviors at program entry

Some high-school-age and older youth reported engaging in sexual behaviors before starting PREP programming. Nearly one-third of participants reported having ever had sex, and 11 percent of those youth had ever been pregnant or gotten someone pregnant. Three percent of youth had ever had a sexually transmitted infection (STI) before starting PREP programming.



Perceptions of program effects

At program exit, just over half of high-school-age and older youth planned to abstain from sex for at least the next three months as a result of participating in PREP. Among those who did not plan to abstain, 41 percent said being in the program made them less likely to have sex in the next three months, 65 percent said they were more likely to use condoms if having sex, and 59 percent said they were more likely to use birth control other than condoms if having sex.



At program exit, many participants reported that participating in PREP had made them much more or somewhat more likely to engage in behaviors reflecting preparation for adulthood. More than three-quarters of youth said they were more likely to better understand what makes a relationship healthy (77 percent), and almost three-quarters were more likely to be respectful of others (73 percent), to resist or say no to pressure to participate in sexual acts (72 percent), and to make plans to reach their goals (72 percent).

Program experiences

At program exit, most youth reported positive perceptions of the PREP programs.

Experienced all or most of the time in the PREP program	Percentage of participants
Felt respected as people	88
Material presented was clear	84
Discussions or activities helped them learn program lessons	82
Had a chance to ask questions	78
Interested in the program sessions and classes	69

More information about PREP performance measures is posted on the www.prepeval.com website.

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OPRE FYSB Family & Youth Services Bureau Mathematica Progress Together

Exhibit 11

PREP

The Personal Responsibility Education Program Evaluation

PREP Performance Measures Final report: 2013-2017

March 2021

OPRE Report Number:
2021-12

Contract Number:
HHSP23320110011YC

Mathematica Reference Number:
06991.OP9

Submitted to:
Caryn Blitz, Project Officer
Kathleen McCoy, Project Monitor
Business Strategy Consultants

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PREP Performance Measures Final Report: 2013–2017

March 2021

Lauren Murphy
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Susan Zief

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I. INTRODUCTION

The proportion of teenagers engaging in sex has declined in recent decades, but risky sexual activity, teen pregnancies, and sexually transmitted infections (STIs) remain a concern. Nationally, 40 percent of high school-age youth have ever had sex (Kann et al. 2018), and some of these youth engage in behaviors that increase their risk of pregnancy and STIs. For instance, 46 percent of sexually active youth did not use a condom at their most recent sexual intercourse, and 10 percent had more than four sexual partners in their life (Kann et al. 2018). In the United States, rates of teen births have reached an historic low, 20.3 per 1,000 females age 15–19 (Martin et al. 2018). Rates of STIs remain high; teens account for nearly half of the 20 million new incidences of STIs each year, and the rates of reported cases among teenagers have been increasing (Centers for Disease Control and Prevention [CDC] 2013, 2017).[1] Pregnancies and STIs pose negative consequences for both the teenagers who experience them and society, including billions of dollars in health care and taxpayer costs (Hoffman and Maynard 2008; CDC 2013).

To help reduce teen pregnancies and STIs, and their negative consequences, Congress authorized the Personal Responsibility Education Program (PREP). Congress first authorized PREP through the amendment of Title V of the Social Security Act as part of the 2010 Patient Protection and Affordable Care Act and has extended PREP authorization three times. The Family and Youth Services Bureau (FYSB) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS) administers PREP. FYSB funds formula and competitive grants to U.S. states, territories, tribes, and local organizations to provide programming on teen pregnancy prevention and adulthood preparation subjects.

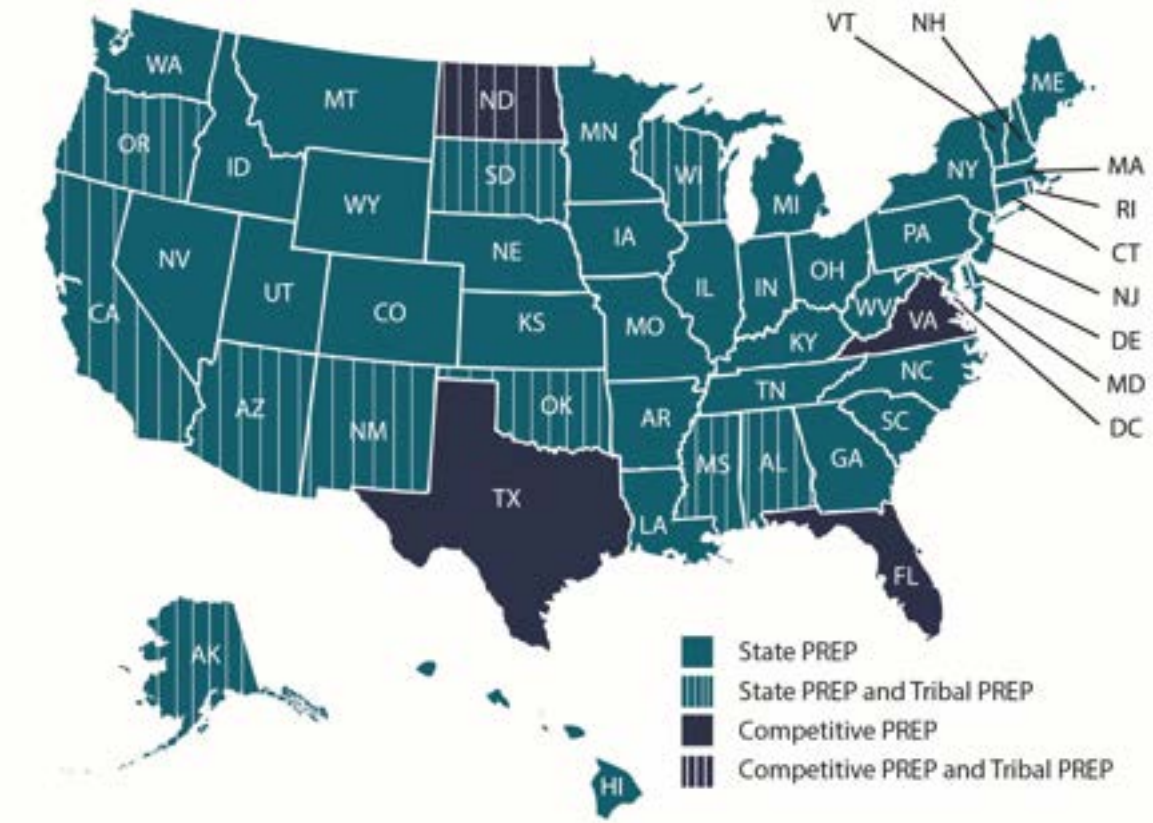
PREP operates through four different funding streams: State PREP, Tribal PREP, Competitive PREP, and the Personal Responsibility Education Innovative Strategies (PREIS) program (Figure I.1).

- **State PREP.** All states and U.S. territories are eligible to apply for these formula grants. Grantees first received four-year grants in fall 2010. Since 2014, FYSB has been awarding grants with annual project periods. Grants range from about $250,000 to $6,500,000 per year.
- **Tribal PREP.** Tribes and tribal organizations are eligible to apply for these competitive grants. Grantees first received four-year grants in fall 2011. FYSB awarded a second cohort of five-year grants in 2016. Grants range from about $128,000 to $638,000 per year.
- **Competitive PREP**. Local entities and organizations in states and territories that did not apply for State PREP funds are eligible to apply for these competitive grants. Grantees received three-year grants in fall 2012. In fall 2015, FYSB awarded a new cohort of grantees for three years. Grants range from about $187,000 to $794,000 per year.

[1] For youth age 15–19 from 2015 to 2016, rates of chlamydia increased 4.0 percent, rates of gonorrhea increased 11.3 percent, and rates of syphilis increased 13.0 percent (CDC, 2017).

- **PREIS**. Local entities and organizations implementing and evaluating innovative strategies are eligible to apply for these competitive grants. Grantees received five-year grants in 2010. In fall 2016, FYSB awarded a new cohort of PREIS grants for five years. Grants range from about $560,000 to $975,000 per year. Analyses of PREIS grantees' performance measures are not included in this report because PREIS grantees responded to a different set of performance measures than the other funding streams.

Figure I.1. States and territories receiving PREP funding between 2010 and 2017



Note: The map indicates the state or territory in which the grantee is located, but does not indicate programming locations.

Territories are not shown on the map. Four territories (Federated State of Micronesia, Palau, Puerto Rico, and Virgin Island) received State PREP grants, American Samoa received a Competitive PREP grant, and Guam and Northern Marina Island received Competitive PREP grants in some years and State PREP grants in other years.

Per the legislation authorizing PREP, ACF offered expectations to grantees for providing programming (Figure I.2). Per the legislation, grantees must "replicate evidence-based effective programs or substantially incorporate elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth."[2] ACF encouraged grantees to select evidence-based programs (EBPs)

[2] See https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm.

from a list of program models HHS identified as evidence-based through a systematic review.[3] The legislation requires grantees to incorporate activities from at least three adulthood preparation subjects (APSs): (1) healthy relationships, (2) adolescent development, (3) healthy life skills, (4) parent-child communication, (5) educational and career success, and (6) financial literacy. Additionally, grantees are required to emphasize both abstinence and contraception as ways to prevent pregnancy and STIs. Lastly, FYSB expects grantees to serve youth ages 10 to 19, or pregnant and parenting women younger than 21. From these eligible youth, grantees are "encouraged to serve youth populations who are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances."[4] These high-risk and vulnerable populations include, but are not limited to, youth residing in geographic areas with high teen birth rates, adjudicated youth, youth in foster care, and runaway and homeless youth.

Figure I.2. PREP requirements and expectations

Emphasis on evidence-based programming	✓	**Provide evidence-based programs or substantially incorporate elements of them**
Incorporation of adulthood preparation subjects	✓	**Educate youth on at least three adulthood preparation subjects**
Coverage of abstinence and contraception	✓	**Provide education on both abstinence and contraception**
Focus on high-risk youth populations	✓	**Target youth ages 10 to 19 who are the most high-risk or vulnerable for pregnancies or otherwise have special circumstances**

To understand PREP operations nationwide, Congress authorized a federal evaluation of the program. FYSB and the Office of Planning, Research, and Evaluation (OPRE) within ACF contracted with Mathematica Policy Research to conduct the PREP Multi-Component Evaluation (see box below). As part of the evaluation, this report describes PREP programs in operation from 2013 to 2017 using grantee-submitted data on performance measures. Specifically, this report addresses the following questions:

1. How did grantees operate and support PREP programs?
2. What were the characteristics of PREP programs, and how did grantees and providers implement them?
3. Whom did PREP programs serve?

[3] https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/evidence-based-programs/index.html.

[4] See https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm.

4. How did youth respond to the PREP programs, and did youths' perceptions of effectiveness vary by program characteristic?

This report discusses trends over time for each research question. Chapter II describes the structure of the PREP performance measures and our analytic approach for analyzing the data. In Chapter III, we describe how grantees operated and supported PREP programs. In Chapter IV, we describe the characteristics of the programs and how they were implemented. Chapter V describes the youth served by PREP programs. Chapter VI describes youths' response to the program and their perception of program effectiveness. Finally, in Chapter VII we conclude by summarizing the key findings.

The figures and tables in the main body of the report present findings for the four most recent program years: 2013–2014, 2014–2015, 2015–2016, and 2016–2017. These years represent when all performance data measures were required for most funding streams. The appendix tables include the more limited measures available for prior years, for funding streams that reported data in 2011–2012 or 2012–2013. Most of the reported measures are aggregated across all programs, providers, and grantees funded through State PREP, Tribal PREP, and Competitive PREP for each program year. Appendix tables present all results for PREP overall (Appendix A) and separately by funding stream (Appendix B contains findings for State PREP, Appendix C for Tribal PREP, and Appendix D for Competitive PREP).

The PREP Multi-Component Evaluation

To measure PREP's success, Congress authorized a federal evaluation of the program. The eight-year (2011–2019) study has three main components:

1. **Design and implementation study.** The study team conducted descriptive analyses of state PREP grantees to assess how states designed and implemented their programs.
2. **Impact and implementation study.** The team conducted rigorous random assignment impact evaluations and accompanying program implementation evaluations of four program models in a subset of four PREP-funded sites.
3. **Performance analysis study.** The team collected and analyzed performance measurement data from all PREP grantees. The team used these data to track program outputs and outcomes. This study is the focus of the report.

II. OVERVIEW OF PREP PERFORMANCE MEASURES

Purpose of performance measures

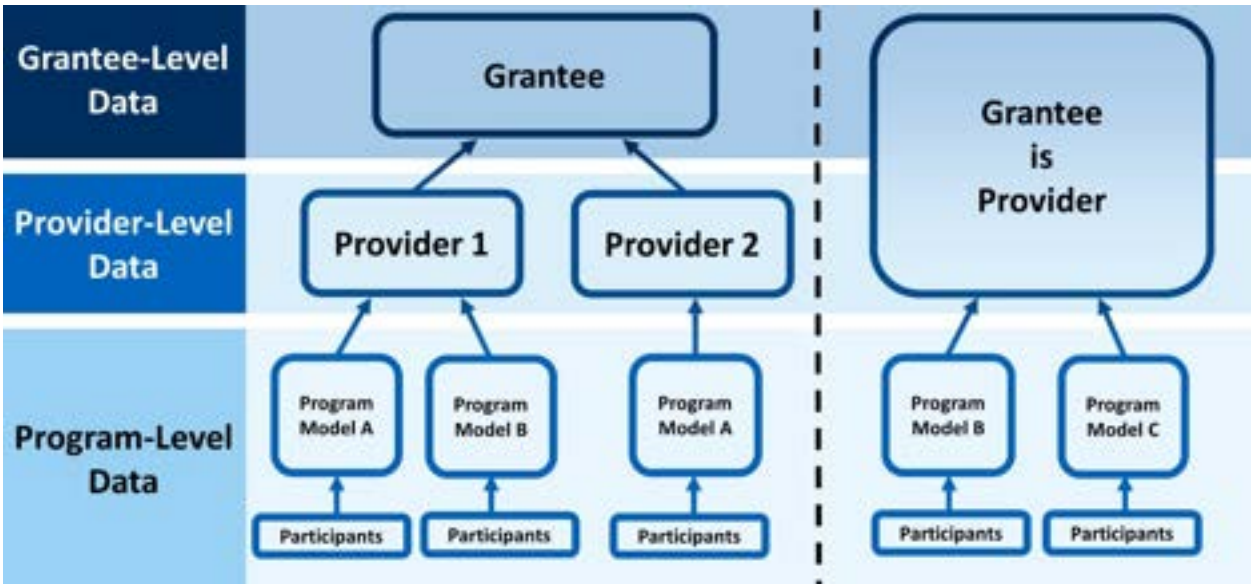
Although performance measures are not designed to assess program effectiveness, they can address issues of vital importance to program operations and evaluation. PREP performance measures can serve as a tool to document whether grantees are delivering the expected set of services to the intended populations and meeting other program objectives. Performance measures can also serve as a means to improve service delivery and promote continuous quality improvement by highlighting areas in which performance might be lagging and identifying grantees, providers, or programs that might need technical assistance. Systematic tracking of program performance and thoughtful analysis of these data can aid in learning about program implementation and identifying factors associated with greater implementation success.

Measures and data collection structure

PREP performance measures data collection aligns with how grants are structured. Grantees are agencies or organizations that receive PREP funding and have administrative responsibility for the grant. Program providers are agencies or organizations that provide direct programming to youth. Grantees can serve as their own providers or can fund subawardees to serve as providers. Each provider then implements one or more program models with youth.

Data are collected and reported at each of three levels: grantee, provider, and program. Although grantees and providers collected data for some measures at a fourth level—from individual youth participants (Figure II.1), they aggregated these measures to the program level before submitting to ACF. Grantees submit annual performance measures to ACF through a web-based system.

Figure II.1. Levels of performance measures data collection



Grantee-level measures. At the grantee level, the performance measures provide data on structure and support for program implementation, including the number of grantee staff involved in program oversight and the training, technical assistance, and observations conducted by grantees or their designees. The reference period for these measures each year was October 1 to September 30.

Provider-level measures. At the provider level, measures focus on staffing, including the number of facilitators employed, trained, and observed, implementation challenges, and interest in technical assistance. The reference period for these measures each year was October 1 to September 30.

Program-level measures. At the program level, measures focus on programming, including the intended number of program hours, program model, and selected adulthood preparation subjects. The reference period for these measures each year was October 1 to September 30.

Additionally, program-level information focuses on measures of attendance, reach, and dosage. These measures include the number of youth served overall and by the setting in which they were served, the extent to which youth in out-of-school-time settings attended most of the intended program hours, and whether the majority of youth served were in one of several identified highly vulnerable populations. The data collection period for these measures was August 1 through July 31 each year.

Programs also report aggregated youth-level measures that capture information on the demographic characteristics and sexual risk behaviors of youth before the start of programming, youth participants' experiences in PREP, and their perceptions of program effects on their preparation for adulthood and their sexual risk behaviors in the future. These measures are based on participants' responses to surveys administered at program entry and exit. The data collection period for these measures was generally August 1 through July 31 each year.[5]

ACF expected providers to administer the full entry survey to all youth in grade 9 or higher in school settings and to youth ages 14 and older in out-of-school settings. Providers in out-of-school settings administered a subset of items to younger youth. Because the entry survey contains potentially sensitive measures of sexual experience, sexual orientation, and gender identity, ACF did not expect providers to administer those items to middle school-aged youth.

Requirements to collect and submit performance measures were rolled out gradually across funding streams and measure domains (Table II.1). State PREP grantees first submitted a limited set of performance measures data for 2011–2012. Tribal PREP grantees first submitted limited measures for 2012–2013, and Competitive PREP grantees first did so for 2013–2014. All grantees began submitting all required measures for 2013–2014.[6]

[5] New cohorts of Competitive PREP grantees had a shortened data collection period in 2013–2014 and 2015–2016, see Table II.1.

[6] This report presents analysis of data starting in 2013-2014 when all funding streams began submitting all measures. The appendix presents data reported by a subset of grantees and for a subset of measures for prior years.

Table II.1. Performance measures reported by year and funding stream

Reporting period	State PREP	Tribal PREP	Competitive PREP
2011–2012	All grantee- and provider-level measures. Partial program-level measures[a]	None	None
2012–2013	All grantee- and provider-level measures. Partial program-level measures[a]	All grantee- and provider-level measures. Partial program-level measures[a]	None
2013–2014	All measures	All measures	All measures[b]
2014–2015	All measures	All measures	All measures
2015–2016	All measures	All measures	All measures[c]
2016–2017	All measures	None	All measures

[a] Excludes measures of attendance, reach, and dosage, and measures based on data from entry and exit surveys.

[b] Competitive PREP grantees collected performance measures data for a six-month period (February 1–July 31 2014) in 2013–2014.

[c] The length of the 2015–2016 reporting period varied by grantee for Competitive PREP grantees. ACF provided guidance that returning grantees should begin data collection when their programming started in the new cycle, and grantees newly funded in fall 2015 should begin data collection on February 1, 2016.

Limitations of performance measures data and analyses

PREP performance measures serve as a tool for documenting grantee structures and supports, program characteristics, and youth characteristics and outcomes. However, there are limitations to the data and analyses.

Grantees were responsible for ensuring the data submitted were accurate, and our ability to confirm data quality was limited. Although the web-based reporting system provided some validation checks when grantees submitted the data, we identified some remaining data issues through additional checks conducted after receiving the data. For example, race was reported for a substantially smaller number of youth than was ethnicity. In addition, a small number of youth who reported never having sexual intercourse were included in the measures of youth who had engaged in sexual behaviors, such as condom and birth control use, likely because youth did not follow survey skip logic. Other undetected data quality issues may have been present, in particular because data were reported to ACF in the aggregate and not by individuals. Additionally, the self-report surveys programs used to collect participant data are subject to response bias, especially for the more sensitive items such as sexual behaviors and intentions.

Not having individual-level data on youth participants limited the types of analyses that could be conducted. Notably, we were not able to conduct cross-tabulations of participant characteristics and outcomes at a more detailed level than program-level. Also, we could not analyze the combination of responses for items for which youth could select multiple response categories, if more than one applied to them.

Comparisons between reporting periods should be interpreted with the understanding that the grantees, providers, programs, and participants for which data are reported can change over time due to changes in the grantees, subawardee providers, and programs funded each year. For example, as new cohorts received grants, continuing grantees may have continued to collect and report performance measures, while new grantees were often delayed in starting data collection and reporting. The most notable example of changes in grantees is the end of the first cohort of

Competitive PREP grantees and the beginning of a new cohort in 2015–2016. Changes in measures over time could also be a result of shifts in the sample of grantees providing complete data. Each year, some grantees or providers did not report the expected measures.[7] As a result, changes in performance measures across reporting periods can reflect a combination of changes in (1) the composition of the funded grantees, (2) the completeness of data provided, and (3) programming decisions among the grantees funded and submission of complete data continuously throughout the period. We did not conduct any tests of statistical significance. Reported associations should not be interpreted as showing causal relationships.

Despite these limitations, the performance measures provide a picture of how grantees implemented PREP through the years and across different funding streams.

[7] Providers were not expected to report attendance, reach, and dosage measures or any survey-based measures for reporting periods during which they did not serve youth. Providers were also not expected to report measures based on entry survey data if no youth began a program during a given reporting period or to report attendance, reach, and dosage measures or measures based on exit survey data if no youth completed the program during the reporting period. In addition, grantees with programs serving as study sites in the Impact and Implementation Study components of the PREP Multi-Component Evaluation were not expected to report attendance, reach, dosage, and survey-based data.

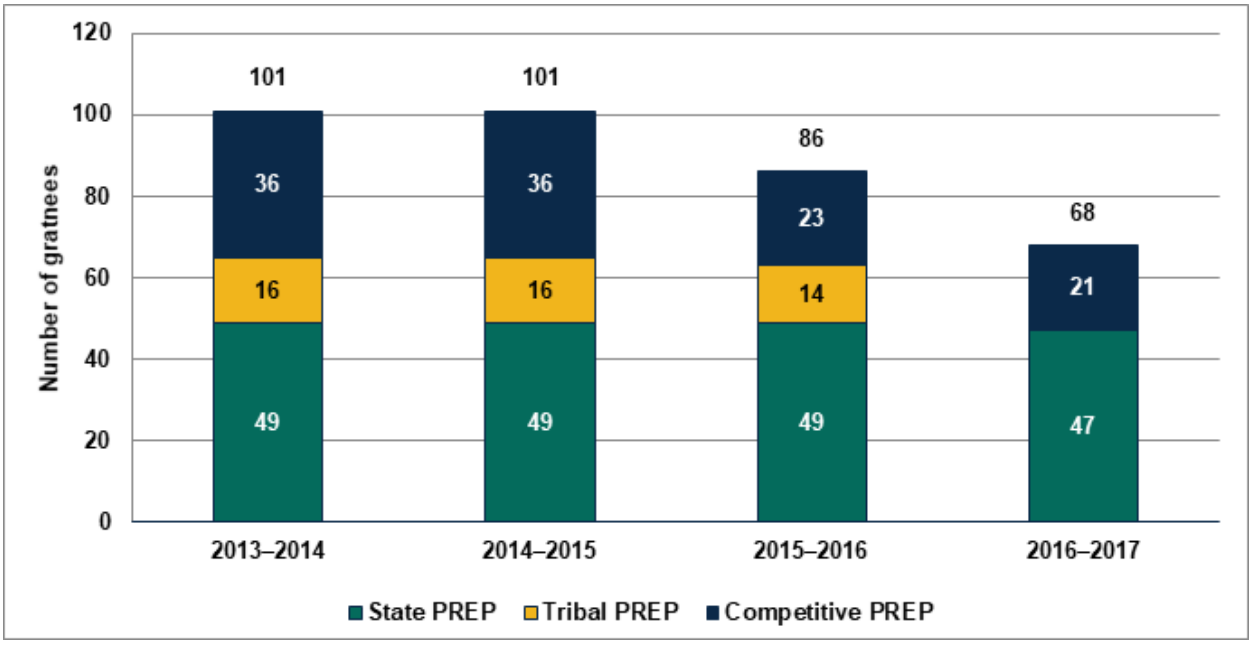
III. GRANTEE STRUCTURE AND SUPPORT

PREP operated at a large scale through many grantees and providers that implemented programming. Grantees had different grant structures, but nearly all grantees supported implementation through similar activities. This chapter describes the structure and scale of the grants and how grantees supported PREP implementation.

PREP operated at a large scale

The number of grantees reporting PREP performance measures changed over time. The number of grantees reporting remained stable for the first two years, and then decreased (Figure III.1). [8] In 2015–2016, the first cohort of Competitive PREP grantees ended and FYSB awarded grants to a new cohort with fewer grantees.[9] Additionally, two Tribal PREP grantees stopped receiving funding in 2015–2016 and, therefore, did not report performance measures. Finally, the number of grantees decreased again in 2016–2017 when FYSB funded a new cohort of Tribal PREP grantees that were not required to report performance measures in their first grant year.

Figure III.1. Number of grantees reporting performance measures



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

PREP grants operated through two different structures to provide programming to youth: (1) grantees could act as program providers serving youth directly, and (2) they could pass funds to subawardees to act as program providers. Also, grantees could structure their programs to

[8] From 2013–2014 through 2016–2017, FYSB funded 49 State PREP grantees. FYSB funded 16 Tribal PREP grantees from 2013–2014 to 2014–2015 and 14 grantees in 2015–2016. FYSB funded 37 Competitive PREP grantees in 2013–2014 and 2014–2015, 23 grantees in 2015–2016, and 21 grantees in 2016–2017.

[9] For fiscal year 2015, the funding floors and ceilings were raised for Competitive PREP, which resulted in fewer grantees.

combine these two approaches. Funding other organizations to serve as the sole program providers was the most common approach across PREP overall, and this structure became more common among grantees over time (Table III.I). State PREP grantees were the most likely to have subawardees serve as sole providers; each year, between 83 and 92 percent of grantees used this approach (Appendix Table B.1). Tribal PREP and Competitive PREP grantees were more likely to serve as program providers themselves; each year, between 61 and 69 percent and 69 and 81 percent, respectively, (Appendix Table C.1 and Table D.1, respectively). Combining approaches was the least frequent structure across all funding streams.

Table III.1. Grant structure

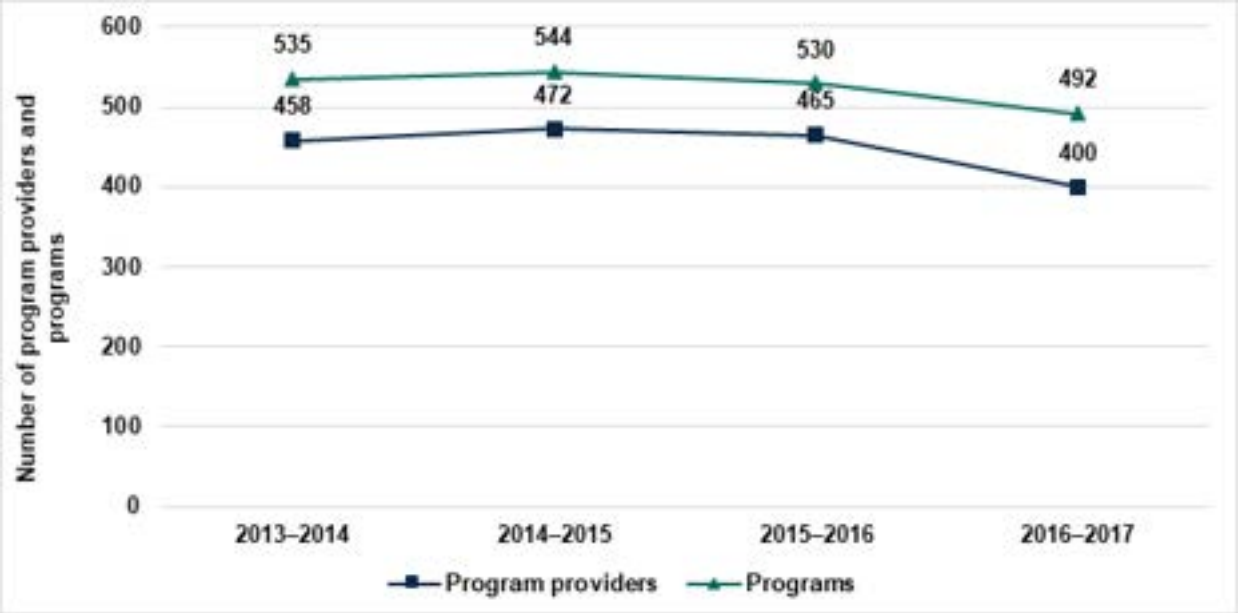
Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of grantees that				
Serve as program provider only	44.4	41.6	32.9	25.8
Have subawardees as program providers only	48.1	51.5	61.0	69.7
Combine methods for program providers	7.4	6.9	6.1	4.5
Number of grantees	**101**	**101**	**86**	**68**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Percentages might not sum to 100 percent due to rounding.

As the number and types of grantees changed, so did the number of providers and programs. The number of programs and providers peaked in 2014–2015, but then decreased. Because providers could operate more than one program model, there were more programs than providers. Operating at a large scale, each year PREP had more than 400 providers often implementing over 500 programs (Figure III.2).

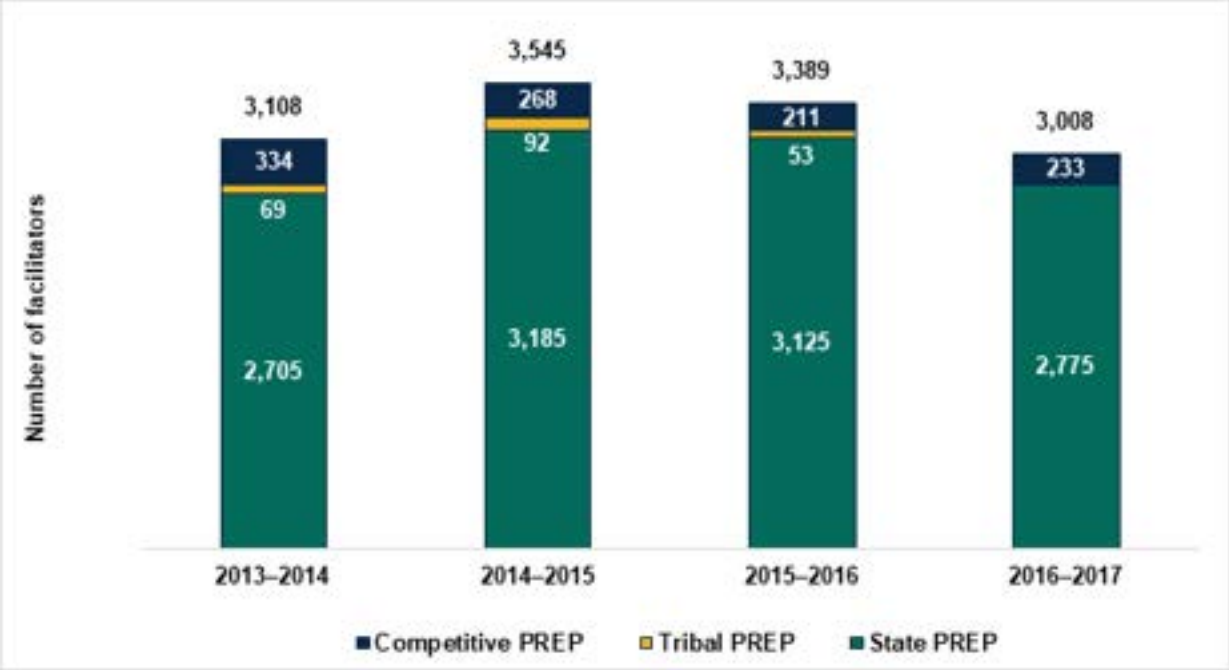
Figure III.2. Number of program providers and programs



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

To provide PREP programming to youth, programs employed more than 3,000 facilitators each year (Figure III.3). The number of facilitators increased and then decreased, following a similar pattern as the number of programs implemented.

Figure III.3. Number of facilitators

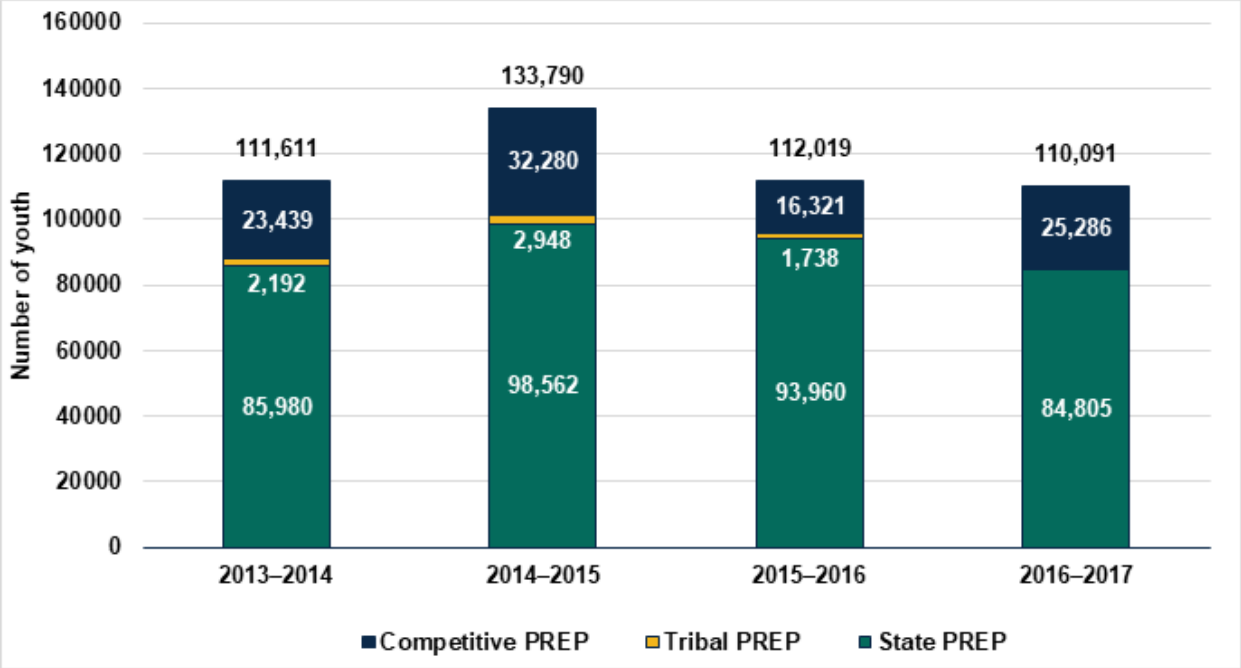


Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: One outlier in 2015–2016 was removed from the analysis of facilitators. This provider reported 1,583 facilitators in 2015–2016, compared with 23 in 2014–2015 and 53 in 2016–2017.

PREP programs served more than 100,000 youth each year. Following a similar pattern as the numbers of grantees, providers, and programs implemented, the number of youth served peaked during 2014–2015, with 133,790 served that year (Figure III.4). State PREP served more than 300,000 youth between 2013–2014 and 2016–2017. During the same reporting period, Competitive PREP served almost 100,000 youth. Tribal PREP served almost 7,000 youth across the three years that Tribal PREP grantees reported performance measures (2013–2014 through 2015–2016).

Figure III.4. Number of youth served



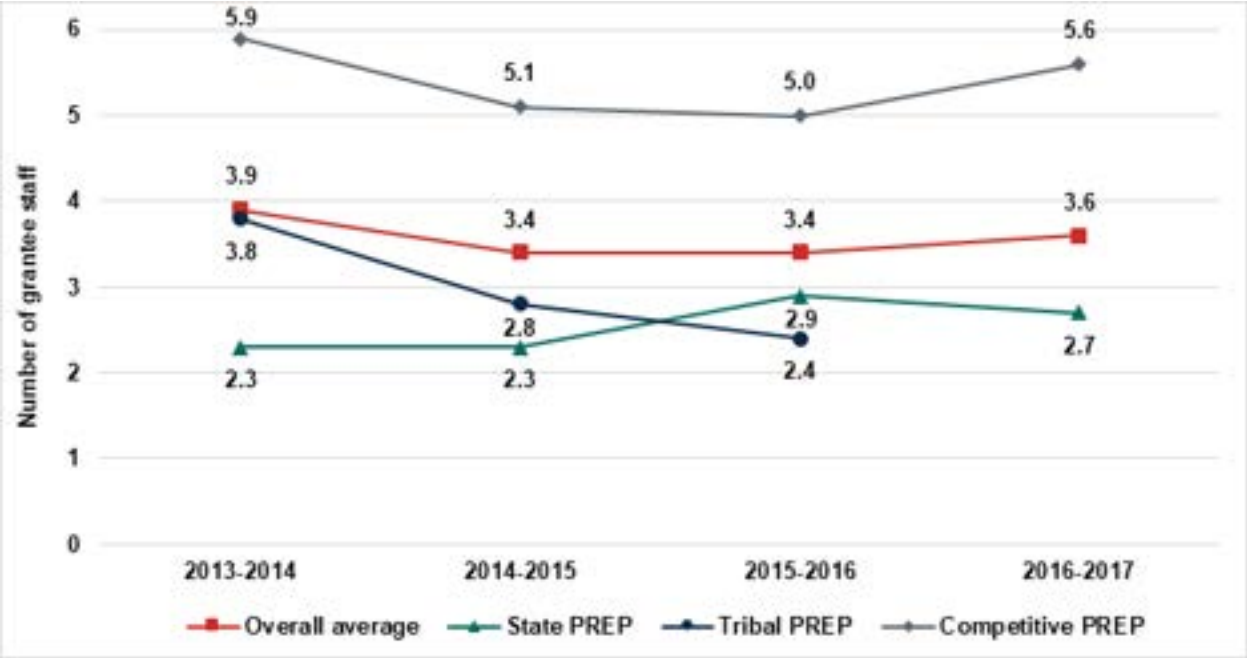
Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Most grantees supported implementation through three key activities

To support PREP, grantees needed staff to oversee the grants. On average, three to four staff members per grantee oversaw PREP (Figure III.5). These staff included program directors and coordinators as well as other staff members who were directly responsible for administering, managing, and overseeing PREP. Between 2013–2014 and 2016–2017, State PREP had the lowest average number of staff per grantee, between two and three staff. Competitive PREP had the highest average, between five and six staff. This difference may be due to the different grant structures; for instance, Competitive PREP grantees most often served as program providers themselves rather than passing funds to subawardees.

Most grantees supported implementation each year, either directly or through designees, by providing training and ongoing technical assistance (TA), and monitoring program implementation (Figure III.6). Observing program delivery was the most common support activity conducted by grantees. This support activity remained consistent across time. An earlier report from the PREP Multi-Component Evaluation examined the infrastructures that states developed to support training, TA, and monitoring activities (Del Grosso et al. 2016).

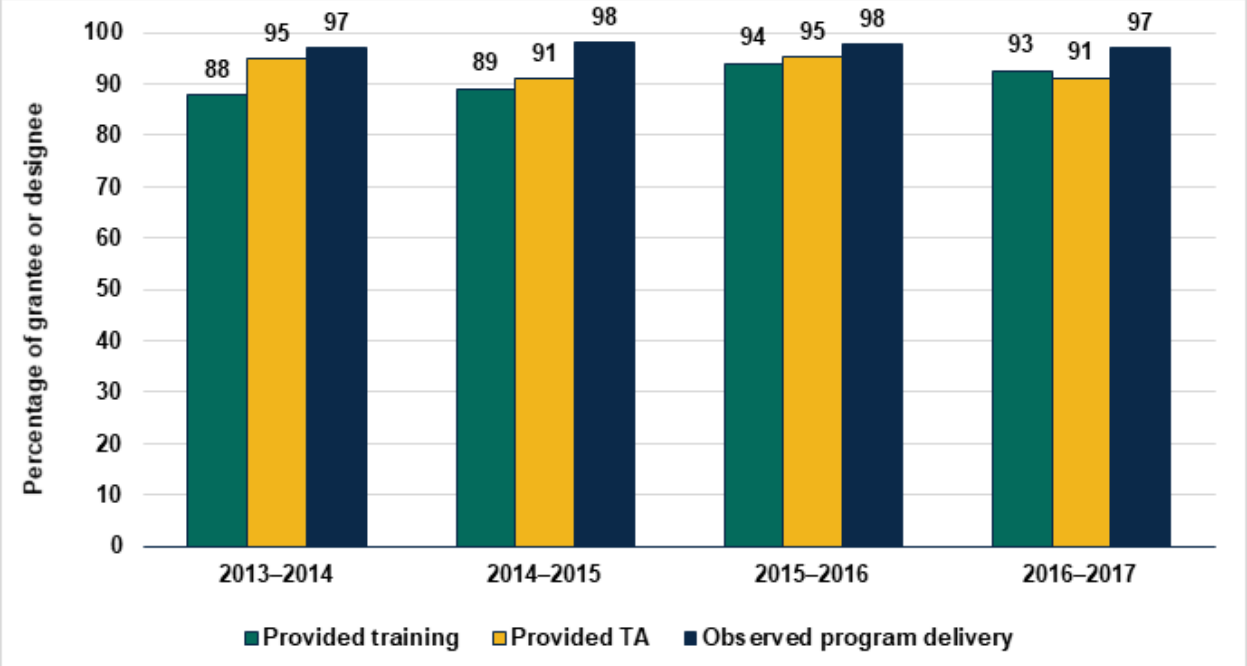
Figure III.5. Grantee staff overseeing PREP



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Staff includes grantee staff involved in overseeing PREP and does not include program provider or facilitator staff.

Figure III.6. Support for program implementation



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

TA = technical assistance.

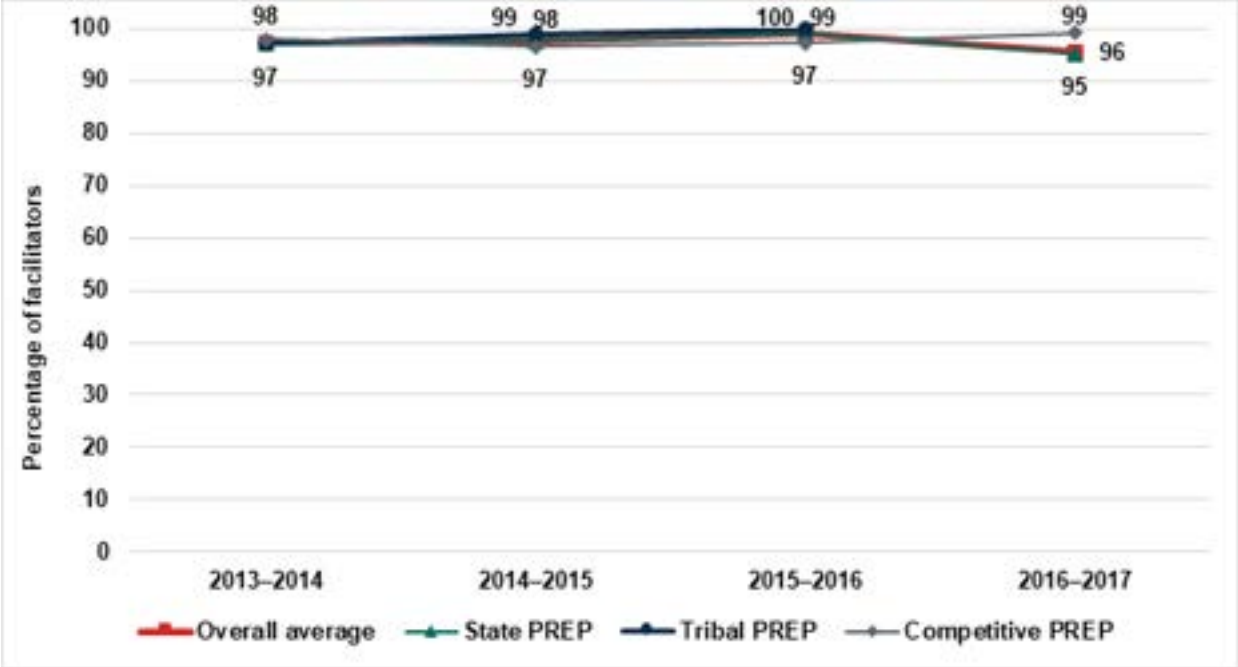
To support the facilitators in serving youth, facilitators were trained on the program models and were observed delivering programming. From 2013–2014 to 2016–2017, nearly all facilitators were trained each year (between 96 and 99 percent each year; Figure III.7). The percentage of facilitators trained had little variation across funding streams. Fewer than half of facilitators were observed each year, despite nearly all grantees or their designees observing program delivery (Figure III.8). Over time, the percentage of facilitators observed decreased. Larger percentages of Tribal PREP (between 55 and 77 percent each year) and Competitive PREP (between 82 and 95 percent each year) facilitators were observed than State PREP facilitators (between 37 and 48 percent each year). Although fewer than half of facilitators were observed, between 86 and 88 percent of providers had at least one facilitator observed each year (Figure III.9).

Box III.1. Implementation challenges and technical assistance (TA) needs related to staffing

Each year a higher percentage of providers reported staff turnover was a somewhat or serious problem, from 29 percent in 2013–2014 to 34 percent in 2016–2017 (Appendix Table A.19). The percentage of providers interested in TA on the topics of retaining staff and recruiting staff increased from 23 percent in 2013–2014 to 29 percent in 2015–2016, before decreasing again.

Few providers reported ensuring facilitators understood content as a problem (between 7 and 10 percent each year), but a larger set of providers (between 38 and 43 percent each year) had an interest on TA related to training staff (Appendix Table A.19). The percentages of providers fluctuated across the years.

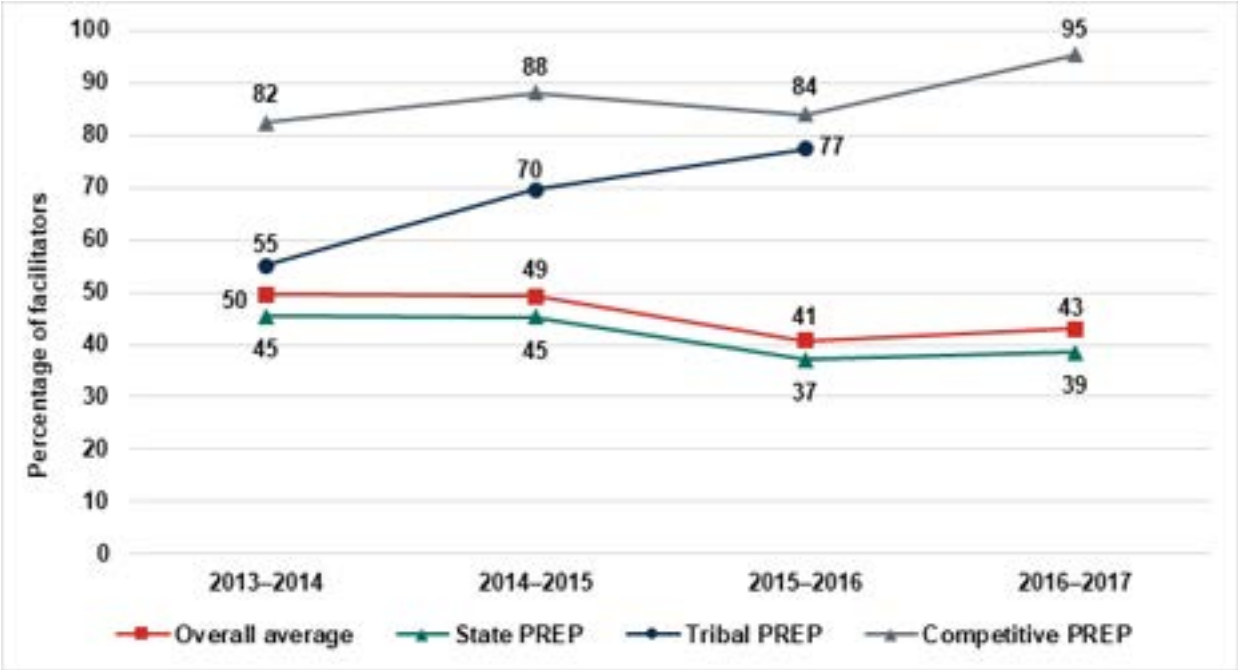
Figure III.7. Percentage of facilitators trained



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: One outlier provider was removed from the analysis in 2015–2016. This provider reported 1,583 facilitators in 2015–2016, compared with 23 in 2014–2015 and 53 in 2016–2017.

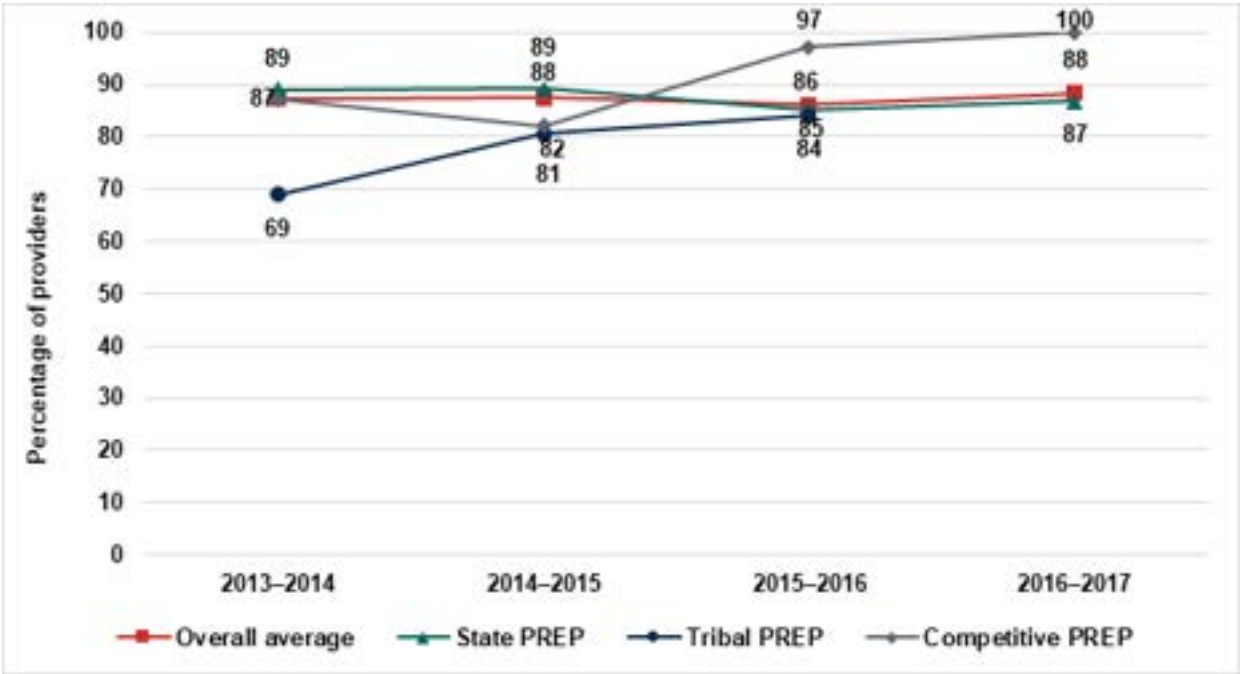
Figure III.8. Percentage of facilitators observed



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: One outlier provider was removed from the analysis in 2015–2016. This provider reported 1,583 facilitators in 2015–2016, compared with 23 in 2014–2015 and 53 in 2016–2017.

Figure III.9. Percentage of providers that had facilitators observed



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

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IV. CHARACTERISTICS OF PREP PROGRAMS

Programming implemented through a variety of settings generally met the PREP requirements. This chapter first describes key characteristics of programs, such as the program models and adulthood preparation subjects implemented. Next, it describes the settings in which implementation occurred. Lastly, the chapter describes the dosage youth received.

Most grantees implemented evidence-based programs and covered adulthood preparation subjects

Providers implemented many different adolescent pregnancy prevention program models. Per the grant requirements, program models had to be evidence-based or substantially incorporate elements of evidence-based program models. Through a systematic review of evaluations of the effectiveness of teen pregnancy prevention programs, the HHS Evidence Review developed a list of program models considered evidence-based, which was referenced in the PREP Funding Opportunity Announcements.[10] Between 90 and 94 percent of programs each year implemented models on the HHS Evidence Review list of evidence-based models (Table IV.1). Through these program models, about 92 to 97 percent of youth received evidence-based programming each year.

Table IV.1. Implementation of evidence-based program models

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs implementing an evidence-based program model	93.5	93.9	94.0	90.4
Percentage of youth served by programs implementing an evidence-based program model	91.5	97.2	94.4	91.9
Number of programs	**535**	**544**	**530**	**492**
Number of youth	**111,611**	**133,790**	**112,019**	**110,091**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

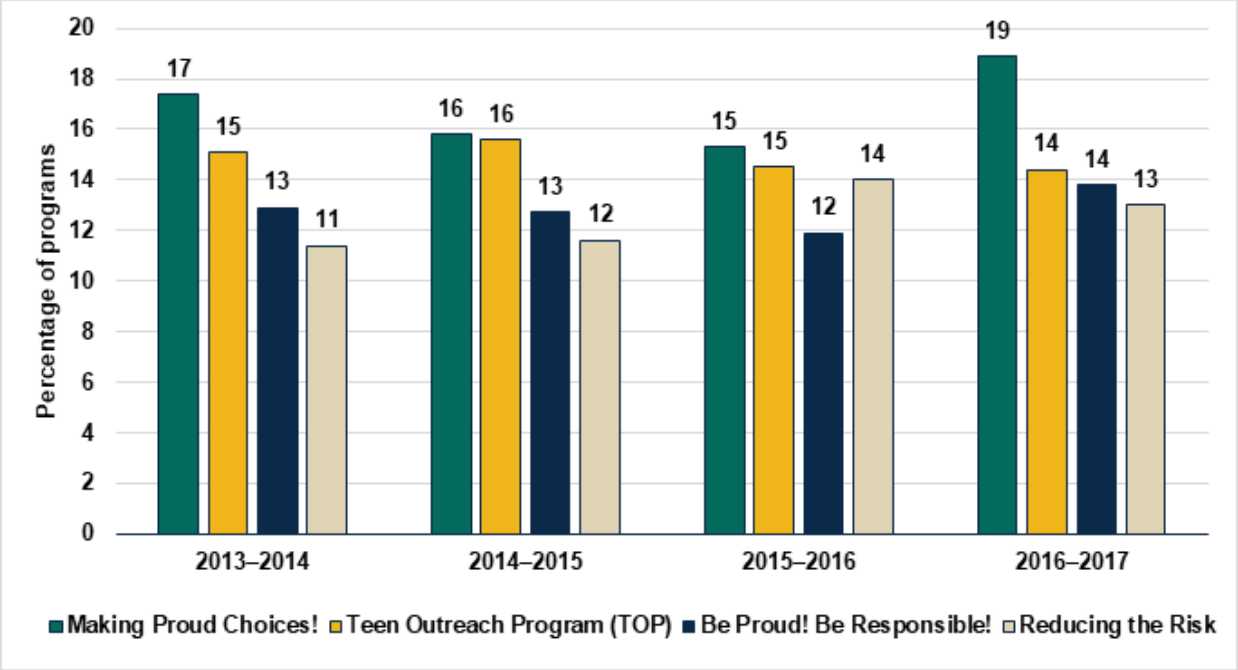
Note: Programs included in HHS Evidence Review list were considered as evidence-based. The study team did not have criteria to systematically assess whether other programs were "evidence-informed."

Between 2013–2014 and 2016–2017, the four most common models remained the same. Making Proud Choices!, Teen Outreach Program (TOP), Be Proud! Be Responsible!, and Reducing the Risk were each consistently reported by more than 10 percent of programs each year (Figure IV.1). No other program model was reported by as much as 10 percent of programs in any year. Only two—SHARP and Draw the Line/Respect the Line—were reported by at least 5 percent of programs (Appendix Table A.5) in at least one year. Together, more than two-thirds of programs implemented these six program models each year.

[10] https://tppevidencereview.youth.gov/

The most commonly implemented program models differed between the funding streams, but were consistent across the years. The four most commonly implemented models by State PREP grantees were the same as PREP overall: Making Proud Choices!, Teen Outreach Program (TOP), Be Proud! Be Responsible!, and Reducing the Risk (Appendix B.5). Between 2013–2014 and 2015–2016, the most commonly implemented programs for Competitive PREP were Making Proud Choices!, TOP, and Be Proud! Be Responsible! (Appendix D.5). In 2016–2017, an additional model, Heritage Keepers Abstinence Education, was the most common model; it was implemented by almost 20 percent of Competitive PREP programs. Across the years, the most commonly reported program models for Tribal PREP, as reported by at least 10 percent of programs, were Becoming a Responsible Teen, Draw the Line/Respect the Line, It's Your Game: Keep it Real, and Making Proud Choices! (Appendix C.5). More than two-thirds of Tribal PREP programs implemented these models each year.

Figure IV.1. Most common program models implemented

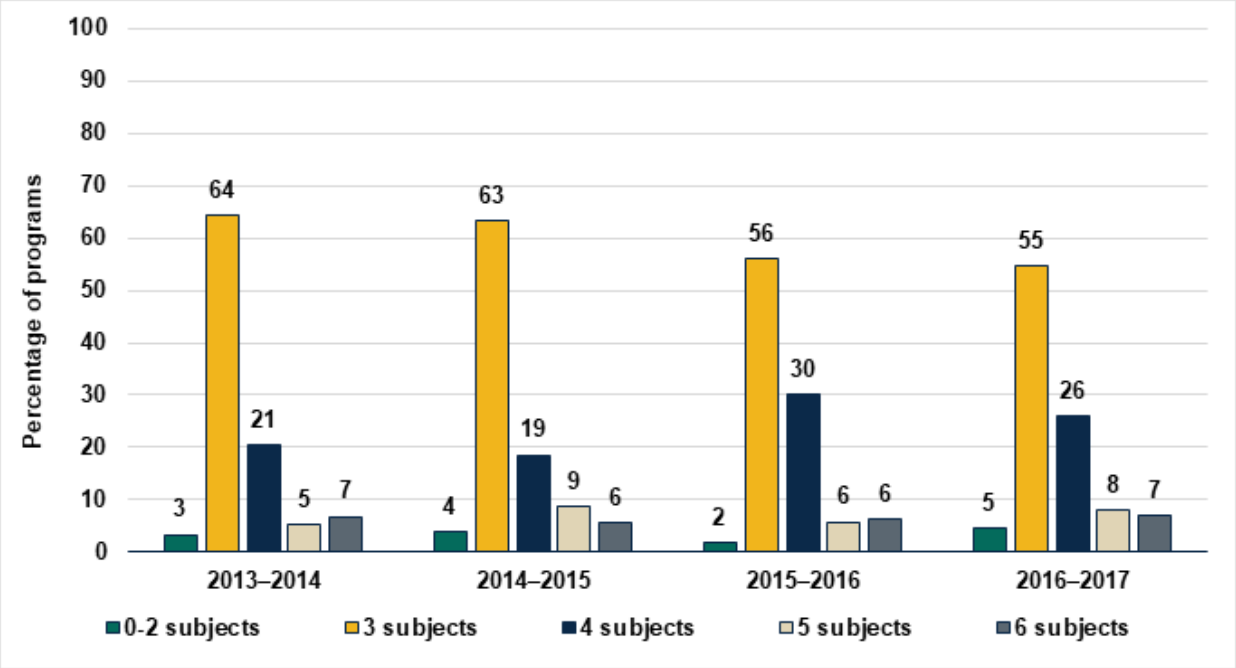


Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

As required, nearly all programs reported covering at least three APSs, and most programs selected similar APSs. Although the majority of programs (between 55 and 64 percent each year) implemented three APSs, many programs went beyond the requirement and implemented up to all six APSs (Figure IV.2). Only a few grantees (fewer than 5 percent each year) did not report meeting this requirement. PREP grantees had discretion in how programs covered APSs. An early report from the PREP Multi-Component Evaluation found that State PREP grantees either directed program providers which APSs to cover or allowed providers to select their own APSs (Zief et al. 2013). States that decided which APSs their providers would cover either selected APSs based on which were covered by their core program model or offered additional content.

Between 2013–2014 and 2016–2017, programs consistently implemented healthy relationships, healthy life skills, and adolescent development APSs most frequently (Figure IV.3). Each year, more than three-quarters of programs implemented at least one of these three APSs. All funding streams implemented the three most common APSs, but Tribal PREP programs commonly (between 84 and 97 percent each year) also addressed parent-child communication (Appendix Table C.6). Educational and career success and financial literacy were the least commonly offered APSs across funding streams, implemented by no more than 30 percent of programs in any year.

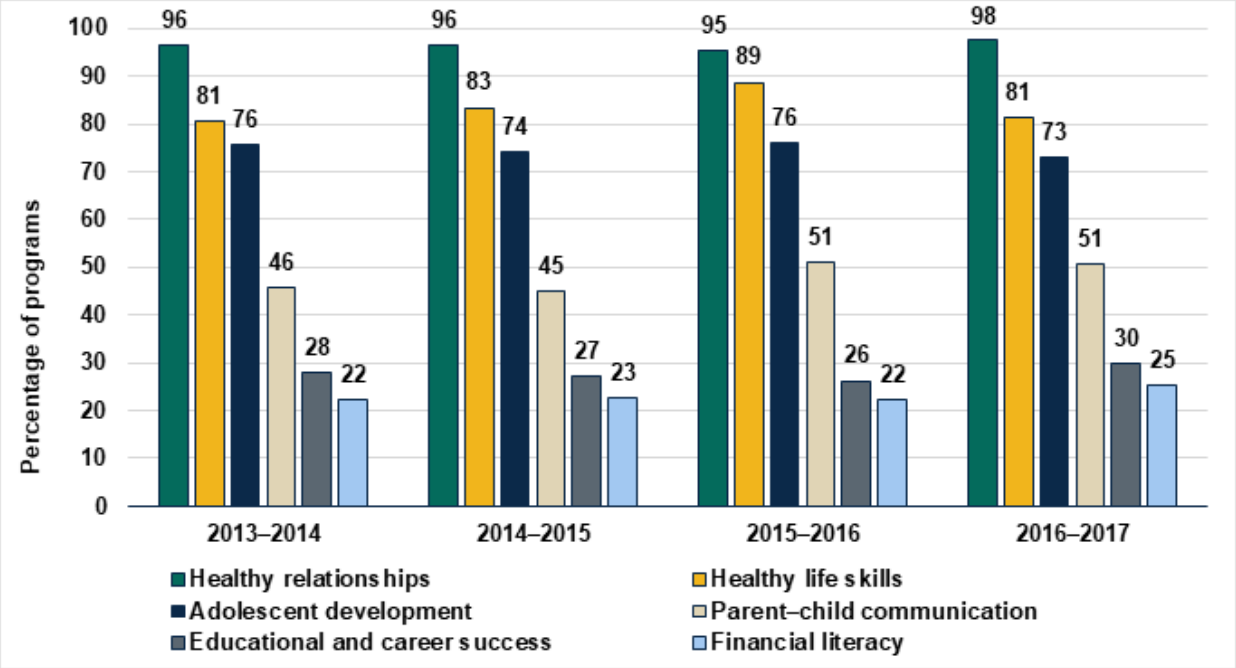
Figure IV.2. Number of adulthood preparation subjects (APSs) implemented



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Percentages might not sum to 100 percent due to rounding.

Figure IV.3. Adulthood preparation subjects (APSs) implemented



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Adulthood preparation topics are not mutually exclusive; programs could implement more than three subjects.

PREP programs reached most youth nationwide through in-school settings

Providers implemented PREP in many different types of settings, but most programs served youth during school. More than half the programs (between 51 and 59 percent each year) implemented PREP in school during the school day (Table IV.2). Programs implemented during the school day tended to be larger than those implemented in out-of-school settings, serving an average of 322 to 369 youth per program each year. Therefore, programs operating in school, during the school day served the majority of youth (between 76 and 79 percent each year). Conversely, programs located in out-of-school settings served fewer youth on average (between 69 and 83 youth per program each year). Therefore, while over one-third of programs (between 33 and 36 percent each year) were implemented in community-based organizations, these programs only served between 8 to 9 percent of youth in these settings each year.

Table IV.2. Implementation setting

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs serving youth in[a]				
Schools, during school	51.3	56.0	59.3	55.3
Community-based organizations	35.1	35.4	33.3	35.9
Schools, after school	17.1	16.2	13.1	13.8
Juvenile detention centers	14.5	17.9	15.1	16.3
Foster care settings	12.3	12.4	11.2	12.0
Clinics	5.0	5.1	3.1	2.1
Other settings	13.3	12.0	9.6	13.2
Percentage of youth served in[b]				
Schools, during school	75.9	77.9	79.0	78.5
Community-based organizations	8.7	8.2	7.5	8.7
Schools, after school	4.9	3.0	3.2	2.9
Juvenile detention centers	4.9	4.3	3.2	3.9
Foster care settings	2.6	2.6	2.9	2.3
Clinics	0.8	1.6	1.4	0.1
Other settings	3.3	2.4	2.7	3.4
Number of programs	**535**	**544**	**530**	**492**
Number of youth	**111,611**	**133,790**	**112,019**	**110,091**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] Percentages do not sum to 100 percent because programs could be implemented in more than one setting.

[b] Percentages may not sum to 100 percent due to rounding.

PREP programs operating outside of the normal school day were well attended

Participants received a high percentage of intended program hours. About three-quarters (between 70 and 76 percent each year) of youth in programs operating outside of school time received at least 75 percent of the intended program dosage (Figure IV.4).[11] For Tribal PREP, this percentage increased from 51 percent in 2013–2014 to 97 percent in 2015–2016. Across the years and funding streams, the average number of intended program hours across all settings ranged from 14 to 20 hours (Appendix A.9).

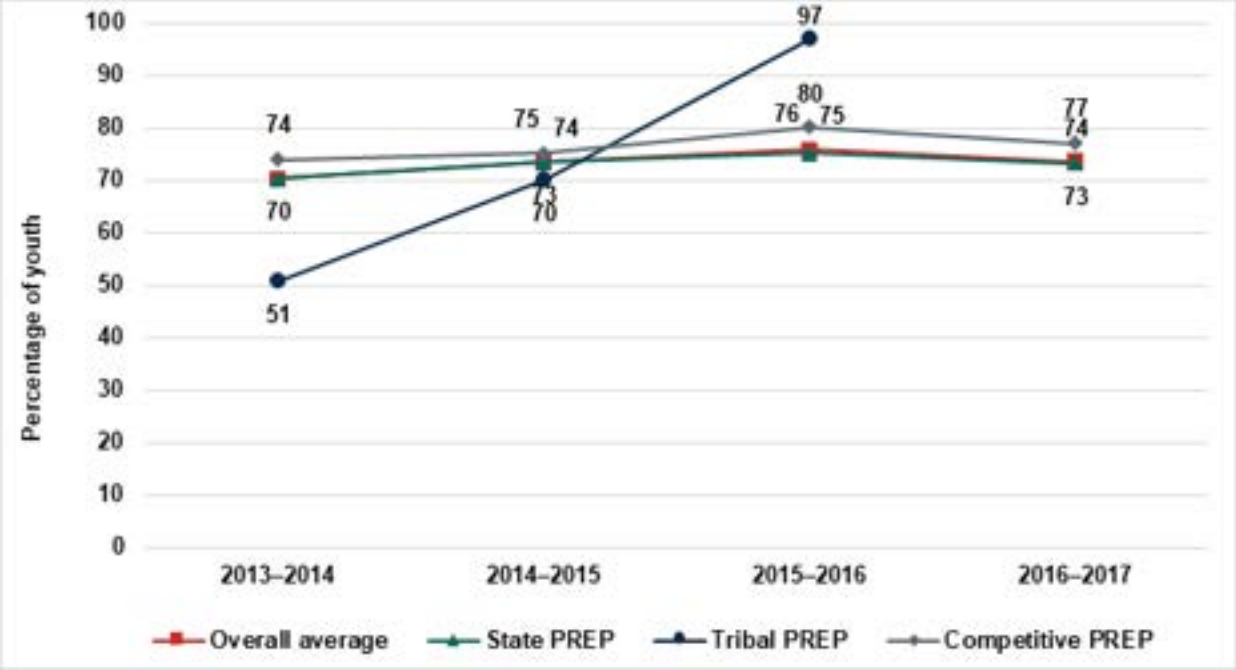
Box IV.1. Implementation challenges and technical assistance (TA) needs related to youth recruitment attendance

Over time, fewer providers reported recruiting youth as being a problem. In 2013–2014, 43 percent of providers reported youth recruitment as a problem, while this percentage decreased to 34 percent in 2016–2017 (Appendix Table A.19). Similarly, a higher percentage of providers reported an interest in TA on this topic in 2013–2014 (47 percent) than in later years (36 percent in 2016–2017).

Getting youth to attend regularly was the most common problem reported each year (Appendix Table A.19). The percentage decreased slightly from 2013–2014 (42 percent) to 2015–2016 (39 percent) before increasing again in 2015–2016 (41 percent). Similarly, between 42 and 45 percent of providers each year were also interested in TA on this the topic.

[11] Because PREP participants served in schools during school time were assumed to have attended most sessions, programs operating only during school time did not report dosage. Programs reported dosage only for youth participating in out-of-school-time settings, which is about one-quarter of all youth served.

Figure IV.4. Percentage of youth in out-of-school-time programs who completed at least 75 percent of the intended dosage



Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

V. CHARACTERISTICS OF YOUTH PREP PROGRAMS SERVED

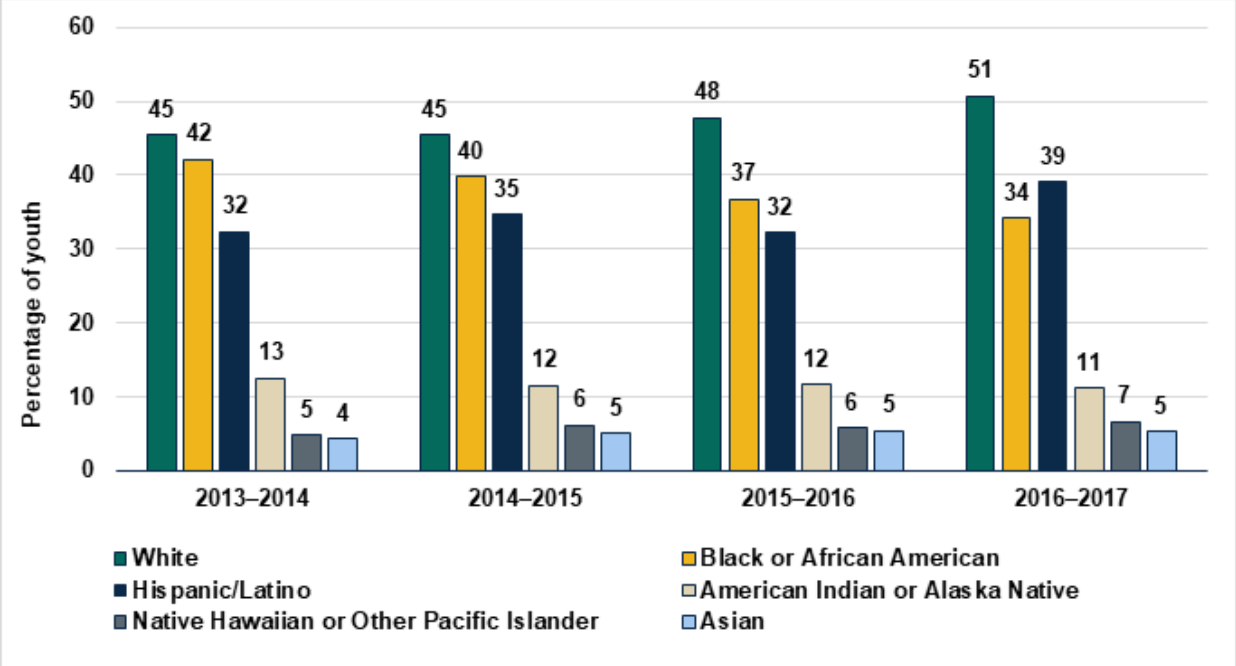
Programs served youth with diverse demographics who have engaged in sexual risk behaviors at varying levels. Most of the youths' characteristics were similar across the years and between funding streams. This chapter first describes the demographic characteristics of youth.[12] Then, it describes the sexual risk behaviors in which youth engaged before starting PREP.

PREP served a diverse set of youth

Across the years, programs served racially and ethnically diverse youth (Figure V.1). Each year, the largest racial group served among all PREP programs was White (between 45 and 51 percent). Over one-third of PREP participants were African American or Black (between 34 and 42 percent each year) and Hispanic or Latino (between 32 and 39 percent each year). Over time, the percentage of youth who identified as White and the percentage who identified as Hispanic slightly increased, while those who identified as African-American or Black slightly decreased.

Between 2013–2014 and 2016–2017, programs primarily served participants ages 13 to 16 (between 69 and 72 percent each year) (Figure V.2). This percentage corresponded to programs mostly serving youth in grades 7 through 10 (Figure V.3). Each year, about 50 percent of participants were female (Appendix A.9).

Figure V.1. Race and ethnicity of youth

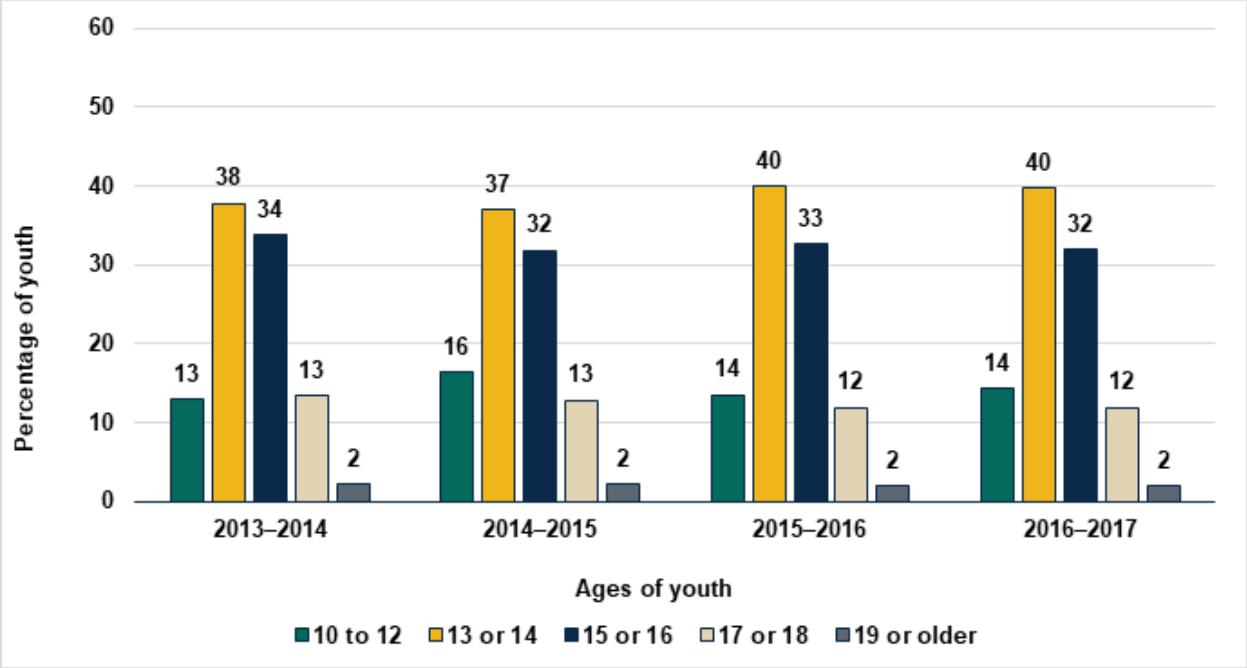


Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Youth could select more than one racial/ethnic category, so percentages can sum to more than 100 percent.

[12] Demographic characteristics are reported based on responses to the exit survey, which reflects a larger sample because youth in 8th grade or below in school-based PREP programs did not complete the entry survey.

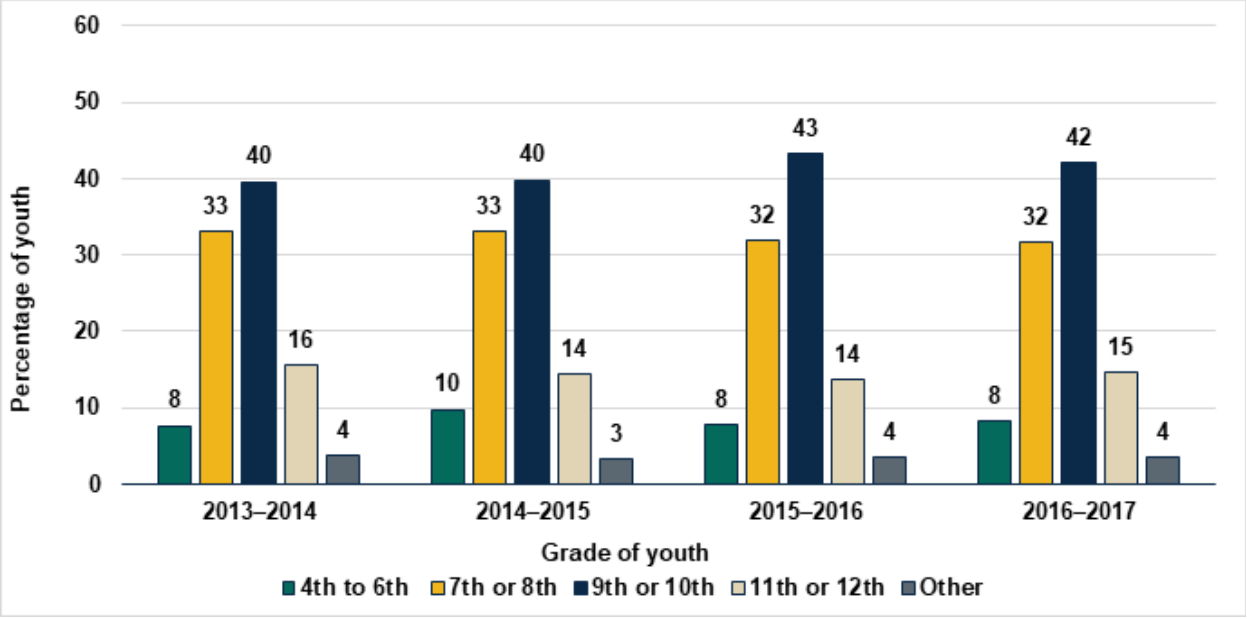
Figure V.2. Age distribution of youth



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Percentages might not sum to 100 percent due to rounding.

Figure V.3. Grade distribution of youth



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Percentages might not sum to 100 percent due to rounding.

The other category includes youth who dropped out of school, are working toward a general equivalency diploma (GED), already earned a diploma or GED, or were in a school without grade levels.

Tribal PREP served a different set of youth compared to State PREP and Competitive PREP (Appendix Table C.9). Tribal PREP programs mostly served American Indian or Alaska Native youth (between 72 and 74 percent each year). Additionally, Tribal PREP programs served younger youth: about one-third of youth each year were ages 10 to 12.

High school-age youth reported their sexual orientation and gender identity on the PREP entry survey.[13] Between 2013–2014 and 2016–2017, the percentage of youth who identified as lesbian, gay, bisexual, or something else/have not decided increased from 10 percent to 14 percent (Figure V.4). This increase is similar to national trends: in 2015 and 2017, 11 percent and 14 percent of high school-age youth identified themselves as lesbian, gay, bisexual, or questioning (Kann et al. 2016; Kann et al. 2018).[14]

Table V.1. Sexual and gender orientation of youth (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Sexual and gender orientation				
Straight	89.9	87.1	87.1	86.8
Gay or lesbian	2.3	2.3	2.4	2.5
Bisexual	6.0	6.9	7.5	8.0
Transgender	0.7	0.5	0.8	0.7
Something else/have not decided	1.9	2.2	3.1	3.3
Reported number of youth completing entry survey	**56,925**	**72,776**	**61,205**	**63,920**

Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

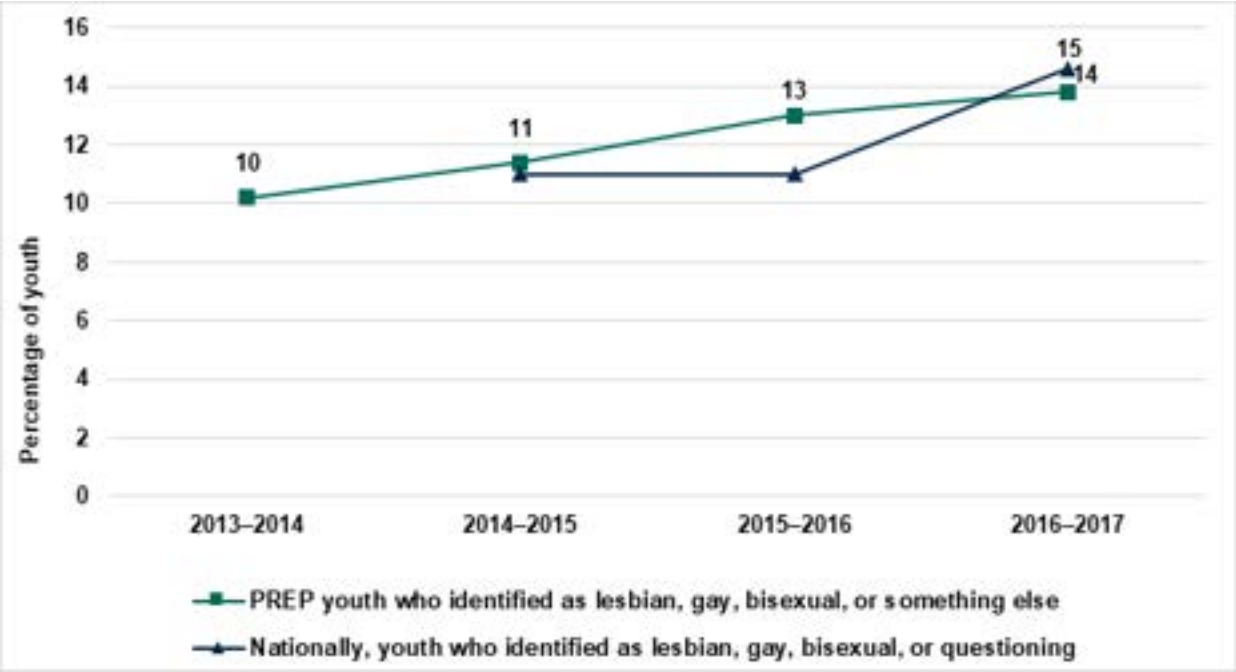
Note: Only youth grade 9 or higher in school settings or ages 14 and older in a community setting responded to the item.

Youth could select more than one sexual and gender orientation, so percentages can sum to more than 100 percent.

[13] The question allowed youth to mark all that applied for the categories of straight, gay or lesbian, bisexual, transgender, and something else/have not decided.

[14] The Youth Risk Behavior Survey, now called the Youth Risk Behavior Surveillance, first collected sexual minority data in 2015.

Figure V.4. Sexual orientation of youth compared to national percentage



Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees. Centers for Disease Control and Prevention. 2015 and 2017 Youth Risk Behavior Survey, now called the Youth Risk Behavior Surveillance. Available at http://www.cdc.gov/yrbs. The Youth Risk Behavior Survey did not include this measure before 2015.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the item.

PREP programs targeted and served highly vulnerable youth

The PREP legislation required programs to target the youth most at risk for pregnancies or in other special circumstances, including youth in foster care, homeless youth, and pregnant and parenting teenagers. ACF encouraged targeting culturally underrepresented youth, such as Hispanic, African American, or Native American youth.[15] Some programs included a range of populations, while others served primarily one group. Between 2013–2014 and 2016–2017, the majority of program (between 73 and 80 percent each year) targeted youth in high-need geographic areas (Table V.2.) Programs also commonly targeted African American youth (between 45 percent and 50 percent, each year) and Hispanic youth (between 39 percent and 43 percent, each year). Nearly all Tribal PREP programs (between 94 percent and 100 percent, each year) targeted Native American youth (Appendix Table C.10.) Programs also targeted additional special populations at-risk for pregnancy, such as youth in adjudication systems, in foster care, or LGBTQ youth (Table V.2).

[15] https://ami.grantsolutions.gov/files/HHS-2016-ACF-ACYF-PREP-1138_1.pdf

Table V.2. Targeted populations (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youth in high-need geographic areas	74.1	72.9	76.6	79.6
African American youth	49.7	47.5	46.3	44.8
Hispanic/Latino youth	42.8	39.6	42.7	38.9
Male youth	36.5	33.5	36.5	35.0
Youth in adjudication systems	30.6	28.1	26.4	35.2
Youth in foster care	31.7	30.9	35.5	33.0
LGBTQ youth	25.3	27.3	34.3	31.8
Pregnant or parenting youth	25.0	24.1	27.7	20.6
Homeless or runaway youth	17.1	14.7	20.8	17.3
Youth in residential treatment for mental health issues	9.2	8.5	12.9	14.7
Out of school/dropout youth	18.2	14.3	11.0	13.6
Native American youth	16.5	21.4	22.3	11.0
Youth living with HIV/AIDS	6.2	5.8	12.1	4.9
Number of programs	**535**	**544**	**530**	**492**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Target populations are not mutually exclusive; programs could target more than one population.

LGBTQ = lesbian, gay, bisexual, transgender or questioning.

To measure the extent to which PREP programs focused on a particular group, programs reported whether they primarily served one of several highly vulnerable populations. Programs indicated whether at least half of the youth served were from any of eight specified populations: youth in foster care; youth in adjudication systems; homeless or runaway youth; pregnant or parenting youth; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth; youth in residential treatment for mental health issues; youth living with HIV/AIDS; and youth who have trouble speaking or understanding English. Because programs operating in school settings tend to serve a more general population, they are limited in the extent to which the majority of the youth served were from one of the eight populations. Therefore, the following analysis focuses on programs only implementing programs during out-of-school time.

About half of programs (between 42 and 49 percent each year) that implemented programming during out-of-school time primarily served at least one of the eight highly vulnerable populations (Table V.3). From 2013–2014 to 2016–2017, the two most common highly vulnerable populations primarily served were youth in adjudication systems (between 17 and 27 percent each year) and youth in foster care (between 16 and 23 percent each year). From 2013–2014 to 2016–2017, the percentage of programs that primarily served youth in residential treatment for mental health issues and LGBTQ youth more than doubled.

Table V.3. Service primarily to specific highly vulnerable populations by programs operating during out-of-school time (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
At least 50 percent of youth served were from any highly vulnerable population	41.5	47.2	48.6	45.2
In adjudication systems	17.4	27.3	22.1	21.7
In foster care	16.2	16.5	22.6	18.0
In residential treatment for mental health	4.7	4.3	9.6	10.6
Identified as LGBTQ	2.0	3.0	4.8	7.8
Pregnant or parenting	3.2	2.2	5.3	4.6
Homeless or runaway	2.8	4.3	3.8	4.6
Trouble speaking or understanding English	2.4	3.0	1.4	3.7
Living with HIV/AIDS	0.0	0.0	0.5	0.9
Number of programs	**253**	**231**	**208**	**217**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: The percentage of population categories do not sum to the percentage of programs primarily serving any highly vulnerable population, because population categories are not mutually exclusive; a program might serve more than one population.

Programs reported whether at least 50 percent of youth served were from each of the highly vulnerable populations. They did not report the percentage of youth in each category.

LGBTQ = lesbian, gay, bisexual, transgender, or questioning.

Programs supported by the different PREP funding streams served highly vulnerable populations at different rates. Across the program years, Competitive PREP programs were the mostly likely to serve these populations. For most years, youth in adjudication systems and youth in foster care were the most common population Competitive PREP programs primarily served, except in 2016–2017, when youth with trouble speaking or understanding English was the most common population (25 percent). Consistently, no Tribal PREP program reported serving any of the eight highly vulnerable populations shown in Table V.3, but all Tribal PREP programs served primarily American Indian or Alaska Native youth, which ACF considers a culturally underrepresented high-risk population (Appendix Table C.9).[16]

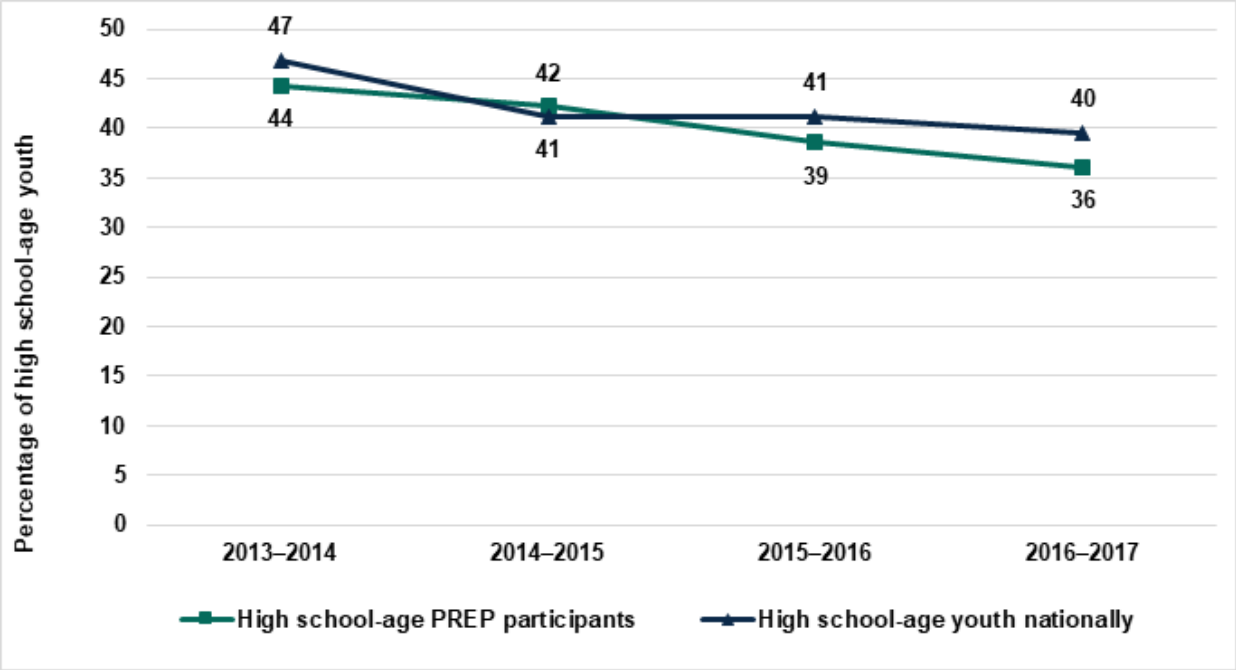
PREP served youth with sexual initiation rates near national levels, and some engaged in risky sexual behavior

Fewer than half of high school-age youth served had engaged in sexual activity at the time they entered the program. Sexual initiation rates were usually near or slightly below national levels for high school-age youth (Figure V.5). Between 2013–2014 and 2016–2017, the percentage of high school-age PREP participants who had had sex before program entry decreased from 44 percent to 36 percent. During this period the national percentage of high school students who had ever had sex also decreased from 47 percent to 40 percent (Kann et al. 2016, 2018). One possible reason for PREP youth having slightly lower rates of sexual initiation compared to national averages is that the high school-age youth that PREP served were younger than the youth reporting nationally. About two-thirds of high school-age youth responding to the entry survey were in 9th and 10th grades. Nationally, between 2013 and 2017, between 20 and

[16] https://ami.grantsolutions.gov/files/HHS-2016-ACF-ACYF-PREP-1138_1.pdf

30 percent of 9th graders, between 36 to 41 percent of 10th graders, between 47 and 54 percent of 11th graders, and between 57 and 64 percent of 12th graders had ever had sex.

Figure V.5. Percentage of high school-age youth who had ever had sex compared to national percentage



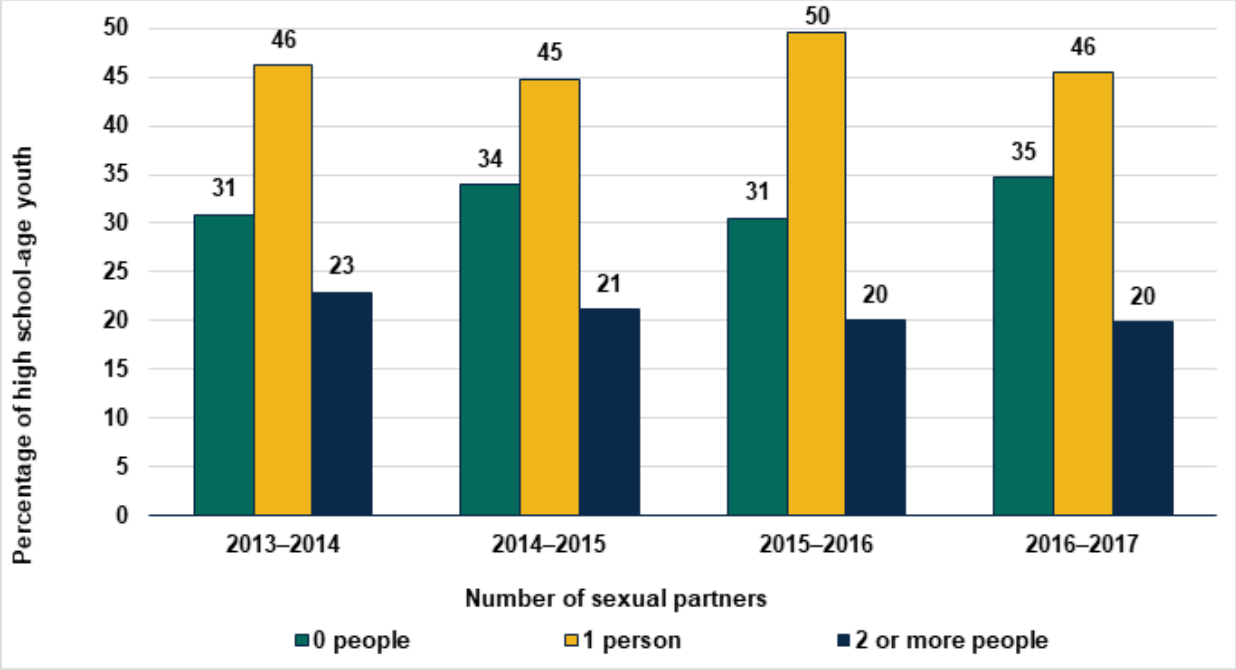
Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees. 2013, 2015, and 2017 Youth Risk Behavior Survey, now called the Youth Risk Behavior Surveillance. Available at http://www.cdc.gov/yrbs.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the item.

Sexually experienced youth engaged in behaviors that increased the risk of pregnancy or STIs prior to their enrollment in PREP programs. Among youth who had ever had sex, about two-thirds (between 65 and 70 percent of youth each year) indicated that they were recently sexually active (Figure V.6), with about one in five (20 to 23 percent) recently sexually active youth reporting more than one partner. The number of recent sexual partners remained stable over time. Between 2013–2014 and 2016–2017, the percentage of youth who never used a condom when having sex in the three months before entering PREP increased (Figure V.7), while the percentage of youth who never used any birth control remained stable (Figure V.8).[17] About 30 percent (27 to 35 percent) of recently sexually active youth said they never used a condom, and about forty percent (39 to 42 percent) said they had never used any birth control in the past three months. Each year across the funding streams, about 20 percent of sexually experienced youth reported having been or gotten someone pregnant.

[17] The entry survey defined birth control as birth control pills, condoms, the shot (Depo Provera), the patch, the ring (NuvaRing), IUD (Mirena or Paragard), or implant (Implanon).

Figure V.6. Number of sexual partners in the three months before program entry among youth who had ever had sex

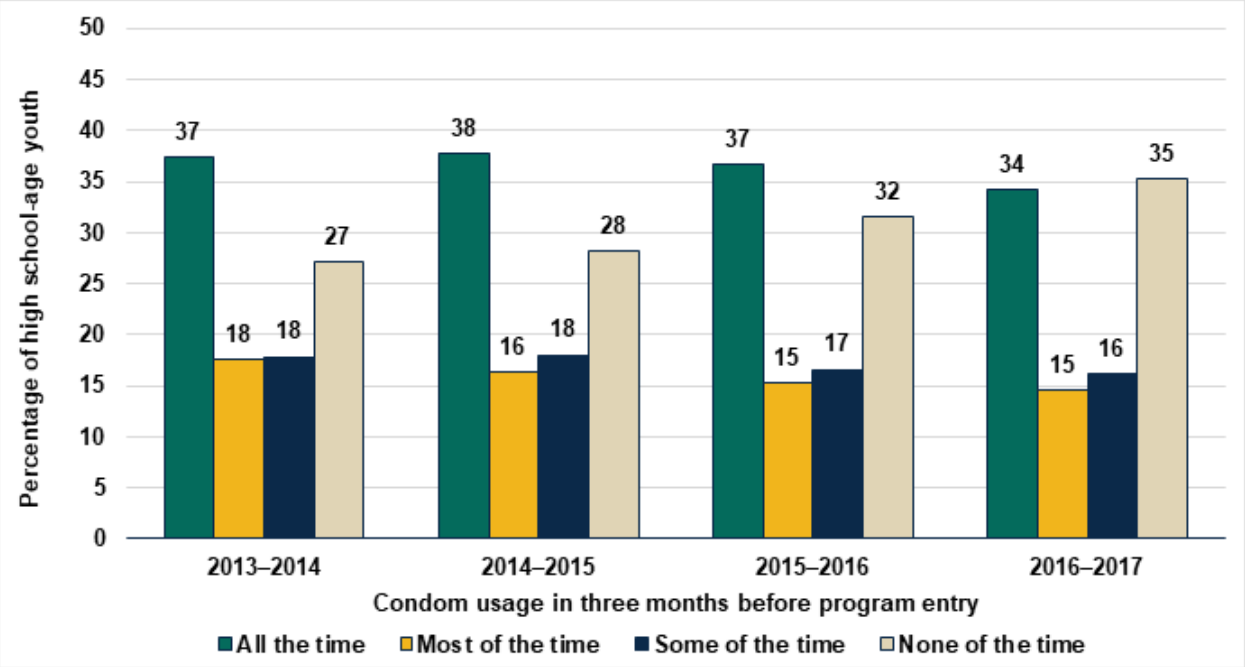


Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting who had ever had sex were asked to respond to the item.

Percentages might not sum to 100 percent due to rounding.

Figure V.7. Condom usage among youth who had sex in the three months before program entry

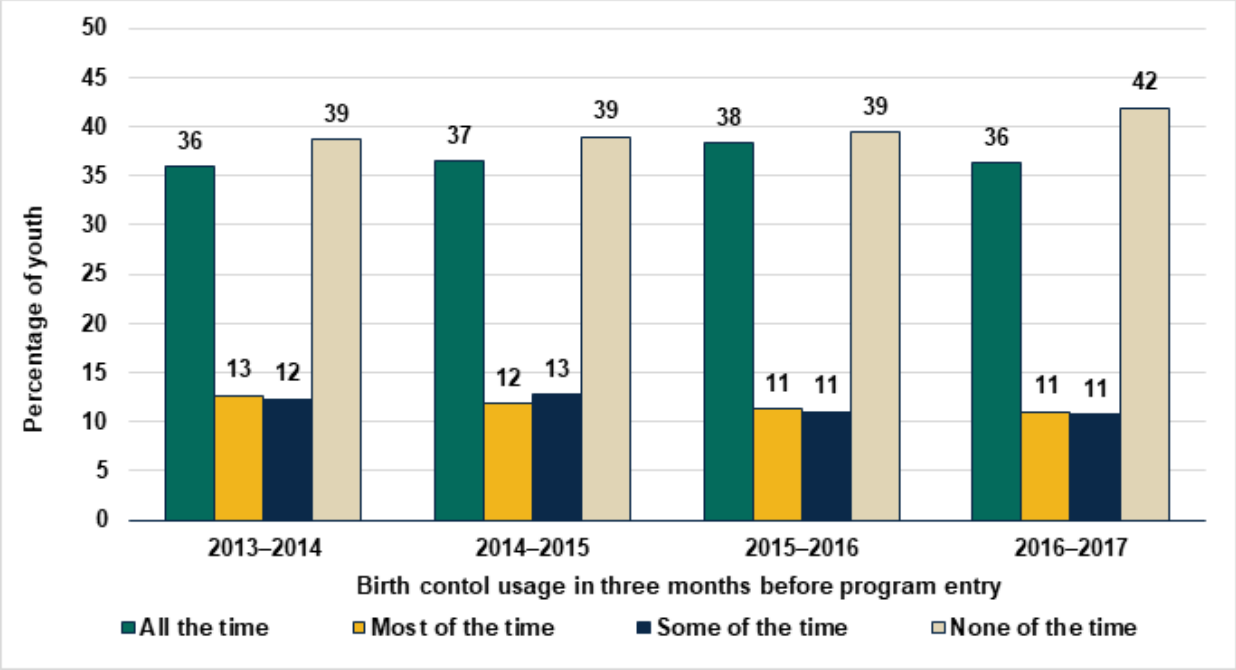


Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting who had one or more sexual partners in the past three months before the survey were asked to respond to the item.

Percentages might not sum to 100 percent due to rounding.

Figure V.8. Birth control usage among youth who had sex in the three months before program entry



Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: The entry survey defined birth control as birth control pills, condoms, the shot (Depo Provera), the patch, the ring (NuvaRing), IUD (Mirena or Paragard), or implant (Implanon).

Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting who had one or more sexual partners in the past three months before the survey were asked to respond to the item.

Percentages might not sum to 100 percent due to rounding.

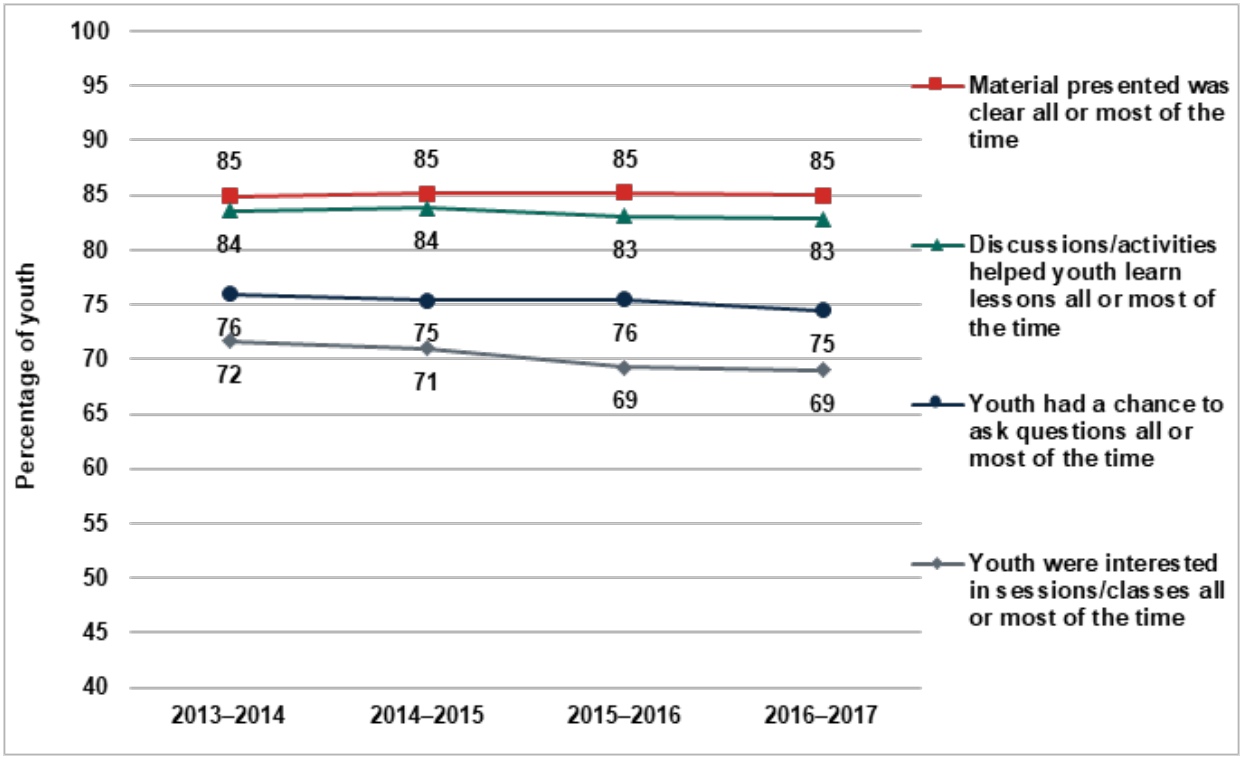
VI. YOUTH RESPONSE TO PREP PROGRAMS

Youth participating in PREP generally reported favorable impressions of the programs, which remained consistent across the four reporting periods. This chapter first describes participating youths' experiences of the programs, followed by their perceptions of the effects the program had on them. Finally, it explores how youths' perceptions of effectiveness vary by key program characteristics.

Most youth reported having positive experiences in their programs

Consistently, youth participants reported that their PREP programs were helpful and engaging (Figure VI.1). At program exit each year, most participating youth reported that, all or most of the time, the material presented was clear (85 percent) and that discussions or activities helped them learn program lessons (between 83 and 84 percent). Each year, three-quarters (75 or 76 percent each year) reported that they had a chance to ask questions about topics or issues that came up in the program all or most of the time. About 70 percent of youth (between 69 and 72 percent each year) were interested in program sessions and classes all or most of the time each year.

Figure VI.1. Youths' perceptions of PREP program delivery



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Youth participants in all funding streams reported positive experiences in their programs, but those attending State PREP programs tended to report positive experiences at the highest rates, and those in Tribal PREP programs tended to report the lowest rates of positive experiences (Appendix Table B.13 and Table C.13).

Youth consistently felt the programming environment was safe and supportive

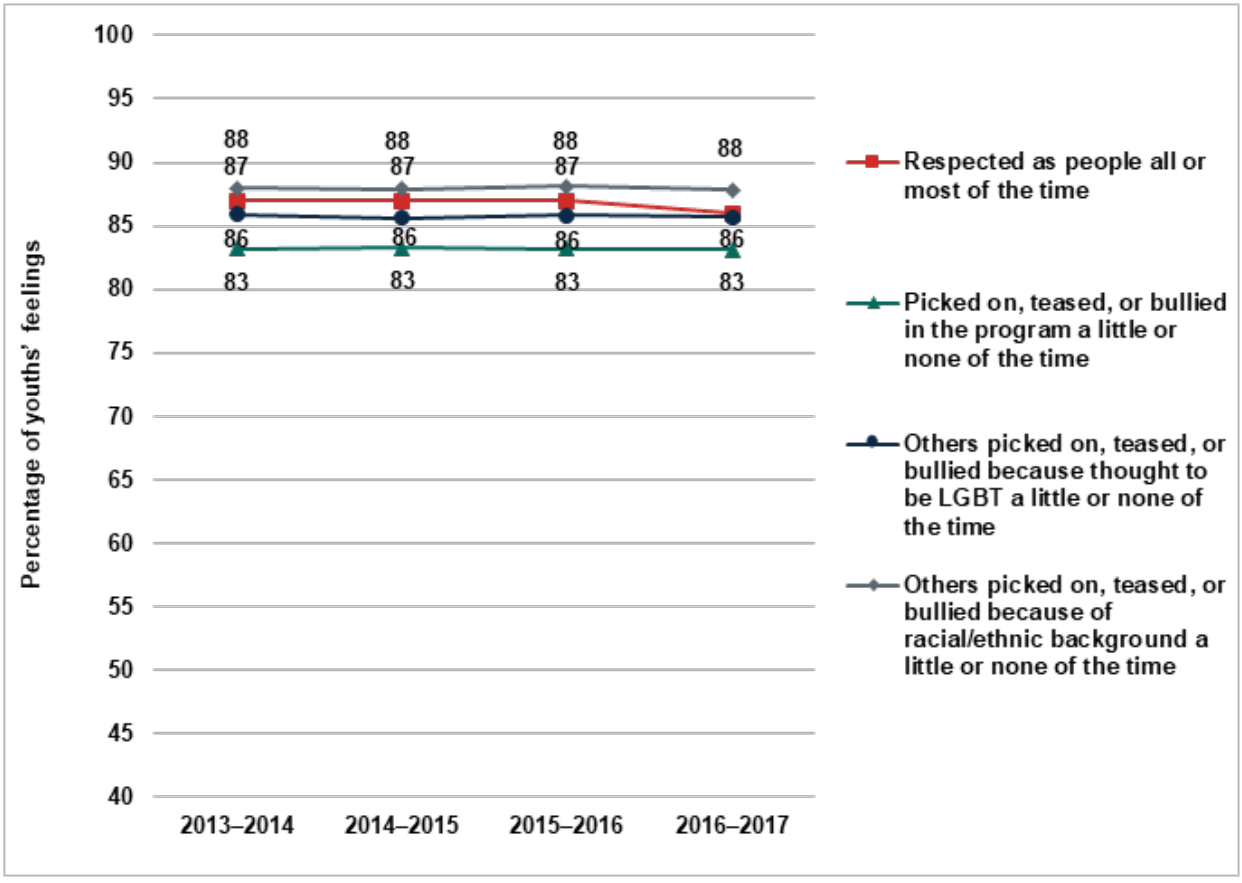
Between 86 and 87 percent of youth each year reported feeling respected as people all or most of the time in the PREP program (Figure VI.2). Youth reported that bullying and teasing happened infrequently in PREP programs. Each year, 83 percent reported that they were rarely or never picked on, teased, or bullied in their program (Figure VI.2). Slightly more youth reported that others were rarely or never picked on, teased, or bullied in the program, either because people thought they were lesbian, gay, bisexual, or transgender (86 percent) or because of their racial or ethnic background (88 percent). However, some youth (17 percent each year) were picked on, teased, or bullied some, most, or all of the time (not shown).

Box VI.1. Implementation challenges and TA needs related to youth engagement and behavior

Each year from 2013–2014 to 2016–2017, 37 percent of providers consistently reported that keeping youth engaged was somewhat of or a serious problem (Appendix Table A.19). The percentage of providers reporting youth behavior to be a problem ranged from to 32 to 39 percent over the four years, with no clear trend.

A larger percentage of providers indicated that they were interested or very interested in TA on each of those topics. Between 44 and 51 percent of providers each year reported interest in TA related to keeping youth engaged, and 42 to 50 percent of providers reported interest on addressing behavior issues, with no clear trend (Appendix Table A.19).

Figure VI.2. Youths' perceptions of PREP program environment

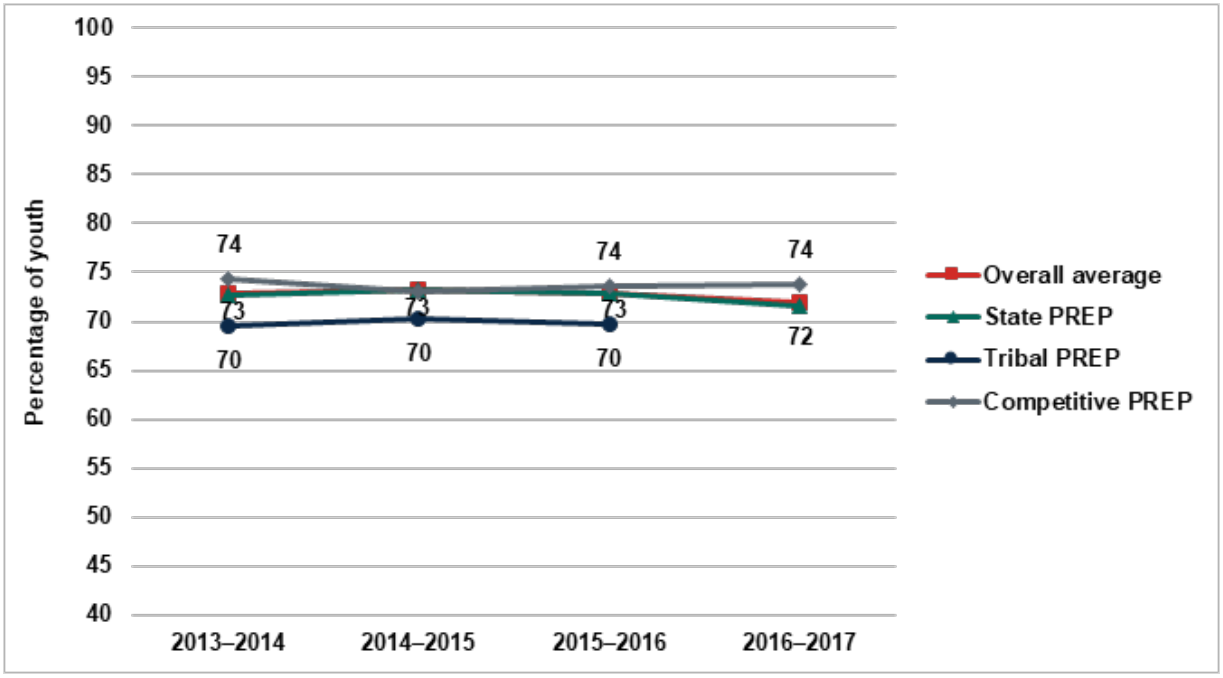


Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Youth reported that the PREP program prepared them for adulthood

In each program year, the majority of youth reported that participating in PREP had made them more likely to exhibit behaviors associated with APSs. (Appendix Table E.1 provides a crosswalk between the six APSs and associated behaviors included in the performance measures.) The percentage of youth indicating at program exit that PREP made them much or somewhat more likely to engage in behaviors related to preparation for adulthood was similar across the four reporting periods, between 72 and 73 percent (Figure VI.3).

Figure VI.3. Youths' perceptions that program participation prepared them for adulthood



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

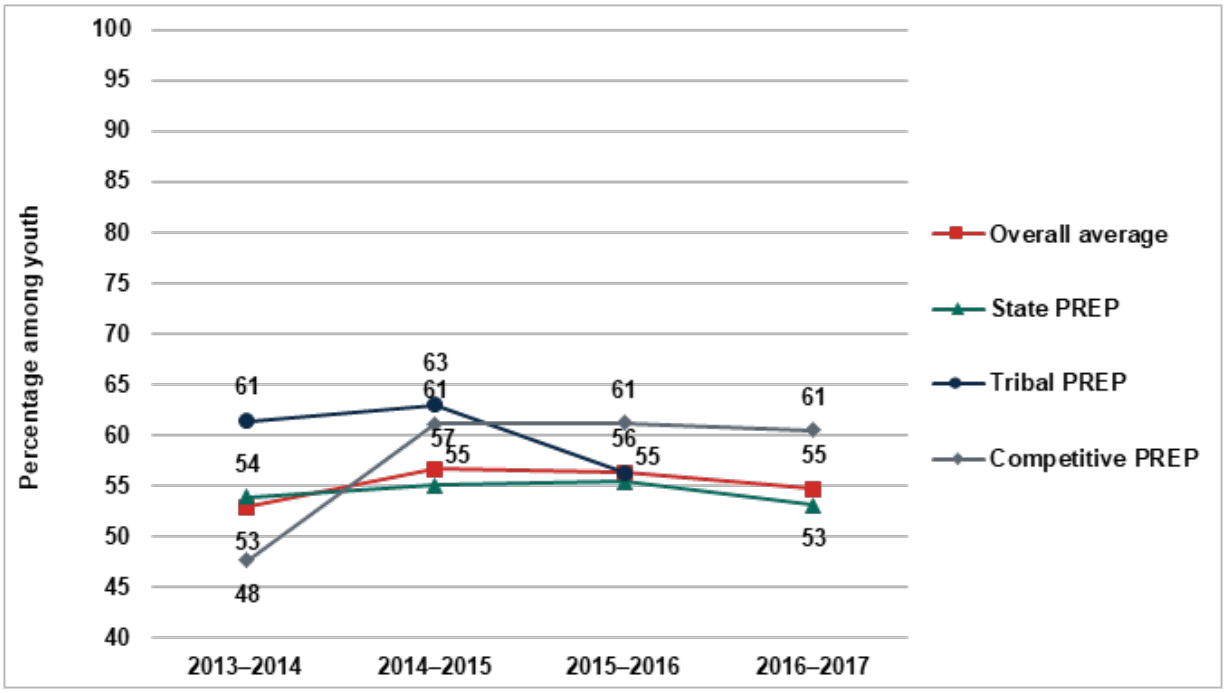
Note: This item is an average percentage of PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

As discussed in Chapter IV, most PREP programs focused on the same three APS topics: healthy relationships, healthy life skills, and adolescent development (between 73 and 98 percent of programs reported each of these). At program exit, youth reported that participation increased 10 behaviors aligned with these three APS topics, such as being respectful toward others and resisting or saying no to peer pressure (Appendix Table A.13). Youth also reported that their participation in PREP affected behaviors aligned with less commonly implemented APSs: parent-child communication, educational and career success, and financial literacy. Although these behaviors do not clearly align with the more prevalent APSs of healthy life skills, adolescent development, and healthy relationships, many of the skills addressed by programs targeting these APS topics could be transferable to other areas of adulthood preparation.

Youth reported that the PREP program changed their intentions toward risky sexual behaviors

A majority of youth perceived that participation in the program increased the likelihood that they would abstain from sex in the next six months. Each year, between 53 and 57 percent of youth who participated in PREP programming reported that being in the program made them much more or somewhat more likely to abstain from sexual intercourse in the six months following the program (Figure VI.4).

Figure VI.4. Participants' perceptions of PREP's influence on their likelihood of abstaining from sex in next six months

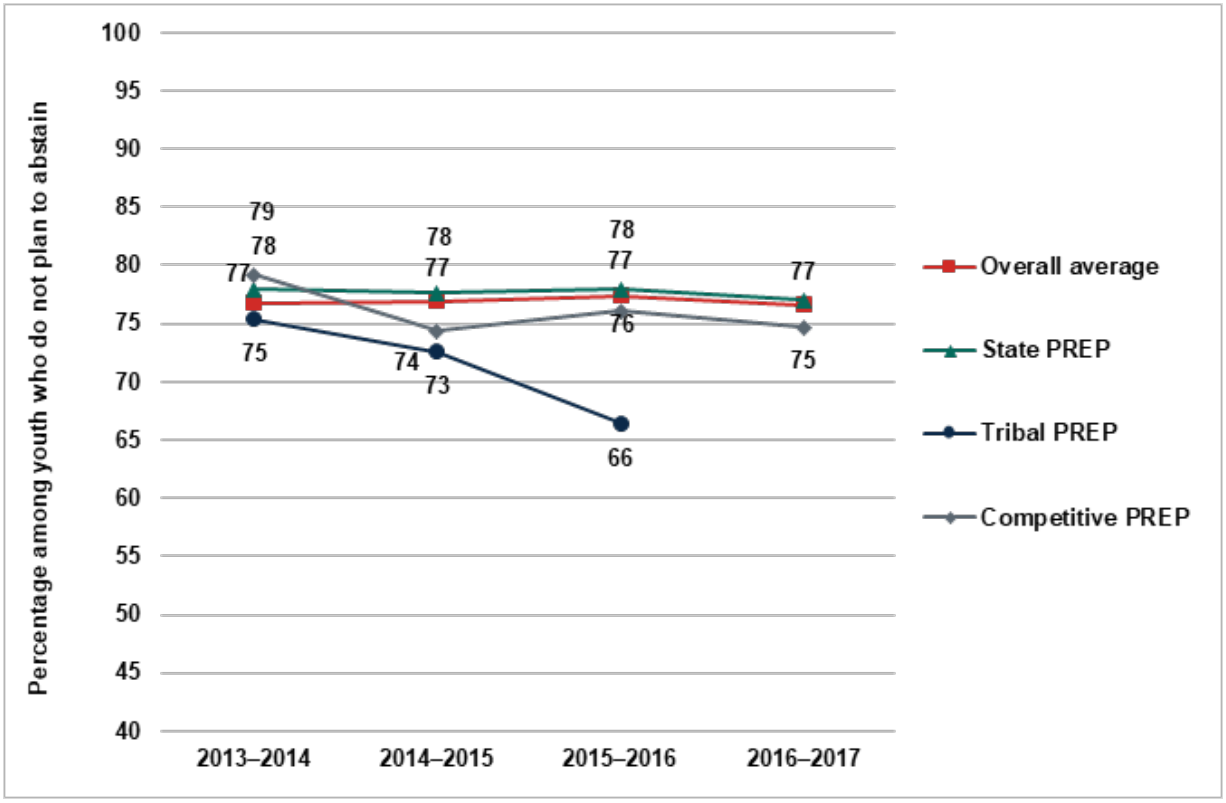


Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Each year, a large proportion of youth perceived that participation in the program increased the likelihood they would use a condom or other birth control if they had sex. Among youth who did not indicate at program exit that they planned to abstain from sex, 77 percent each year reported that they were much more or somewhat more likely to use condoms, and 70 percent were much more or somewhat more likely to use any type of birth control in the next six months because of participating in the program (Figure VI.5 and Figure VI.6).[18]

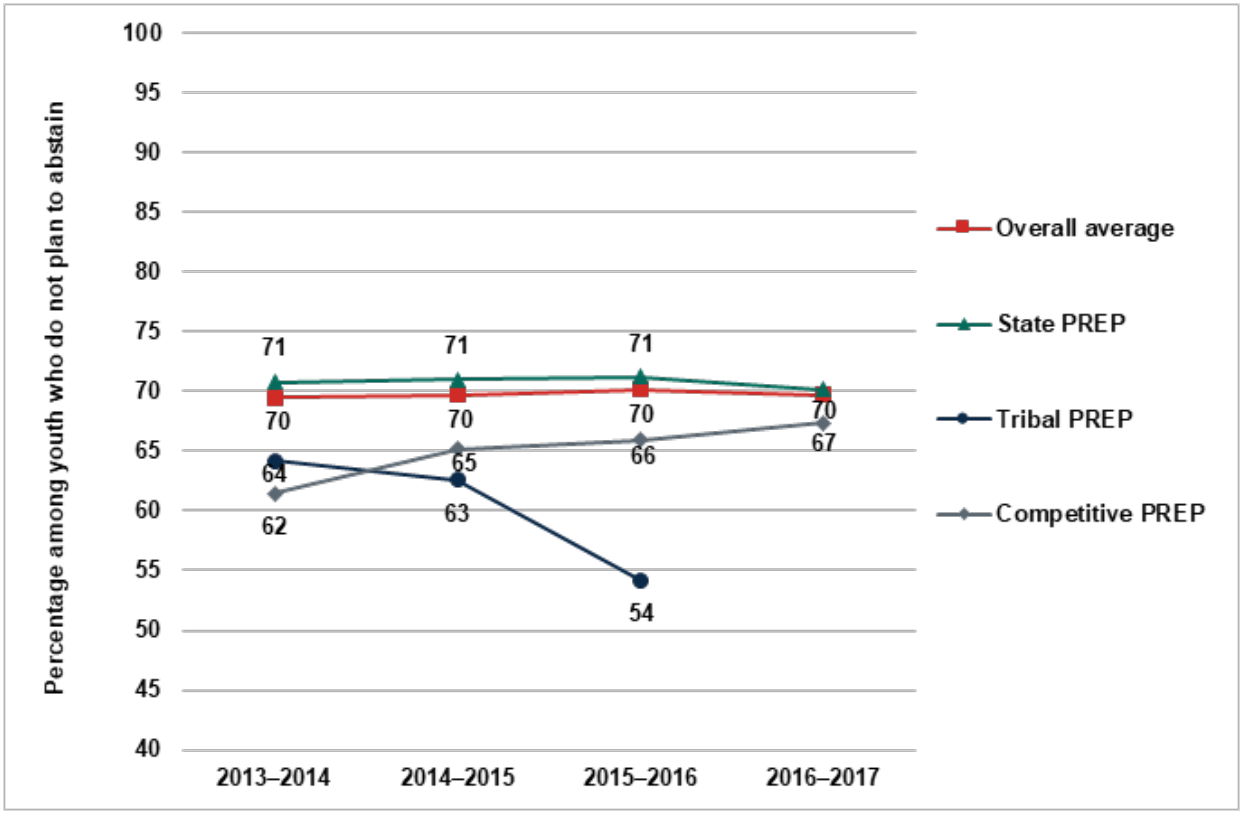
[18] All eligible youth were asked to respond to the questions on condom and birth control use but could select the response option, "I will abstain from sexual intercourse (choose not to have sex) in the next six months." The data presented in Figure VI.5 and Figure VI.6 and the related text are among those PREP participants who did not select the abstinence response option.

Figure VI.5. Perceptions of PREP's influence on likelihood to use a condom if having sex in next six months among participants who do not plan to abstain from sex



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Figure VI.6. Perceptions of PREP's influence on likelihood to use any birth control if having sex in next six months among participants who do not plan to abstain from sex



Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Participants' perceptions of program effects were mostly stable for youth in State and Competitive PREP grantees, but differed for youth in Tribal PREP grantees. For example, there was a downward trend for Tribal PREP reporting that they were likely to abstain from sexual intercourse in the six months following the program (Figure VI.4). There was also a downward trend for Tribal PREP youth reporting that participation affected their likelihood of using condoms or any birth control if having sex in the next six months (Figure VI.5 and Figure VI.6). The percentages of responses to this question remained stable for State PREP and Competitive PREP youth.

Youths' perceptions of PREP's effects on some sexual behavior intentions varied by program characteristics

In addition to examining trends over time, we explored whether program effects varied based on three program characteristics: primary age of youth served, whether programs primarily served a highly vulnerable population, and implementation setting. This analysis was conducted using data aggregated across funding streams and program year. With some exceptions, participants' perceptions of program effects were largely consistent across different types of programs (Table VI.1).

The outcome that differed the most by program characteristic was the percentage of youth reporting that participation in PREP made them much more or somewhat more likely to abstain from sex in the next six months. A larger percentage of youth in programs primarily serving middle school-age youth (69 percent) reported being more likely to abstain from sex in next six months due to PREP, compared to youth in programs primarily serving high school-age youth (54 percent). Similarly, a larger percentage of participants in programs implemented during school (60 percent) reported effects on their likelihood to abstain, compared to those in out-of-school settings (50 percent). Just under half (49 percent) of youth in programs that served primarily highly vulnerable populations reported that participating made them more likely to abstain, compared to 59 percent of youth in other programs.

Table VI.1. Youths' perceptions of program effects on adulthood and sexual behavior at program exit, by program characteristics

	Primary age group program served		Programs serving a highly vulnerable population		Program setting	
Measure	Middle school age	High school age	Primarily	Not primarily	In-school/ during school time	Out-of-school time
Percentage of youth who felt prepared for adulthood[a]	74.8	71.9	73.3	72.7	72.0	76.0
Percentage of youth who were:						
Much less or somewhat less likely to have sexual intercourse in next six months	77.9	56.3	49.6	62.6	63.9	51.1
Much more or somewhat more likely to abstain from sex in next six months	69.2	54.2	49.2	58.5	59.5	50.4
Much more or somewhat more likely to use birth control if having sex in next six months[b]	66.8	70.3	66.4	70.3	70.2	68.5
Much more or somewhat more likely to use a condom if having sex in next six months[b]	76.0	77.1	72.2	77.6	77.6	74.7
Reported number of youth completing exit survey	**102,379**	**241,301**	**34,766**	**300,385**	**277,847**	**65,842**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who reported they plan to abstain from sexual intercourse in next six months.

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VII. DISCUSSION

This report presents a description of PREP operations nationwide between 2013 and 2017 using grantee-submitted performance measures data. In this chapter, we summarize key findings and discuss limitations of the data.

The performance measures data provide systematic information about program operations and outcomes for all PREP grantees, their provider organizations, the programs they operate, and the youth they serve. The data collection plan was limited to grantees' reports of the measures they collected. The data plan also did not include any qualitative data that could help explain some findings. For example, we cannot explain why the proportion of youth enrolled in PREP programs who had previously engaged in sexual activity declined over time. The decline could be related to an overall decline nationwide, and in particular in the areas where PREP programs operate, or programs might be attracting fewer youth with risky sexual behavior over time. Similarly, as noted in Chapter VI, 72 to 73 percent of youth participants each year indicated that participating in a PREP-funded program made them more likely to engage in behaviors related to adulthood preparation. We can only speculate about why these percentages are not higher or did not increase over time. The level could be related to the extent to which each program covered the adulthood preparation subjects relative to the other program content. The performance measures were not designed to assess the content of each program.

In this report, we examined trends for PREP nationwide as well as by funding streams. Many of the characteristics of the grantees, the programs implemented, and the youth served remained stable over time and were similar across funding streams. Between 2013 and 2017, PREP served more than 400,000 youth through hundreds of program and providers operated or supported by grantees. The number of grantees, providers, and programs that implemented PREP fluctuated across reporting periods, as did the number of facilitators working with youth and the number of youth served within programs. This fluctuation across reporting periods was largely due to changes in the number of grants funded and reporting requirements of performance measures each year.

Grantees provided support for program implementation each year. Between 88 and 98 percent of grantees reported that they or a designee provided initial training, offered ongoing TA, and conducted monitoring of fidelity to the program model and the quality of service. Nearly all facilitators were trained each year, but fewer than half of the facilitators were observed, and the percentage observed declined from 2013–2014 to 2016–2017. There were also some differences by funding stream: higher percentages of Tribal PREP and Competitive PREP facilitators were observed than State PREP facilitators.

Most grantees implemented evidence-based programs and covered at least three APSs. Between 90 and 94 percent of programs implemented evidence-based program models with youth. There were differences by funding stream in the most commonly implemented program models, but across all PREP programs, more than 10 percent of programs implemented Making Proud Choices!, Teen Outreach Program (TOP), Be Proud! Be Responsible!, and Reducing the Risk each year. As required, nearly every programs implemented at least three APSs, with healthy relationships, healthy life skills, and adolescent development being the most frequently

implemented each year. Most Tribal PREP programs also addressed parent-child communication.

Programs served youth with diverse demographics. Each year between 2013–2014 and 2016–2017, about half of PREP participants identified as White and more than one-third identified as African American or Black, or as Hispanic or Latino. Grantees met the PREP requirement of serving youth between ages 10 and 19, or up to 21 if a pregnant or parenting mother. More than two-thirds of youth served reported being between 13 and 16 years old. The youth served also reported sexual orientations similar to national counterparts, with those who identified as lesbian, gay, bisexual, or something else increasing from 10 percent to 14 percent. Tribal PREP participants differed from those served by other funding streams in that the majority of youth were American Indian or Alaska Native and about one-third of youth were ages 10 to 12.

While sexual initiation rates declined between 2013–2014 and 2016–2017 for high school-age participants, some recently sexually active youth placed themselves at further risk of pregnancy and STIs. Sexual initiation rates were near national levels for high school-age youth in most years and decreased along with national trends. Fewer than half of high school-age youth served had ever had sex before entering PREP. Those who had ever had sex in the three months before programming engaged in additional risky sexual behaviors. About 30 percent of youth reported never using a condom and about 40 percent reported never using any birth control when having sex in the three months before programming.

PREP participants reported positive impressions of the program and that participating in PREP affected their intended behaviors. The majority of youth had positive perceptions of PREP program delivery and rarely felt they or others were bullied or teased in the program. Each year, youth reported program participation increased their likelihood to engage in behaviors associated with APSs. Youth also reported that participating in PREP programs changed their intentions to engage in risky sexual behaviors. A majority of youth reported that participation in PREP increased the likelihood that they would abstain from sex in the next six months. For those who did not plan to abstain, participation increased their reported likelihood of using condoms or any type of birth control.

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APPENDIX A:

PREP TABLES

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Table A.1. Grant structure and scale

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of grantees	101	101	86	68
Percentage of grantees that[a]				
Serve as program provider only	44.4	41.6	32.9	25.8
Have subawardees as program providers only	48.1	51.5	61.0	69.7
Combine methods for program providers	7.4	6.9	6.1	4.5
Number of program providers	458	472	465	400
Percentage of program providers that first received award during reporting period	14.8	11.2	16.3	21.3
Percentage of program providers serving youth during the reporting period	95.0	93.2	92.7	96.3
Number of programs	535	544	530	492
Average number of providers per grantee	4.5	4.7	5.4	5.9
Average number of programs per grantee	5.3	5.4	6.2	7.2
Average number of programs per program provider	1.2	1.2	1.1	1.2
Number of facilitators	**3,108**	**3,545**	**3,389**	**3,008**
Number of youth	**111,611**	**133,790**	**112,019**	**110,091**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

Table A.2. Grantee staffing

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Average number of grantee staff	3.9	3.4	3.4	3.6
Average number of grantee staff FTE	2.4	2.2	2.3	2.5
Number of grantees	**101**	**101**	**86**	**68**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Staff includes grantee staff involved in overseeing PREP and does not include program provider or facilitator staff.

FTE = full-time equivalent.

Table A.3. Support for program implementation

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of grantees whose staff or designees				
Provided technical assistance	94.9	91.1	95.2	91.2
Provided training	87.9	89.1	94.0	92.6
Observed program delivery	97.0	98.0	97.6	97.1
Percentage of facilitators				
Trained	97.2	97.5	98.9	95.5
Observed at all	49.6	49.2	40.7	43.0
Observed once	23.2	25.4	22.1	19.6
Observed twice or more	26.4	23.8	18.6	23.4
Percentage of providers that observed facilitators	87.4	87.5	86.2	88.3
Number of grantees	**101**	**101**	**86**	**68**
Number of facilitators	**3,108**	**3,545**	**3,389**	**3,008**
Number of providers	**428**	**439**	**464**	**385**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: One outlier in 2015–2016 was removed from the analysis of facilitators. This provider reported 1,583 facilitators in 2015–2016, compared with 23 in 2014–2015 and 53 in 2016–2017.

Table A.4. Implementation of evidence-based program models

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs implementing an evidence-based program model	93.5	93.9	94.0	90.4
Percentage of youth served by programs implementing an evidence-based program model	91.5	97.2	94.4	91.9
Number of programs	**535**	**544**	**530**	**492**
Number of youth	**111,611**	**133,790**	**112,019**	**110,091**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Table A.5. Program models implemented (percentage of programs)

Program model	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Making Proud Choices![a]	17.4	15.8	15.3	18.9
Teen Outreach Program (TOP)[a]	15.1	15.6	14.5	14.4
Be Proud! Be Responsible![a]	12.9	12.7	11.9	13.8
Reducing the Risk[a]	11.4	11.6	14.0	13.0
SHARP[a]	3.4	4.6	4.9	4.9
Draw the Line/Respect the Line[a]	6.2	7.0	9.4	3.9
¡Cuidate![a]	3.2	2.6	3.8	3.7
Making a Difference![a]	3.0	3.5	2.6	2.6
Heritage Keepers Abstinence Education[a]	0.6	0.9	0.8	2.4
Promoting Health Among Teens (PHAT)! Comprehensive Abstinence and Safer Sex Intervention[a]	2.1	1.7	1.5	2.0
SiHLE[a]	2.4	2.2	2.3	1.8
Adult Identity Mentoring (Project AIM)[a]	0.9	0.9	0.6	0.4
Becoming a Responsible Teen (BART)[a,b]	3.4	2.6	2.6	1.4
Family Life and Sexual Health (FLASH)	0.0	0.0	0.0	1.4
Safer Choices[a]	1.9	1.8	2.1	1.4
Wise Guys	0.6	0.6	1.1	1.4
Power Through Choices[a,b]	0.2	0.2	0.6	1.0
Sisters Saving Sisters[a]	0.0	0.0	0.0	1.0
Rikers Health Advocacy Program (RHAP)[a,b]	1.9	1.5	0.8	0.8
Street Smart	2.4	2.4	1.5	0.8
17 Days[a]	1.3	1.3	1.5	0.8
All4You![a]	0.9	0.6	0.8	0.6
Be Proud! Be Responsible! Be Protective![a]	1.1	1.3	0.9	0.6
Get Real[a]	0.0	0.0	0.0	0.6
FOCUS[a]	0.4	0.4	0.4	0.4
Michigan Model–Healthy & Responsible Relationships	0.4	0.4	0.4	0.4
Promoting Health Among Teens (PHAT)! Abstinence Only Intervention[a]	0.4	0.4	0.4	0.4
Safer Sex	0.4	0.2	0.2	0.4
Families Talking Together[a]	0.0	0.0	0.0	0.2
Sexual Wellness and Advocacy by Teens	0.2	0.2	0.2	0.2
The Fourth R: Alaska Perspectives	0.0	0.0	0.4	0.2
The Grassroots Project	0.2	0.2	0.2	0.2
Teen Health Project[a]	1.5	1.8	0.4	0.0
It's Your Game: Keep It Real (IYG)[a]	0.9	2.4	1.3	0.0
Teen Life Clubs–Steps to S.T.A.R.dom Curriculum	0.2	0.2	0.2	0.0
Other	1.7	1.3	1.5	2.4
Number of programs	**535**	**544**	**530**	**492**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] The U.S. Department of Health and Human Services (HHS) has identified the program model as an evidence-based program.

[b] Becoming a Responsible Teen and Rikers Health Advocacy Program were included during the 2013–2014 through 2015–2016 reporting periods but were no longer included on the list of HHS evidence-based teen pregnancy prevention programs in the 2016–2017 reporting period. Power Through Choices was added to the list in 2016–2017.

Table A.6. Adulthood preparation subjects (APSs) implemented (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of APSs implemented[a]				
0–2 subjects	3.4	3.9	1.7	4.5
3 subjects	64.2	63.3	56.0	54.6
4 subjects	20.5	18.6	30.0	25.9
5 subjects	5.3	8.7	5.8	8.1
6 subjects	6.8	5.5	6.4	6.9
Subject implemented[b]				
Healthy relationships	96.4	96.3	95.5	97.6
Healthy life skills	80.6	83.4	88.7	81.3
Adolescent development	75.6	74.1	76.0	72.9
Parent-child communication	45.7	45.0	51.1	50.7
Educational and career success	27.8	27.2	26.2	29.7
Financial literacy	22.1	22.7	22.1	25.3
Number of programs	**535**	**544**	**530**	**492**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Percentages do not sum to 100 percent because programs could implement more than three subjects. Adult preparation subjects are not mutually exclusive.

Table A.7. Implementation setting

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs serving youth in[a]				
Schools, during school	51.3	56.0	59.3	55.3
Community-based organizations	35.1	35.4	33.3	35.9
Schools, after school	17.1	16.2	13.1	13.8
Juvenile detention centers	14.5	17.9	15.1	16.3
Foster care settings	12.3	12.4	11.2	12.0
Clinics	5.0	5.1	3.1	2.1
Other settings	13.3	12.0	9.6	13.2
Percentage of youth served in[b]				
Schools, during school	75.9	77.9	79.0	78.5
Community-based organizations	8.7	8.2	7.5	8.7
Schools, after school	4.9	3.0	3.2	2.9
Juvenile detention centers	4.9	4.3	3.2	3.9
Foster care settings	2.6	2.6	2.9	2.3
Clinics	0.8	1.6	1.4	0.1
Other settings	3.3	2.4	2.7	3.4
Number of programs	**535**	**544**	**530**	**492**
Number of youth	**111,611**	**133,790**	**112,019**	**110,091**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] Percentages do not sum to 100 percent because programs could be implemented in more than one setting.

[b] Percentages may not sum to 100 percent due to rounding.

Table A.8. Intended dosage and receipt

Measure	2013–2014 reporting period	2014–2015 reporting period	201–-2016 reporting period	2016–2017 reporting period
Average hours of intended programming	16.5	19.7	18.6	13.8
Percentage of youth in out-of-school-time programs who completed at least 75 percent of the intended dosage[a]	70.3	73.6	75.9	73.6
Number of programs	**535**	**544**	**530**	**492**
Number of youth from out-of-school-time programs	**24,724**	**28,981**	**23,445**	**23,604**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] This result is based on programs that served youth during out-of-school time. Because these programs are generally voluntary and do not take place during the school day, youth are likely to attend less frequently.

Table A.9. Demographic characteristics of youth (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Female	51.5	51.7	52.2	50.7
Hispanic or Latino	32.3	34.7	32.2	39.0
Ethnicity[a]				
Mexican, Mexican American, Chicano	67.9	64.8	64.9	64.9
Puerto Rican	12.2	12	13.1	11.8
Cuban	3.2	2.9	1.6	1.7
Other Hispanic or Latino	16.7	20.3	20.4	21.7
Race[b]				
American Indian or Alaska Native	12.5	11.5	11.6	11.2
Asian	4.3	5.0	5.4	5.3
Black or African American	42.1	39.8	36.7	34.1
Native Hawaiian or Other Pacific Islander	4.8	6.1	5.8	6.6
White	45.4	45.4	47.8	50.7
Age[a]				
10–12	12.9	16.3	13.5	14.3
13 or 14	37.8	37	39.9	39.8
15 or 16	33.8	31.8	32.7	32.0
17 or 18	13.4	12.8	11.9	11.9
19 and older	2.1	2.2	2.0	2.0
Grade level[a]				
4th–6th	7.6	9.7	7.7	8.2
7th or 8th	33.1	33.0	31.9	31.6
9th or 10th	39.6	39.8	43.3	42.1
11th or 12th	15.5	14.4	13.7	14.6
Dropped out of school	0.3	0.2	0.3	0.3
Working toward GED	0.7	0.8	0.7	0.8
Earned diploma or GED and in postsecondary school	0.6	0.7	0.8	0.8
Earned diploma or GED and not in postsecondary school	0.9	1.1	1.3	1.1
School does not assign grade levels	1.7	0.4	0.4	0.5
Sexual and gender orientation[b, c]				
Straight	89.9	87.1	87.1	86.8
Gay or lesbian	2.3	2.3	2.4	2.5
Bisexual	6.0	6.9	7.5	8.0

Table A.9. (*continued*)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Transgender	0.7	0.5	0.8	0.7
Something else/have not decided	1.9	2.2	3.1	3.3
Reported number of youth completing entry survey	**56,925**	**72,776**	**61,205**	**63,920**
Reported number of youth completing exit survey	**55,413**	**71,180**	**64,333**	**64,587**

Source: Entry and exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: All items except for sexual and gender orientation were from the exit survey.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Youth could select more than one item, so percentages can sum to more than 100 percent.

[c] This item was considered a sensitive item and was only asked of high school-age youth on the entry survey.

GED = general equivalency diploma.

Table A.10 Targeted populations (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youth in high-need geographic areas	74.1	72.9	76.6	79.6
African American youth	49.7	47.5	46.3	44.8
Hispanic/Latino youth	42.8	39.6	42.7	38.9
Male youth	36.5	33.5	36.5	35.0
Youth in adjudication systems	30.6	28.1	26.4	35.2
Youth in foster care	31.7	30.9	35.5	33.0
LGBTQ youth	25.3	27.3	34.3	31.8
Pregnant or parenting youth	25.0	24.1	27.7	20.6
Homeless or runaway youth	17.1	14.7	20.8	17.3
Youth in residential treatment for mental health issues	9.2	8.5	12.9	14.7
Out of school/dropout youth	18.2	14.3	11.0	13.6
Native American youth	16.5	21.4	22.3	11.0
Youth living with HIV/AIDS	6.2	5.8	12.1	4.9
Number of programs	**535**	**544**	**530**	**492**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Target populations are not mutually exclusive; programs could target more than one population.

LGBTQ = lesbian, gay, bisexual, transgender or questioning.

Table A.11. Service to highly vulnerable populations, by programs operating during out-of-school time (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
At least 50 percent of youth served were from any highly vulnerable population	41.5	47.2	48.6	45.2
In adjudication systems	17.4	27.3	22.1	21.7
In foster care	16.2	16.5	22.6	18.0
In residential treatment for mental health	4.7	4.3	9.6	10.6
Identified as LGBTQ	2.0	3.0	4.8	7.8
Pregnant or parenting	3.2	2.2	5.3	4.6
Homeless or runaway	2.8	4.3	3.8	4.6
Trouble speaking or understanding English	2.4	3.0	1.4	3.7
Living with HIV/AIDS	0.0	0.0	0.5	0.9
Number of programs	**253**	**231**	**208**	**217**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: The percentage of population categories do not sum to the percentage of programs primarily serving any highly vulnerable population, because population categories are not mutually exclusive; a program might serve more than one population.

Programs reported whether at least 50 percent of youth served were from each of the highly vulnerable populations. They did not report the percentage of youth in each category.

LGBTQ = lesbian, gay, bisexual, transgender, or questioning.

Table A.12. High school-age youth sexual behaviors at program entry (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Ever had sexual intercourse	44.3	42.2	38.6	36.1
Ever been pregnant or gotten someone pregnant[a]	20.4	18.4	18.9	17.1
Number of times pregnant or gotten someone pregnant[a,b]				
0 pregnancies	79.8	82.0	81.9	82.7
1 pregnancy	14.5	13.3	13.1	12.2
2 pregnancies	3.8	3.3	3.3	3.4
3 or more pregnancies	1.9	1.6	1.7	1.7
Number of sexual partners in the past three months[a,b]				
0 people	30.9	34.0	30.5	34.7
1 person	46.2	44.8	49.5	45.5
2 or 3 people	16.0	14.7	14.9	14.2
4 or more people	6.9	6.5	5.2	5.6
Frequency of birth control use in the past three months[b,c]				
All the time	35.9	36.5	38.3	36.3
Most of the time	12.7	11.9	11.3	11.0
Some of the time	12.3	12.8	11.0	10.8
None of the time	38.7	39.0	39.4	41.9
Frequency of condom use in the past three months[b,c]				
All the time	37.4	37.7	36.6	34.2
Most of the time	17.6	16.3	15.3	14.5
Some of the time	17.8	18.0	16.6	16.1
None of the time	27.1	28.2	31.5	35.2
Reported number of youth completing entry survey	**56,925**	**72,776**	**61,205**	**63,920**

Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the items.

[a] Asked only of those who had ever had sexual intercourse.

[b] Percentages might not sum to 100 percent due to rounding.

[c] Asked only of those who had one or more sexual partners in the past three months.

Table A.13. Youths' perceptions of the program at program exit (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youths' perceptions of PREP program delivery				
The material presented was clear all or most of the time	84.9	85.1	85.2	85.0
Discussions or activities helped youth learn program lessons all or most of the time	83.6	83.8	83.1	82.8
Youth had a chance to ask questions about topics or issues that came up in the program all or most of the time	76.0	75.4	75.5	74.5
Youth were interested in program sessions and classes all or most of the time	71.7	71.0	69.3	69.0
Youths' perceptions of PREP program environment				
Youth felt respected as people all or most of the time	87.2	87.2	86.8	86.1
Youth felt picked on, teased, or bullied in the program a little or none of the time	83.2	83.3	83.2	83.1
Youth felt others in the program were picked on, teased, or bullied because people thought they were lesbian, gay, bisexual, or transgender a little or none of the time	85.9	85.6	85.8	85.7
Youth felt others in the program were picked on, teased, or bullied because of their racial or ethnic background a little or none of the time	88.0	87.9	88.1	87.8
Reported number of youth completing exit survey	**55,413**	**71,180**	**64,333**	**64,587**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Table A.14. Youths' perceptions that program participation prepared them for adulthood

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were much more or somewhat more likely to				
Be prepared for adulthood[a]	72.9	73.2	72.9	72.0
Be the best they can be	80.9	80.7	80.0	79.6
Make plans to reach goals	79.7	80.1	79.7	78.8
Get a steady job after they finish school	80.0	79.2	79.1	78.6
Care about doing well in school	78.5	78.8	78.1	77.2
Make healthy decisions about drugs or alcohol	76.8	76.8	77.2	76.5
Get more education after high school	76.8	76.4	75.9	74.7
Be respectful toward others	74.0	74.2	74.1	73.8
Resist or say no to peer pressure	72.8	73.1	73.5	72.8
Manage money carefully	73.1	73.8	73.0	72.6
Form friendships that keep them out of trouble	68.7	68.9	69.0	68.1
Share ideas or talk with parent/guardian	64.1	65.3	65.3	63.7
Manage conflict without causing more conflict	61.3	61.8	61.6	60.2
Know how to manage stress	61.5	62.1	61.4	59.7
Reported number of youth completing exit survey	**55,413**	**71,180**	**64,333**	**64,587**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] This item is an average percentage of PREP program participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

Table A.15. Youths' intentions toward sex at program exit

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were				
Much less or somewhat less likely to have sexual intercourse in next six months	59.0	62.2	61.8	61.2
Much more or somewhat more likely to abstain from sex in next six months	52.9	56.7	56.3	54.7
Much more or somewhat more likely to use birth control if having sex in next six months[a]	69.5	69.7	70.2	69.7
Much more or somewhat more likely to use a condom if having sex in next six months[a]	76.8	76.9	77.4	76.6
Reported number of youth completing exit survey	**55,413**	**71,180**	**64,333**	**64,587**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

[a] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table A.16. Youths' perceptions of program effects on adulthood and sexual behavior at program exit, by primary age group program served

Measure	Programs primarily serving middle school-age youth	Programs primarily serving high school-age youth
Percentage of youth who felt prepared for adulthood[a]	74.8	71.9
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	77.9	56.3
Much more or somewhat more likely to abstain from sex in next six months	69.2	54.2
Much more or somewhat more likely to use birth control if having sex in next six months[b]	66.8	70.3
Much more or somewhat more likely to use a condom if having sex in next six months[b]	76.0	77.1
Reported number of youth completing exit survey	**102,379**	**241,301**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of PREP program participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table A.17. Youths' perceptions of program effects on adulthood and sexual behavior at program exit, by programs primarily serving highly vulnerable populations

Measure	Programs primarily serving a highly vulnerable population	Programs not primarily serving a highly vulnerable population
Percentage of youth who felt prepared for adulthood[a]	73.3	72.7
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	49.6	62.6
Much more or somewhat more likely to abstain from sex in next six months	49.2	58.5
Much more or somewhat more likely to use birth control if having sex in next six months[b]	66.4	70.3
Much more or somewhat more likely to use a condom if having sex in next six months[b]	72.2	77.6
Reported number of youth completing exit survey	**34,766**	**300,385**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of PREP program participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table A.18. Youths' perceptions of program effects on adulthood and sexual behavior at program exit, by program setting

Measure	Programs operating during school	Programs operating out of school
Percentage of youth who felt prepared for adulthood[a]	72.0	76.0
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	63.9	51.1
Much more or somewhat more likely to abstain from sex in next six months	59.5	50.4
Much more or somewhat more likely to use birth control if having sex in next six months[b]	70.2	68.5
Much more or somewhat more likely to use a condom if having sex in next six months[b]	77.6	74.7
Reported number of youth completing exit survey	**277,847**	**65,842**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of PREP program participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table A.19. Implementation challenges and interest in technical assistance (percentage of providers)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of providers who reported that a challenge was somewhat or a serious problem				
Getting youth to attend regularly	42.1	40.3	38.6	40.8
Youth behavioral problems	35.3	36.2	31.5	39.5
Keeping youth engaged	37.0	36.9	36.9	36.9
Staff turnover	28.6	31.2	32.7	33.8
Recruiting youth	42.7	34.9	32.5	33.5
Recruiting qualified staff	18.7	21.0	15.9	20.8
Ensuring facilitators understand content	7.6	6.8	8.4	10.1
Percentage of providers who reported being interested or very interested in a technical assistance topic				
Keeping youth engaged	51.0	46.2	50.7	43.6
Addressing youth behavior issues	44.6	44.4	50.0	41.8
Getting youth to attend regularly	44.8	41.8	42.3	41.6
Training facilitators	39.3	41.5	42.5	38.4
Recruiting youth	47.1	41.5	43.0	36.4
Minimizing negative peer reactions	32.6	36.7	31.5	34.3
Retaining staff	22.9	26.7	29.4	24.9
Recruiting qualified staff	23.1	26.2	29.4	22.6
Number of providers	**428**	**439**	**464**	**385**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State, Tribal, and Competitive PREP grantees.

APPENDIX B:

STATE PREP TABLES

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Table B.1. State PREP grant structure and scale

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of grantees	48	48	49	49	49	47
Percentage of grantees that[a]						
Serve as program provider only	n.a	n.a	16.7	6.1	6.3	4.3
Have subawardees as program providers only	n.a	n.a	83.3	87.8	91.7	89.4
Combine methods for program providers	n.a	n.a	0.0	6.1	2.1	6.4
Number of program providers	306	323	339	358	387	353
Percentage of program providers that first received award during reporting period	78.1	15.8	10.9	8.7	15.0	19.3
Percentage of program providers serving youth during the reporting period	79.1	96	97.1	94.1	95.1	96.3
Number of programs	267	386	417	426	453	426
Average number of providers per grantee	6.4	6.7	6.9	7.3	7.9	7.5
Average number of programs per grantee	5.6	8.0	8.5	8.7	9.2	9.1
Average number of programs per program provider	0.9	1.2	1.2	1.2	1.2	1.2
Number of facilitators	**1,315**	**2,415**	**2,705**	**3,185**	**3,125**	**2,775**
Number of youth	**n.a**	**n.a**	**85,980**	**98,562**	**93,960**	**84,805**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

n.a. = not applicable.

Table B.2. State PREP grantee staffing

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Average number of grantee staff	2.5	2.4	2.3	2.3	2.9	2.7
Average number of grantee staff FTE	1.5	1.4	1.4	1.4	1.7	1.9
Number of grantees	**48**	**48**	**49**	**49**	**49**	**47**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Staff includes grantee staff involved in overseeing PREP and does not include program provider or facilitator staff.

FTE = full-time equivalent.

Table B.3. State PREP support for program implementation

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of grantees whose staff or designees						
Provided technical assistance	89.6	100.0	95.7	95.9	98.0	95.7
Provided training	85.4	93.8	85.1	89.8	91.8	91.5
Observed program delivery	77.1	89.6	95.7	98.0	98.0	97.9
Percentage of facilitators						
Trained	102.7	84.0	97.1	97.6	99.0	95.2
Observed at all	39.8	47.7	45.4	45.3	37.2	38.6
Observed once	17.1	23.3	24.7	25.9	21.9	19.1
Observed twice or more	22.7	24.4	20.7	19.4	15.4	19.4
Percentage of providers that observed facilitators	69.4	71.6	89.1	89.3	85.2	86.8
Number of grantees	**48**	**48**	**49**	**49**	**49**	**47**
Number of facilitators	**1,315**	**2,415**	**2,705**	**3,185**	**3,125**	**2,775**
Number of providers	**242**	**310**	**329**	**336**	**386**	**340**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: One outlier in 2015–2016 was removed from the analysis of facilitators. This provider reported 1,583 facilitators in 2015–2016, compared with 23 in 2014–2015 and 53 in 2016–2017.

Table B.4. State PREP implementation of evidence-based program models

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs implementing an evidence-based program model	93.8	93.9	94.3	90.8
Percentage of youth served by programs implementing an evidence-based program model	95.9	97.1	95.5	92.8
Number of programs	**417**	**426**	**453**	**426**
Number of youth	**85,980**	**98,562**	**93,960**	**84,805**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Table B.5. State PREP program models implemented (percentage of programs)

Program model	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Making Proud Choices![a]	15.7	14.8	17.7	16.7	16.1	20.0
Teen Outreach Program (TOP)[a]	17.6	17.1	15.8	16.4	14.3	15.0
Be Proud! Be Responsible![a]	4.5	10.6	12.0	12.7	12.8	14.6
Reducing the Risk[a]	19.5	13.7	13.7	13.8	15.7	14.3
SHARP[a]	0.0	4.7	4.1	5.6	5.3	5.2
¡Cuidate![a]	4.1	5.7	4.1	3.3	3.5	3.3
Draw the Line/Respect the Line[a]	4.1	3.4	6.0	6.8	9.1	3.3
Making a Difference![a]	2.2	3.4	2.9	3.3	2.6	2.8
SiHLE[a]	0.0	3.6	2.9	2.8	2.6	2.1
Promoting Health Among Teens (PHAT)! Comprehensive Abstinence and Safer Sex Intervention[a]	1.9	2.3	2.4	1.9	1.3	1.9
Family Life and Sexual Health (FLASH)	0.0	0.0	0.0	0.0	0.0	1.6
Wise Guys	1.1	0.8	0.7	0.7	1.3	1.6
Adult Identity Mentoring (Project AIM)[a]	1.1	1.0	1.0	0.7	0.7	1.4
Safer Choices[a]	3.4	2.3	1.9	1.9	2.0	1.4
Becoming a Responsible Teen (BART)[a,b]	2.2	2.1	1.4	0.7	1.1	0.9
Rikers Health Advocacy Program (RHAP)[a,b]	2.2	2.6	2.4	1.9	0.9	0.9
Sisters Saving Sisters[a]	4.5	0.0	0.0	0.0	0.0	0.9
Street Smart	5.6	3.4	3.1	3.1	1.8	0.9
All4You![a]	1.5	1.3	0.7	0.5	0.9	0.7
Be Proud! Be Responsible! Be Protective![a]	0.7	1.3	1.0	1.2	1.1	0.7
FOCUS[a]	0.7	0.5	0.5	0.5	0.4	0.5
Get Real[a]	0.0	0.0	0.0	0.0	0.0	0.5
Michigan Model–Healthy & Responsible Relationships	0.7	0.5	0.5	0.5	0.4	0.5
It's Your Game: Keep It Real (IYG)[a]	0.4	0.3	0.2	0.2	0.2	0.0
Power Through Choices[a,b]	0.4	0.3	0.2	0.2	0.4	0.5
Safer Sex	0.0	0.3	0.5	0.2	0.2	0.5
Families Talking Together[a]	0.0	0.0	0.0	0.0	0.0	0.2
Promoting Health Among Teens (PHAT)! Abstinence Only Intervention[a]	0.4	0.3	0.2	0.2	0.2	0.2
Sexual Wellness and Advocacy by Teens	0.4	0.3	0.2	0.2	0.2	0.2
The Fourth R: Alaska Perspectives	0.4	0.3	0.0	0.0	0.2	0.2
The Grassroots Project	0.4	0.3	0.2	0.2	0.2	0.2
17 Days[a]	0.0	0.0	0.0	0.0	0.0	0.2
Teen Health Project[a]	1.5	1.0	0.5	0.5	0.4	0.0
Teen Life Clubs–Steps to S.T.A.R.dom Curriculum	0.4	0.3	0.2	0.2	0.2	0.0
Other	0.0	0.0	0.5	0.5	0.9	2.3
Number of programs	**267**	**386**	**417**	**426**	**453**	**426**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] The U.S. Department of Health and Human Services (HHS) has identified the program model as an evidence-based program.

[b] Becoming a Responsible Teen and Rikers Health Advocacy Program were included during the 2013–2014 through 2015–2016 reporting periods but were no longer included on the list of HHS evidence-based teen pregnancy prevention programs in the 2016–2017 reporting period. Power Through Choices was added to the list in 2016–2017.

Table B.6. State PREP adulthood preparation subjects (APSs) implemented (percentage of programs)

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of APSs implemented[a]						
0–2 subjects	6.7	8.5	3.4	4.7	2.0	4.7
3 subjects	60.3	61.7	67.0	70.4	60.3	57.9
4 subjects	22.1	19.9	18.8	16.0	29.4	22.8
5 subjects	5.2	5.7	5.1	4.7	3.8	7.3
6 subjects	5.6	4.1	5.8	4.2	4.6	7.3
Subject implemented[b]						
Healthy relationships	88.0	94.0	97.3	96.9	96.0	97.4
Healthy life skills	71.5	74.9	79.0	80.7	88.3	80.2
Adolescent development	69.7	69.9	76.9	71.7	75.3	71.3
Parent-child communication	45.3	45.6	41.9	39.2	46.1	48.2
Educational and career success	34.6	25.7	26.0	23.8	23.8	31.1
Financial literacy	27.4	20.0	20.6	20.5	19.7	25.2
Number of programs	**267**	**386**	**417**	**426**	**453**	**426**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Percentages do not sum to 100 percent because programs could implement more than three subjects. Adult preparation subjects are not mutually exclusive.

Table B.7. State PREP implementation setting

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs serving youth in[a]				
Schools, during school	51.3	54.6	58.1	54.9
Community-based organizations	35.3	35.6	34.2	35.3
Juvenile detention centers	15.8	19.5	16.1	16.9
Schools, after school	18.2	16.6	13.8	15.5
Foster care settings	12.4	13.2	12.4	12.2
Clinics	3.9	5.0	3.2	2.4
Other settings	14.8	13.2	9.7	13.4
Percentage of youth served in[b]				
Schools, during school	73.3	75.6	77.2	75.3
Community-based organizations	9.8	8.5	7.9	9.9
Juvenile detention centers	5.8	4.9	3.5	4.5
Schools, after school	5.3	3.2	3.5	3.8
Foster care settings	3.0	3.0	3.4	2.6
Clinics	0.9	2.0	1.6	0.2
Other settings	3.3	2.8	2.9	3.7
Number of programs	**417**	**426**	**453**	**426**
Number of youth	**85,980**	**98,562**	**93,960**	**84,805**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] Percentages do not sum to 100 percent because programs could be implemented in more than one setting.

[b] Percentages may not sum to 100 percent due to rounding.

Table B.8. State PREP intended dosage and receipt

Measure	2013–2014 reporting period	2014–2015 reporting period	201–-2016 reporting period	2016–2017 reporting period
Average hours of intended programming	15.8	19.4	19.3	14.2
Percentage of youth in out-of-school-time programs who completed at least 75 percent of the intended dosage[a]	70.4	73.4	75.1	73.2
Number of programs	**417**	**426**	**453**	**426**
Number of youth from out-of-school-time programs	**22,086**	**23,933**	**21,406**	**20,905**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] This result is based on programs that served youth during out-of-school time. Because these programs are generally voluntary and do not take place during the school day, youth are likely to attend less frequently.

Table B.9. State PREP demographic characteristics of youth (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Female	51.6	52.3	52.5	50.6
Hispanic or Latino	33.5	35.8	33.8	39.3
Ethnicity[a]				
Mexican, Mexican American, Chicano	71.5	68.2	66.8	67.4
Puerto Rican	11.9	12.4	13.1	12.1
Cuban	1.0	1.1	1.0	1.1
Other Hispanic or Latino	15.6	18.3	19.1	19.5
Race[b]				
American Indian or Alaska Native	11.9	11.0	10.6	12.4
Asian	3.6	3.7	3.9	4.6
Black or African American	45.3	42.3	38.6	34.5
Native Hawaiian or Other Pacific Islander	2.2	3.1	3.0	4.2
White	46.3	47.8	51.3	53.8
Age[a]				
10–12	11.6	12.9	12.3	10.5
13 or 14	37.9	37.8	41.1	40.3
15 or 16	34.8	33.5	32.3	34.7
17 or 18	13.5	13.3	12.3	12.7
19 and older	2.2	2.5	2.0	1.9
Grade level[a]				
4th–6th	6.0	6.9	6.7	5.5
7th or 8th	31.6	31.3	32.1	29.6
9th or 10th	41.8	42.6	43.2	45.2
11th or 12th	15.8	15.4	14.5	16.1
Dropped out of school	0.3	0.3	0.3	0.3
Working toward GED	0.8	0.9	0.7	0.9
Earned diploma or GED and in postsecondary school	0.7	0.8	0.9	0.9
Earned diploma or GED and not in postsecondary school	1.0	1.4	1.3	0.7
School does not assign grade levels	2.1	0.5	0.4	0.7
Sexual and gender orientation[b,c]				
Straight	90.3	86.6	87.6	86.7
Gay or lesbian	2.0	2.2	2.3	2.5
Bisexual	5.9	7.1	7.5	8.3
Transgender	0.8	0.5	0.7	0.7
Something else/have not decided	1.9	2.2	2.8	3.3
Reported number of youth completing entry survey	**48,799**	**53,978**	**51,378**	**52,521**
Reported number of youth completing exit survey	**47,092**	**52,822**	**53,743**	**53,250**

Source: Entry and exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Notes: All items except for sexual and gender orientation were from the exit survey.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Youth could select more than one item, so percentages can sum to more than 100 percent.

[c] This item was considered a sensitive item and was only asked of high school-age youth on the entry survey.

GED = general equivalency diploma.

Table B.10. State PREP targeted populations (percentage of programs)

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youth in high-need geographic areas	77.4	74.1	75.7	73.2	77.0	78.4
African American youth	57.0	54.4	48.9	45.6	45.8	44.7
Hispanic/Latino youth	41.1	46.9	40.2	39.2	41.1	38.6
Youth in foster care	34.6	34.2	31.1	31.6	38.5	34.4
Youth in adjudication systems	32.2	29.8	31.8	27.9	26.9	36.5
Male youth	42.4	41.2	32.1	28.1	32.1	31.1
LGBTQ youth	22.3	22.0	21.2	24.8	32.4	30.6
Pregnant or parenting youth	29.4	24.6	21.7	19.1	27.8	21.2
Homeless or runaway youth	16.2	16.1	14.7	13.7	22.0	17.6
Youth in residential treatment for mental health issues	14.4	14.5	9.6	9.9	13.7	16.5
Out of school/dropout youth	18.6	16.6	15.4	11.3	10.2	13.6
Native American youth	13.3	12.4	11.1	13.5	18.6	10.6
Youth living with HIV/AIDS	10.2	4.4	5.5	4.3	12.9	4.7
Number of programs	**267**	**386**	**417**	**426**	**453**	**426**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Target populations are not mutually exclusive; programs could target more than one population.

LGBTQ = lesbian, gay, bisexual, transgender or questioning.

Table B.11. State PREP service to highly vulnerable populations, by programs operating during out-of-school time (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
At least 50 percent of youth served were from any highly vulnerable population	42.0	49.2	50.3	41.8
In adjudication systems	19.5	30.7	23.2	22.2
In foster care	15.5	16.4	24.3	18.0
In residential treatment for mental health	5.5	4.8	10.3	11.1
Identified as LGBTQ	2.0	3.2	4.9	6.9
Homeless or runaway	2.0	4.2	4.3	5.3
Pregnant or parenting	2.5	2.6	5.9	3.7
Living with HIV/AIDS	0.0	0.0	0.5	1.1
Trouble speaking or understanding English	2.5	2.6	1.1	0.5
Number of programs	**200**	**189**	**185**	**189**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: The percentage of population categories do not sum to the percentage of programs primarily serving any highly vulnerable population, because population categories are not mutually exclusive; a program might serve more than one population.

Programs reported whether at least 50 percent of youth served were from each of the highly vulnerable populations. They did not report the percentage of youth in each category.

LGBTQ = lesbian, gay, bisexual, transgender, or questioning.

Table B.12. State PREP high school-age youth sexual behaviors at program entry (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Ever had sexual intercourse	44.4	42.9	39.5	37.1
Ever been pregnant or gotten someone pregnant[a]	20.2	18.0	19.5	19.5
Number of times pregnant or gotten someone pregnant[a,b]				
0 pregnancies	79.8	82.5	81.6	80.3
1 pregnancy	14.7	12.8	13.2	13.9
2 pregnancies	3.9	3.3	3.3	3.8
3 or more pregnancies	1.7	1.6	1.8	2.0
Number of sexual partners in the past three months[a,b]				
0 people	30.4	34.7	29.6	29.2
1 person	46.8	44.8	50.0	48.9
2 or 3 people	16.1	14.4	15.1	15.6
4 or more people	6.7	6.3	5.2	6.4
Frequency of birth control use in the past three months[b,c]				
All the time	37.3	38.2	39.0	37.0
Most of the time	12.2	12	11.6	11.4
Some of the time	11.8	11.9	11.1	11.3
None of the time	38.6	38.2	38.2	40.2
Frequency of condom use in the past three months[b,c]				
All the time	38.9	38.0	36.8	33.8
Most of the time	17.4	16.1	15.7	14.9
Some of the time	18.0	17.8	16.4	17.2
None of the time	25.7	28.4	31.0	34.2
Reported number of youth completing entry survey	**48,799**	**53,978**	**51,378**	**52,521**

Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the items.

[a] Asked only of those who had ever had sexual intercourse.

[b] Percentages might not sum to 100 percent due to rounding.

[c] Asked only of those who had one or more sexual partners in the past three months.

Table B.13. State PREP youths' perceptions of the program at program exit (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youths' perceptions of PREP program delivery				
The material presented was clear all or most of the time	85.3	85.9	85.8	85.7
Discussions or activities helped youth learn program lessons all or most of the time	84.2	84.5	83.9	83.5
Youth had a chance to ask questions about topics or issues that came up in the program all or most of the time	76.8	76.3	76.7	76.2
Youth were interested in program sessions and classes all or most of the time	72.2	71.5	70.4	70.1
Youths' perceptions of PREP program environment				
Youth felt respected as people all or most of the time	87.3	87.4	87.2	86.6
Youth felt picked on, teased, or bullied in the program a little or none of the time	82.6	83.2	82.9	82.7
Youth felt others in the program were picked on, teased, or bullied because people thought they were lesbian, gay, bisexual, or transgender a little or none of the time	85.9	85.7	86.3	85.6
Youth felt others in the program were picked on, teased, or bullied because of their racial or ethnic background a little or none of the time	88.0	87.9	88.4	87.7
Reported number of youth completing exit survey	**47,092**	**52,822**	**53,743**	**53,250**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Table B.14. State PREP youths' perceptions that program participation prepared them for adulthood

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were much more or somewhat more likely to				
Be prepared for adulthood[a]	72.7	73.3	72.9	71.5
Be the best they can be	80.8	81.0	79.8	79.1
Make plans to reach goals	79.8	80.5	79.6	78.4
Get a steady job after they finish school	79.9	79.3	78.9	77.9
Care about doing well in school	78.0	78.9	77.9	76.4
Make healthy decisions about drugs or alcohol	76.6	76.8	77.3	76.0
Get more education after high school	76.7	76.6	75.8	73.7
Be respectful toward others	73.8	74.4	73.7	73.4
Resist or say no to peer pressure	72.5	73.4	73.6	72.3
Form friendships that keep them out of trouble	68.4	68.9	69.0	67.5
Share ideas or talk with parent/guardian	64.0	65.5	65.5	63.3
Manage conflict without causing more conflict	61.2	62.1	62.2	60.0
Know how to manage stress	61.4	62.1	61.6	59.2
Reported number of youth completing exit survey	**47,092**	**52,822**	**53,743**	**53,250**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] This item is an average percentage of State PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

Table B.15. State PREP youths' intentions toward sex at program exit

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were				
Much less or somewhat less likely to have sexual intercourse in next six months	56.9	59.5	60.4	59.4
Much more or somewhat more likely to abstain from sex in next six months	53.9	55.1	55.4	53.1
Much more or somewhat more likely to use birth control if having sex in next six months[a]	70.8	71.0	71.2	70.2
Much more or somewhat more likely to use a condom if having sex in next six months[a]	77.9	77.6	77.9	77.0
Reported number of youth completing exit survey	**47,092**	**52,822**	**53,743**	**53,250**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

[a] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table B.16. State PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by primary age group program served

Measure	Programs primarily serving middle school-age youth	Programs primarily serving high school-age youth
Percentage of youth who felt prepared for adulthood[a]	75.2	71.8
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	76.9	55.0
Much more or somewhat more likely to abstain from sex in next six months	66.5	51.6
Much more or somewhat more likely to use birth control if having sex in next six months[b]	68.9	71.1
Much more or somewhat more likely to use a condom if having sex in next six months[b]	77.6	77.6
Reported number of youth completing exit survey	**66,150**	**197,784**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of State PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table B.17. State PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by programs primarily serving highly vulnerable populations

Measure	Programs primarily serving a highly vulnerable population	Programs not primarily serving a highly vulnerable population
Percentage of youth who felt prepared for adulthood[a]	72.4	72.5
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	45.6	60.9
Much more or somewhat more likely to abstain from sex in next six months	44.9	55.5
Much more or somewhat more likely to use birth control if having sex in next six monthsb	67.5	71.3
Much more or somewhat more likely to use a condom if having sex in next six monthsb	73.3	78.3
Reported number of youth completing exit survey	**26,198**	**230,181**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of State PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table B.18. State PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by program setting

Measure	Programs operating during school	Programs operating out of school
Percentage of youth who felt prepared for adulthood[a]	71.8	75.8
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	62.0	49.7
Much more or somewhat more likely to abstain from sex in next six months	56.2	48.3
Much more or somewhat more likely to use birth control if having sex in next six months[b]	71.4	69.1
Much more or somewhat more likely to use a condom if having sex in next six months[b]	78.5	75.1
Reported number of youth completing exit survey	**207,599**	**56,344**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of State PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table B.19. State PREP implementation challenges and interest in technical assistance (percentage of providers)

Measure	2011–2012 reporting period	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of providers who reported that a challenge was somewhat or a serious problem						
Getting youth to attend regularly	53.7	52.4	43.3	43.2	41.0	42.1
Youth behavioral problems	31.0	33.9	41.0	39.9	33.0	37.7
Keeping youth engaged	40.5	35.6	38.9	40.5	39.0	37.7
Staff turnover	31.0	29.4	28.3	32.4	34.3	34.4
Recruiting youth	52.1	44.8	43.8	36.0	33.0	33.8
Recruiting qualified staff	17.8	20.0	19.2	22.0	16.1	21.2
Ensuring facilitators understand content	14.9	9.4	8.2	7.4	7.9	10.9
Percentage of providers who reported being interested or very interested in a technical assistance topic						
Keeping youth engaged	59.1	42.9	52.0	50.9	53.4	45.3
Getting youth to attend regularly	53.3	40.3	46.2	45.8	44.1	43.8
Addressing youth behavior issues	51.5	45.6	48.3	47.9	52.3	43.5
Training facilitators	36.8	33.2	42.3	43.5	44.4	40.3
Recruiting youth	36.8	33.2	42.3	43.5	44.4	40.3
Minimizing negative peer reactions	38.4	37.4	35.0	40.2	32.4	36.2
Retaining staff	27.3	26.1	23.4	27.1	30.0	25.6
Recruiting qualified staff	23.6	18.7	25.2	26.8	29.4	23.2
Number of providers	**242**	**310**	**329**	**336**	**386**	**340**

Source: Measures of structure and support for implementation data from 2011–2012, 2012–2013, 2013–2014, 2014–2015, 2015–2016, and 2016–2017 State PREP grantees.

APPENDIX C:

TRIBAL PREP TABLES

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Table C.1. Tribal PREP grant structure and scale

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Number of grantees	16	16	16	14
Percentage of grantees that[a]				
Serve as program provider only	n.a	61.5	62.5	69.2
Have subawardees as program providers only	n.a	30.8	18.8	23.1
Combine methods for program providers	n.a	7.7	18.8	7.7
Number of program providers	27	37	41	38
Percentage of program providers that first received award during reporting period	14.8	27.0	34.1	2.6
Percentage of program providers serving youth during the reporting period	96.3	81.1	87.8	67.6
Number of programs	27	32	37	26
Average number of providers per grantee	1.7	2.3	2.6	2.7
Average number of programs per grantee	1.7	2.0	2.3	1.9
Average number of programs per program provider	1.0	0.9	0.9	0.7
Number of facilitators	**75**	**69**	**92**	**53**
Number of youth		**2,192**	**2,948**	**1,738**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

n.a. = not applicable.

Table C.2. Tribal PREP grantee staffing

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Average number of grantee staff	4.6	3.8	2.8	2.4
Average number of grantee staff FTE	2.0	1.9	1.6	1.7
Number of grantees	**16**	**16**	**16**	**14**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: Staff includes grantee staff involved in overseeing PREP and does not include program provider or facilitator staff.

FTE = full-time equivalent.

Table C.3. Tribal PREP support for program implementation

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of grantees whose staff or designees				
Provided technical assistance	87.5	93.8	81.3	92.3
Provided training	87.5	81.3	87.5	92.3
Observed program delivery	93.8	100.0	100.0	92.3
Percentage of facilitators				
Trained	100.0	97.1	98.9	100.0
Observed at all	73.3	55.1	69.6	77.4
Observed once	24.0	14.5	31.5	50.9
Observed twice or more	49.3	40.6	38.0	26.4
Percentage of providers that observed facilitators	73.1	69.0	80.6	84.0
Number of grantees	**16**	**16**	**16**	**14**
Number of facilitators	**75**	**69**	**92**	**53**
Number of providers	**26**	**29**	**36**	**25**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Table C.4. Tribal PREP Implementation of evidence-based program models

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of programs implementing an evidence-based program model	90.6	86.5	88.5
Percentage of youth served by programs implementing an evidence-based program model	86.4	78.0	48.6
Number of programs	**32**	**37**	**26**
Number of youth	**2,192**	**2,948**	**1,738**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Tribal PREP grantees.

Table C.5. Tribal PREP program models implemented (percentage of programs)

Program model	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Becoming a Responsible Teen (BART)[a,b]	22.2	21.9	13.5	23.1
Draw the Line/Respect the Line[a]	22.2	18.8	16.2	23.1
It's Your Game: Keep It Real (IYG)[a]	18.5	12.5	32.4	23.1
Making Proud Choices![a]	18.5	15.6	13.5	11.5
Making a Difference![a]	3.7	0.0	2.7	3.8
SHARP[a]	3.7	3.1	2.7	3.8
The Fourth R: Alaska Perspectives	0.0	0.0	0.0	3.8
Adult Identity Mentoring (Project AIM)[a]	0.0	0.0	2.7	3.1
CAS-Carrera Program[a]	3.7	3.1	2.7	0.0
SiHLE[a]	0.0	3.1	0.0	0.0
All4You![a]	3.7	3.1	0.0	0.0
Other	3.7	6.3	10.8	7.7
Number of programs	**27**	**32**	**37**	**26**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] The U.S. Department of Health and Human Services (HHS) has identified the program model as an evidence-based program.

[b] Becoming a Responsible Teen and Rikers Health Advocacy Program were included during the 2013–2014 through 2015–2016 reporting periods but were no longer included on the list of HHS evidence-based teen pregnancy prevention programs in the 2016–2017 reporting period.

Table C.6. Tribal PREP adulthood preparation subjects (APSs) implemented (percentage of programs)

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Number of APSs implemented[a]				
0–2 subjects	0.0	9.4	0.0	0.0
3 subjects	70.4	40.6	29.7	42.3
4 subjects	18.5	37.5	40.5	26.9
5 subjects	0.0	6.3	21.6	23.1
6 subjects	11.1	6.3	8.1	7.7
Subject implemented[b]				
Healthy life skills	63.0	84.4	97.3	92.3
Parent-child communication	88.9	84.4	97.3	92.3
Healthy relationships	77.8	87.5	86.5	76.9
Adolescent development	66.7	43.8	83.8	76.9
Educational and career success	40.7	25.0	27.0	34.6
Financial literacy	14.8	15.6	16.2	23.1
Number of programs	**27**	**32**	**37**	**26**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Percentages do not sum to 100 percent because programs could implement more than three subjects. Adult preparation subjects are not mutually exclusive.

Table C.7. Tribal PREP implementation setting

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of programs serving youth in[a]			
Schools, during school	37.5	58.1	60.0
Community-based organizations	31.3	22.6	40.0
Schools, after school	12.5	16.1	10.0
Clinics	28.1	16.1	10.0
Foster care settings	0.0	0.0	0.0
Juvenile detention centers	0.0	0.0	0.0
Other settings	0.0	3.2	5.0
Percentage of youth served in[b]			
Schools, during school	74.6	81.1	69.7
Community-based organizations	7.1	3.8	14.0
Schools, after school	10.5	11.0	12.0
Clinics	7.8	3.5	1.7
Foster care settings	0.0	0.0	0.0
Juvenile detention centers	0.0	0.0	0.0
Other settings	0.0	0.5	2.6
Number of programs	**32**	**37**	**26**
Number of youth	**2,192**	**2,948**	**1,738**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] Percentages do not sum to 100 percent because programs could be implemented in more than one setting.

[b] Percentages may not sum to 100 percent due to rounding.

Table C.8. Tribal PREP intended dosage and receipt

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–-2016 reporting period
Average hours of intended programming	28.5	30.1	16.5
Percentage of youth in out-of-school-time programs who completed at least 75 percent of the intended dosage[a]	50.8	70.2	97.0
Number of programs	**32**	**37**	**26**
Number of youth from out-of-school-time programs	**541**	**523**	**526**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] This result is based on programs that served youth during out-of-school time. Because these programs are generally voluntary and do not take place during the school day, youth are likely to attend less frequently.

Table C.9. Tribal PREP demographic characteristics of youth (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Female	50.4	51.7	50.6
Hispanic or Latino	18.6	17.7	18.2
Ethnicity[a]			
Mexican, Mexican American, Chicano	79.5	76.1	78.2
Puerto Rican	1.7	1.5	1.8
Cuban	1.4	1.0	1.0
Other Hispanic or Latino	17.5	21.4	18.9
Race[b]			
American Indian or Alaska Native	73.9	70.2	72.9
Asian	1.3	1.5	1.5
Black or African American	5.9	11.7	8.0
Native Hawaiian or Other Pacific Islander	1.8	2.6	1.5
White	43.1	41.5	37.1
Age[a]			
10–12	27.4	33.0	29.1
13 or 14	56.6	49.7	50.5
15 or 16	11.1	11.9	13.5
17 or 18	3.9	4.9	6.4
19 and older	1.0	0.5	0.5
Grade level[a]			
4th–6th	22.6	28.6	26.3
7th or 8th	62.2	60.1	53.9
9th or 10th	8.7	9.1	11
11th or 12th	6	2.1	8.6
Dropped out of school	0.1	0.0	0.0
Working toward GED	0.1	0.0	0.0
Earned diploma or GED and in postsecondary school	0.1	0.0	0.0
Earned diploma or GED and not in postsecondary school	0.3	0.1	0.2
School does not assign grade levels	0.0	0.0	0.0
Sexual and gender orientation[b,c]			
Straight	85.2	85.1	83.8
Gay or lesbian	2.3	2.3	2.7
Bisexual	9.9	12.5	13.5
Transgender	2.0	0.3	0.0
Something else/have not decided	1.9	1.8	2.2
Reported number of youth completing entry survey	**1,748**	**1,170**	**640**
Reported number of youth completing exit survey	**1,624**	**968**	**841**

Source: Entry and exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: All items except for sexual and gender orientation were from the exit survey.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Youth could select more than one item, so percentages can sum to more than 100 percent.

[c] This item was considered a sensitive item and was only asked of high school-age youth on the entry survey.

GED = general equivalency diploma.

Table C.10. Tribal PREP targeted populations (percentage of programs)

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Youth in high-need geographic areas	77.8	37.5	45.9	50.0
Native American youth	100.0	93.8	100.0	100.0
Male youth	37.0	12.5	18.9	42.3
LGBTQ youth	33.3	9.4	5.4	26.9
Hispanic/Latino youth	14.8	6.3	8.1	11.5
African American youth	14.8	0.0	5.6	11.5
Out of school/dropout youth	29.6	0.0	5.4	11.5
Pregnant or parenting youth	22.2	6.3	24.3	7.7
Youth living with HIV/AIDS	22.2	3.1	0.0	7.7
Youth in adjudication systems	11.1	3.1	2.7	3.8
Homeless or runaway youth	22.2	6.3	2.7	0.0
Youth in foster care	29.6	12.5	0.0	0.0
Youth in residential treatment for mental health issues	0.0	0.0	0.0	0.0
Number of programs	**27**	**32**	**37**	**26**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: Target populations are not mutually exclusive; programs could target more than one population.

LGBTQ = lesbian, gay, bisexual, transgender or questioning.

Table C.11. Tribal PREP service to highly vulnerable populations by programs operating during out-of-school time (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
At least 50 percent of youth served were from any highly vulnerable population	0.0	0.0	0.0
In adjudication systems	0.0	0.0	0.0
In foster care	0.0	0.0	0.0
In residential treatment for mental health	0.0	0.0	0.0
Identified as LGBTQ	0.0	0.0	0.0
Pregnant or parenting	0.0	0.0	0.0
Homeless or runaway	0.0	0.0	0.0
Trouble speaking or understanding English	0.0	0.0	0.0
Living with HIV/AIDS	0.0	0.0	0.0
Number of programs	**20**	**13**	**8**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: The percentage of population categories do not sum to the percentage of programs primarily serving any highly vulnerable population, because population categories are not mutually exclusive; a program might serve more than one population.

Programs reported whether at least 50 percent of youth served were from each of the highly vulnerable populations. They did not report the percentage of youth in each category.

LGBTQ = lesbian, gay, bisexual, transgender, or questioning.

Table C.12. Tribal PREP high school-age youth sexual behaviors at program entry (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Ever had sexual intercourse	32.8	46.8	41.3
Ever been pregnant or gotten someone pregnant[a]	17.6	12.8	18.8
Number of times pregnant or gotten someone pregnant[a,b]			
0 pregnancies	82.9	86.9	82.4
1 pregnancy	14.0	10.8	15.9
2 pregnancies	1.9	0.8	1.6
3 or more pregnancies	1.2	1.5	0.0
Number of sexual partners in the past three months[a,b]			
0 people	34.0	30.7	28.4
1 person	39.7	44.1	45.4
2 or 3 people	20.6	19.1	20.2
4 or more people	5.7	6.2	6.0
Frequency of birth control use in the past three months[b,c]			
All the time	38.4	36.8	35.7
Most of the time	10.6	8.9	12.4
Some of the time	12.6	14.1	12.4
None of the time	38.4	40.1	39.5
Frequency of condom use in the past three months[b,c]			
All the time	37.2	35.6	36.4
Most of the time	14.1	17.2	18.6
Some of the time	16.6	17.2	16.3
None of the time	32.2	30.0	28.7
Reported number of youth completing entry survey	**1,748**	**1,170**	**640**

Source: Entry survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the items.

[a] Asked only of those who had ever had sexual intercourse.

[b] Percentages might not sum to 100 percent due to rounding.

[c] Asked only of those who had one or more sexual partners in the past three months.

Table C.13. Tribal PREP youths' perceptions of the program at program exit (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Youths' perceptions of PREP program delivery			
The material presented was clear all or most of the time	81.4	76.7	76.8
Discussions or activities helped youth learn program lessons all or most of the time	80.3	77.6	75.6
Youth had a chance to ask questions about topics or issues that came up in the program all or most of the time	73.4	68.0	67.7
Youth were interested in program sessions and classes all or most of the time	64.9	61.3	62.4
Youths' perceptions of PREP program environment			
Youth felt respected as people all or most of the time	84.4	82.6	79.9
Youth felt picked on, teased, or bullied in the program a little or none of the time	87.3	83.5	82.7
Youth felt others in the program were picked on, teased, or bullied because people thought they were lesbian, gay, bisexual, or transgender a little or none of the time	88.0	85.4	84.2
Youth felt others in the program were picked on, teased, or bullied because of their racial or ethnic background a little or none of the time	90.3	87.1	85.8
Reported number of youth completing exit survey	**1,624**	**968**	**841**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Table C.14. Tribal PREP youths' perceptions that program participation prepared them for adulthood

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of youth who were much more or somewhat more likely to			
Be prepared for adulthood[a]	69.5	70.2	69.7
Be the best they can be	76.2	78.5	76.9
Make plans to reach goals	75.8	76.7	77.2
Get a steady job after they finish school	74.5	75.8	76.5
Care about doing well in school	73.1	74.8	74.2
Make healthy decisions about drugs or alcohol	73.8	76.1	73.9
Get more education after high school	72.0	74.1	73.5
Be respectful toward others	72.7	74.6	75.4
Resist or say no to peer pressure	72.7	70.6	69.5
Manage money carefully	69.5	70.2	72.2
Form friendships that keep them out of trouble	65.6	66.3	64.5
Share ideas or talk with parent/guardian	60.5	61.7	62.1
Manage conflict without causing more conflict	57.9	56.8	55.1
Know how to manage stress	58.6	56.0	55.4
Reported number of youth completing exit survey	**1,624**	**968**	**841**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] This item is an average percentage of Tribal PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

Table C.15. Tribal PREP youths' intentions toward sex at program exit

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of youth who were			
Much less or somewhat less likely to have sexual intercourse in next six months	71.8	76.8	72.8
Much more or somewhat more likely to abstain from sex in next six months	61.4	63.0	56.3
Much more or somewhat more likely to use birth control if having sex in next six months[a]	64.2	62.6	54.2
Much more or somewhat more likely to use a condom if having sex in next six months[a]	75.4	72.6	66.4
Reported number of youth completing exit survey	**1,624**	**968**	**841**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

[a] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table C.16. Tribal PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by primary age group program served

Measure	Programs primarily serving middle school-age youth	Programs primarily serving high school-age youth
Percentage of youth who felt prepared for adulthood[a]	70.8	67.5
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	78.1	64.0
Much more or somewhat more likely to abstain from sex in next six months	64.7	49.2
Much more or somewhat more likely to use birth control if having sex in next six months[b]	60.3	59.6
Much more or somewhat more likely to use a condom if having sex in next six months[b]	71.8	70.3
Reported number of youth completing exit survey	**4,705**	**1,916**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.
Note: Data are aggregated across 2013–2014 through 2015–2016 program years.

[a] This item is an average percentage of Tribal PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table C.17. Tribal PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by programs primarily serving highly vulnerable populations

Measure	Programs primarily serving a highly vulnerable population	Programs not primarily serving a highly vulnerable population
Percentage of youth who felt prepared for adulthood[a]	0.0	69.9
Percentage of youth who were	0.0	
Much less or somewhat less likely to have sexual intercourse in next six months	0.0	73.4
Much more or somewhat more likely to abstain from sex in next six months	0.0	59.8
Much more or somewhat more likely to use birth control if having sex in next six months[b]	0.0	60.0
Much more or somewhat more likely to use a condom if having sex in next six months[b]	0.0	71.5
Reported number of youth completing exit survey	**0**	**5,647**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: Data are aggregated across 2013–2014 through 2015–2016 program years.

[a] This item is an average percentage of Tribal PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table C.18. Tribal PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by program setting

Measure	Programs operating during school	Programs operating out of school
Percentage of youth who felt prepared for adulthood[a]	69.8	70.3
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	75.0	62.0
Much more or somewhat more likely to abstain from sex in next six months	61.0	52.0
Much more or somewhat more likely to use birth control if having sex in next six months[b]	60.0	60.5
Much more or somewhat more likely to use a condom if having sex in next six months[b]	71.4	69.6
Reported number of youth completing exit survey	**6,084**	**537**

Source: Exit survey data from 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

Note: Data are aggregated across 2013–2014 through 2015–2016 program years.

[a] This item is an average percentage of Tribal PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table C.19. Tribal PREP implementation challenges and interest in technical assistance (percentage of providers)

Measure	2012–2013 reporting period	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period
Percentage of providers who reported that a challenge was somewhat or a serious problem				
Keeping youth engaged	38.5	41.4	41.7	36.0
Staff turnover	38.5	27.6	22.2	32.0
Recruiting youth	46.2	48.3	38.9	32.0
Recruiting qualified staff	26.9	20.7	19.4	20.0
Getting youth to attend regularly	38.5	41.4	36.1	16.0
Youth behavioral problems	34.6	24.1	30.6	12.0
Ensuring facilitators understand content	7.7	13.8	8.3	12.0
Percentage of providers who reported being interested or very interested in a technical assistance topic				
Recruiting youth	42.3	51.7	30.6	44.0
Keeping youth engaged	34.6	62.1	41.7	40.0
Addressing youth behavior issues	42.3	48.3	47.2	36.0
Getting youth to attend regularly	38.5	55.2	36.1	32.0
Training facilitators	34.6	34.5	50.0	24.0
Minimizing negative peer reactions	30.8	37.9	47.2	24.0
Retaining staff	26.9	27.6	25.0	24.0
Recruiting qualified staff	23.1	24.1	25.0	24.0
Number of providers	**26**	**29**	**36**	**25**

Source: Measures of structure and support for implementation data from 2012–2013, 2013–2014, 2014–2015, and 2015–2016 Tribal PREP grantees.

APPENDIX D:

COMPETITIVE PREP TABLES

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Table D.1. Competitive PREP grant structure and scale

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of grantees	36	36	23	21
Percentage of grantees that[a]				
Serve as program provider only	68.8	80.6	71.4	78.9
Have subawardees as program providers only	15.6	16.7	14.3	21.1
Combine methods for program providers	15.6	2.8	14.3	0.0
Number of program providers	82	73	40	47
Percentage of program providers that first received award during reporting period	25.6	11.0	42.5	36.2
Percentage of program providers serving youth during the reporting period	92.7	91.8	92.3	95.7
Number of programs	86	81	51	66
Average number of providers per grantee	2.3	2.0	1.7	2.2
Average number of programs per grantee	2.4	2.3	2.2	3.1
Average number of programs per program provider	1.0	1.1	1.3	1.4
Number of facilitators	**334**	**268**	**211**	**233**
Number of youth	**23,439**	**32,280**	**16,321**	**25,286**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

Table D.2. Competitive PREP grantee staffing

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Average number of grantee staff	5.9	5.1	5.0	5.6
Average number of grantee staff FTE	4.1	3.5	3.9	4.0
Number of grantees	**36**	**36**	**23**	**21**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Staff includes grantee staff involved in overseeing PREP and does not include program provider or facilitator staff.

FTE = full-time equivalent.

Table D.3. Competitive PREP support for program implementation

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of grantees whose staff or designees				
Provided technical assistance	94.4	88.9	90.9	81.0
Provided training	94.4	88.9	100.0	95.2
Observed program delivery	97.2	97.2	100.0	95.2
Percentage of facilitators				
Trained	97.9	96.6	97.2	99.1
Observed at all	82.3	88.1	83.9	95.3
Observed once	12.6	17.2	18.5	24.9
Observed twice or more	69.8	70.9	65.4	70.4
Percentage of providers that observed facilitators	87.1	82.1	97.1	100.0
Number of grantees	**36**	**36**	**23**	**21**
Number of facilitators	**334**	**268**	**211**	**233**
Number of providers	**70**	**67**	**36**	**45**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Table D.4. Competitive PREP implementation of evidence-based program models

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs implementing an evidence-based program model	93	97.5	94.1	87.9
Percentage of youth served by programs implementing an evidence-based program model	75.7	99.2	92.8	88.9
Number of programs	**86**	**81**	**51**	**66**
Number of youth	**23,439**	**32,280**	**16,321**	**25,286**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Table D.5. Competitive PREP program models implemented (percentage of programs)

Program model	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Heritage Keepers Abstinence Education[a]	3.5	6.2	7.8	18.2
Making Proud Choices![a]	16.3	12.3	9.8	12.1
Teen Outreach Program (TOP)[a]	17.4	18.5	23.5	10.6
Be Proud! Be Responsible![a]	22.1	18.5	9.8	9.1
Draw the Line/Respect the Line[a]	2.3	3.7	5.9	7.6
¡Cuidate![a]	0.0	0.0	7.8	6.1
Becoming a Responsible Teen (BART)[a,b]	5.8	7.4	5.9	4.5
Power Through Choices[a,b]	0.0	0.0	2.0	4.5
Reducing the Risk[a]	4.7	4.9	5.9	4.5
17 Days[a]	0.0	0.0	2.0	4.5
Promoting Health Among Teens (PHAT)! Comprehensive Abstinence and Safer Sex Intervention[a]	1.2	1.2	3.9	3.0
SHARP[a]	0.0	0.0	2.0	3.0
Adult Identity Mentoring (Project AIM)[a]	1.2	1.2	0.0	1.5
Get Real[a]	0.0	0.0	0.0	1.5
Making a Difference![a]	4.7	4.9	2.0	1.5
Promoting Health Among Teens (PHAT)! Abstinence Only Intervention[a]	1.2	1.2	2.0	1.5
Safer Choices[a]	2.3	2.5	3.9	1.5
Sisters Saving Sisters[a]	0.0	0.0	0.0	1.5
Steps to Success	1.2	1.2	0.0	0.0
All4You![a]	1.2	1.2	0.0	0.0
Teen Health Project[a]	7.0	9.9	0.0	0.0
Be Proud! Be Responsible! Be Protective![a]	2.3	2.5	0.0	0.0
Other	5.8	1.2	3.9	3.0
Number of programs	**86**	**81**	**51**	**66**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] The U.S. Department of Health and Human Services (HHS) has identified the program model as an evidence-based program.

[b] Becoming a Responsible Teen and Rikers Health Advocacy Program were included during the 2013–2014 through 2015–2016 reporting periods but were no longer included on the list of HHS evidence-based teen pregnancy prevention programs in the 2016–2017 reporting period. Power Through Choices was added to the list in 2016–2017.

Table D.6. Competitive PREP adulthood preparation subjects (APSs) implemented (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Number of APSs implemented[a]				
0–2 subjects	1.2	1.3	0.0	3.0
3 subjects	59.3	41.3	25.5	33.3
4 subjects	22.1	22.5	37.3	45.5
5 subjects	5.8	23.8	15.7	13.6
6 subjects	11.6	11.3	21.6	4.5
Subject implemented[b]				
Healthy relationships	95.3	97.5	100.0	98.5
Healthy life skills	87.1	91.1	90.2	87.9
Adolescent development	81.2	82.3	82.4	83.3
Parent-child communication	50.0	51.9	74.5	66.7
Financial literacy	33.3	37.5	43.1	25.8
Educational and career success	39.2	45.6	43.1	21.2
Number of programs	**86**	**81**	**51**	**66**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Percentages do not sum to 100 percent because programs could implement more than three subjects. Adult preparation subjects are not mutually exclusive.

Table D.7. Competitive PREP implementation setting

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of programs serving youth in[a]				
Schools, during school	56.6	62.8	69.4	57.6
Community-based organizations	35.5	39.2	22.4	39.4
Juvenile detention centers	13.2	16.7	12.2	12.1
Foster care settings	17.1	12.8	4.1	10.6
Schools, after school	13.2	14.1	8.2	3.0
Clinics	1.3	1.3	0.0	0.0
Other settings	10.5	9.0	10.2	12.1
Percentage of youth served in[b]				
Schools, during school	85.4	84.8	90.5	89.3
Community-based organizations	4.9	7.7	4.8	4.4
Juvenile detention centers	1.8	2.9	2.1	2.1
Foster care settings	1.3	1.5	0.5	1.2
Schools, after school	3.2	1.8	0.7	0.2
Clinics	0.1	0.1	0.0	0.0
Other settings	3.3	1.3	1.4	2.7
Number of programs	**86**	**81**	**51**	**66**
Number of youth	**23,439**	**32,280**	**16,321**	**25,286**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] Percentages do not sum to 100 percent because programs could be implemented in more than one setting.

[b] Percentages may not sum to 100 percent due to rounding.

Table D.8. Competitive PREP intended dosage and receipt

Measure	2013–2014 reporting period	2014–2015 reporting period	201–-2016 reporting period	2016–2017 reporting period
Average hours of intended programming	15.4	16.3	13.3	11.5
Percentage of youth in out-of-school-time programs who completed at least 75 percent of the intended dosage[a]	74.0	75.1	80.1	77.1
Number of programs	**86**	**81**	**51**	**66**
Number of youth from out-of-school-time programs	**2,097**	**4,525**	**1,513**	**2,699**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] This result is based on programs that served youth during out-of-school time. Because these programs are generally voluntary and do not take place during the school day, youth are likely to attend less frequently.

Table D.9. Competitive PREP demographic characteristics of youth (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Female	51.2	50.2	50.7	51.1
Hispanic or Latino	28.5	33.1	26.4	38.0
Ethnicity[a]				
Mexican, Mexican American, Chicano	47.4	54.0	50.4	56.7
Puerto Rican	14.9	11.3	14.2	10.9
Cuban	15.5	8.3	5.5	3.4
Other Hispanic or Latino	22.2	26.4	29.9	29.0
Race[b]				
American Indian or Alaska Native	5.1	6.2	5.0	7.4
Asian	7.9	8.9	13.4	7.4
Black or African American	33.0	36.3	32.6	33.2
Native Hawaiian or Other Pacific Islander	17.6	14.3	20.5	14.0
White	41.8	39.5	32.7	40.9
Age[a]				
10–12	17.8	24.3	16.7	26.3
13 or 14	34.5	33.3	32.2	38.3
15 or 16	32.0	29.0	38.1	23.7
17 or 18	14.2	11.9	10.5	9.4
19 and older	1.5	1.5	2.5	2.4
Grade level[a]				
4th–6th	13.5	15.7	10.0	16.4
7th or 8th	36.7	35.3	26.9	37.8
9th or 10th	32.9	34.8	49.7	32.5
11th or 12th	15.3	12.7	10.8	9.9
Dropped out of school	0.1	0.1	0.1	0.1
Working toward GED	0.6	0.5	0.6	0.3
Earned diploma or GED and in postsecondary school	0.4	0.4	0.5	0.5
Earned diploma or GED and not in postsecondary school	0.5	0.5	1.2	2.3
School does not assign grade levels	0.1	0	0.3	0.1
Sexual and gender orientation[b,c]				
Straight	87.4	88.8	84.5	87.3
Gay or lesbian	4.6	2.6	3.1	2.5
Bisexual	6.2	5.8	7.3	6.5
Transgender	0.3	0.4	1.6	0.6
Something else/have not decided	2	2.3	4.3	3.4
Reported number of youth completing entry survey	**6,378**	**17,628**	**9,187**	**11,399**
Reported number of youth completing exit survey	**6,697**	**17,390**	**9,749**	**11,337**

Source: Entry and exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: All items except for sexual and gender orientation were from the exit survey.

[a] Percentages might not sum to 100 percent due to rounding.

[b] Youth could select more than one item, so percentages can sum to more than 100 percent.

[c] This item was considered a sensitive item and was only asked of high school-age youth on the entry survey.

GED = general equivalency diploma.

Table D.10. Competitive PREP targeted populations (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youth in high-need geographic areas	80.2	83.5	86.3	87.9
Male youth	66.3	68.8	72.5	60.6
African American youth	72.1	76.3	68.6	45.5
Hispanic/Latino youth	68.6	56.3	72.5	40.9
LGBTQ youth	51.2	50.6	54.9	39.4
Youth in adjudication systems	34.9	41.3	33.3	27.3
Youth in foster care	41.9	41.8	27.5	24.2
Pregnant or parenting youth	47.7	50.0	37.3	16.7
Homeless or runaway youth	32.6	25.3	21.6	15.2
Out of school/dropout youth	38.4	33.8	17.6	13.6
Native American youth	14.0	26.6	15.7	13.6
Youth living with HIV/AIDS	10.5	16.5	7.8	6.1
Youth in residential treatment for mental health issues	10.5	5.1	11.8	3.0
Number of programs	**86**	**81**	**51**	**66**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Target populations are not mutually exclusive; programs could target more than one population.

LGBTQ = lesbian, gay, bisexual, transgender or questioning.

Table D.11. Competitive PREP service to highly vulnerable populations by programs operating during out-of-school time (percentage of programs)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
At least 50 percent of youth served were from any highly vulnerable population	63.6	55.2	53.3	67.9
Trouble speaking or understanding English	3.0	6.9	6.7	25.0
In adjudication systems	15.2	17.2	20.0	17.9
In foster care	30.3	24.1	13.3	17.9
Identified as LGBTQ	3.0	3.4	6.7	14.3
Pregnant or parenting	9.1	0.0	0.0	10.7
In residential treatment for mental health	3.0	3.4	6.7	7.1
Homeless or runaway	9.1	6.9	0.0	0.0
Living with HIV/AIDS	0.0	0.0	0.0	0.0
Number of programs	**33**	**29**	**15**	**28**

Source: Attendance, reach, and dosage data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: The percentage of population categories do not sum to the percentage of programs primarily serving any highly vulnerable population, because population categories are not mutually exclusive; a program might serve more than one population.

Programs reported whether at least 50 percent of youth served were from each of the highly vulnerable populations. They did not report the percentage of youth in each category.

LGBTQ = lesbian, gay, bisexual, transgender, or questioning.

Table D.12. Competitive PREP high school-age youth sexual behaviors at program entry (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Ever had sexual intercourse	45.1	39.3	32.9	31.9
Ever been pregnant or gotten someone pregnant[a]	22.2	20.7	15.2	8.9
Number of times pregnant or gotten someone pregnant[a,b]				
0 pregnancies	79.9	79.1	83.7	91.4
1 pregnancy	13.2	15.7	11.9	6.1
2 pregnancies	3.9	3.5	3.0	1.8
3 or more pregnancies	3.0	1.6	1.4	0.7
Number of sexual partners in the past three months[a,b]				
0 people	34.5	31.4	36.1	53.8
1 person	42.7	45.2	46.3	33.5
2 or 3 people	14.6	16.2	13.0	9.6
4 or more people	8.1	7.1	4.6	3.0
Frequency of birth control use in the past three months[b,c]				
All the time	26.0	29.9	33.2	33.7
Most of the time	16.3	11.7	9.1	9.0
Some of the time	16.0	16.2	9.8	8.7
None of the time	38.8	42.3	47.9	48.7
Frequency of condom use in the past three months[b,c]				
All the time	27.0	36.7	34.9	36.1
Most of the time	19.4	17.1	12.4	12.9
Some of the time	16.3	18.7	17.5	11.8
None of the time	37.2	27.5	35.1	39.2
Reported number of youth completing entry survey	**6,378**	**17,628**	**9,187**	**11,399**

Source: Entry survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Only youth in grade 9 or higher in school settings or ages 14 and older in a community setting responded to the items.

Youth in grades 4–8 in school settings were exempt from the entry survey. Youth ages 13 or younger in a community setting were exempt from all items regarding sexual intentions and behaviors.

[a] Asked only of those who had ever had sexual intercourse.

[b] Percentages might not sum to 100 percent due to rounding.

[c] Asked only of those who had one or more sexual partners in the past three months.

Table D.13. Competitive PREP youths' perceptions of the program at program exit (percentage of youth)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Youths' perceptions of PREP program delivery				
The material presented was clear all or most of the time	83.1	83.6	83.6	82.9
Discussions or activities helped youth learn program lessons all or most of the time	81.3	82.5	79.8	80.5
Youth had a chance to ask questions about topics or issues that came up in the program all or most of the time	73.0	73.4	70.5	69.4
Youth were interested in program sessions and classes all or most of the time	70.4	70.5	64.6	65.5
Youths' perceptions of PREP program environment				
Youth felt respected as people all or most of the time	86.7	87.0	85.9	84.5
Youth felt picked on, teased, or bullied in the program a little or none of the time	85.7	83.8	84.5	84.1
Youth felt others in the program were picked on, teased, or bullied because people thought they were lesbian, gay, bisexual, or transgender a little or none of the time	85.8	85.2	83.4	85.9
Youth felt others in the program were picked on, teased, or bullied because of their racial or ethnic background a little or none of the time	87.5	88.0	87.0	87.8
Reported number of youth completing exit survey	**6,697**	**17,390**	**9,749**	**11,337**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Table D.14. Competitive PREP youths' perceptions that program participation prepared them for adulthood

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were much more or somewhat more likely to				
Be prepared for adulthood[a]	74.4	73.0	73.6	73.8
Be the best they can be	82.3	80.0	81.5	81.2
Make plans to reach goals	80.2	79.2	80.5	80.2
Get a steady job after they finish school	81.5	79.2	80.5	80.7
Care about doing well in school	81.9	79.0	80.4	79.6
Make healthy decisions about drugs or alcohol	78.0	77.0	76.9	78.3
Get more education after high school	77.9	76.0	77.4	77.8
Be respectful toward others	75.4	73.8	76.0	75.0
Resist or say no to peer pressure	74.4	72.5	74.0	74.3
Manage money carefully	76.1	74.4	74.6	75.4
Form friendships that keep them out of trouble	70.4	69.2	69.4	70.1
Share ideas or talk with parent/guardian	65.0	65.0	64.7	64.7
Manage conflict without causing more conflict	62.1	61.4	60.0	61.0
Know how to manage stress	62.3	62.6	61.1	61.3
Reported number of youth completing exit survey	**6,697**	**17,390**	**9,749**	**11,337**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] This item is an average percentage of Competitive PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

Table D.15. Competitive PREP youths' intentions toward sex at program exit

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of youth who were				
Much less or somewhat less likely to have sexual intercourse in next six months	67.8	69.3	67.2	67.6
Much more or somewhat more likely to abstain from sex in next six months	47.7	61.1	61.2	60.5
Much more or somewhat more likely to use birth control if having sex in next six months[a]	61.5	65.2	65.9	67.4
Much more or somewhat more likely to use a condom if having sex in next six months[a]	70.2	74.4	76.1	74.7
Reported number of youth completing exit survey	**6,697**	**17,390**	**9,749**	**11,337**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

[a] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table D.16. Competitive PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by primary age group program served

Measure	Programs primarily serving middle school-age youth	Programs primarily serving high school-age youth
Percentage of youth who felt prepared for adulthood[a]	74.4	73.1
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	80.3	62.4
Much more or somewhat more likely to abstain from sex in next six months	62.6	56.2
Much more or somewhat more likely to use birth control if having sex in next six months[b]	61.5	66.3
Much more or somewhat more likely to use a condom if having sex in next six months[b]	71.8	74.7
Reported number of youth completing exit survey	**31,524**	**41,601**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of Competitive PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table D.17. Competitive PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by programs primarily serving highly vulnerable populations

Measure	Programs primarily serving a highly vulnerable population	Programs not primarily serving a highly vulnerable population
Percentage of youth who felt prepared for adulthood[a]	76.0	73.3
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	64.3	68.7
Much more or somewhat more likely to abstain from sex in next six months	57.0	58.5
Much more or somewhat more likely to use birth control if having sex in next six months[b]	60.9	66.0
Much more or somewhat more likely to use a condom if having sex in next six months[b]	66.4	75.2
Reported number of youth completing exit survey	**8,568**	**64,557**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of Competitive PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table D.18. Competitive PREP youths' perceptions of program effects on adulthood and sexual behavior at program exit, by program setting

Measure	Programs operating during school	Programs operating out of school
Percentage of youth who felt prepared for adulthood[a]	73.0	77.5
Percentage of youth who were		
Much less or somewhat less likely to have sexual intercourse in next six months	69.6	59.2
Much more or somewhat more likely to abstain from sex in next six months	59.0	54.0
Much more or somewhat more likely to use birth control if having sex in next six months[b]	65.4	65.1
Much more or somewhat more likely to use a condom if having sex in next six months[b]	74.5	72.1
Reported number of youth completing exit survey	**64,164**	**8,961**

Source: Exit survey data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

Note: Data are aggregated across 2013–2014 through 2016–2017 program years.

[a] This item is an average percentage of Competitive PREP participants who responded "Much more likely" or "Somewhat more likely" to 13 items.

[b] Excludes youth who plan to abstain from sexual intercourse in next six months.

Table D.19. **Competitive** PREP implementation challenges and interest in technical assistance (percentage of providers)

Measure	2013–2014 reporting period	2014–2015 reporting period	2015–2016 reporting period	2016–2017 reporting period
Percentage of providers who reported that a challenge was somewhat or a serious problem				
Youth behavioral problems	14.7	20.9	30.6	53.3
Getting youth to attend regularly	37.3	28.4	30.6	31.1
Recruiting youth	36.0	26.9	27.8	31.1
Keeping youth engaged	26.7	16.4	16.7	31.1
Staff turnover	30.7	29.9	16.7	28.9
Recruiting qualified staff	16.0	16.4	11.1	17.8
Ensuring facilitators understand content	2.7	3.0	11.1	4.4
Percentage of providers who reported being interested or very interested in a technical assistance topic				
Keeping youth engaged	42.7	25.4	30.6	31.1
Addressing youth behavior issues	26.7	25.4	36.1	28.9
Recruiting youth	42.7	29.9	33.3	28.9
Getting youth to attend regularly	34.7	24.2	30.6	24.4
Training facilitators	28.0	26.9	36.1	24.4
Minimizing negative peer reactions	20.0	13.4	27.8	20.0
Retaining staff	18.7	25.4	27.8	20.0
Recruiting qualified staff	13.3	23.9	33.3	17.8
Number of providers	**70**	**67**	**36**	**45**

Source: Measures of structure and support for implementation data from 2013–2014, 2014–2015, 2015–2016, and 2016–2017 Competitive PREP grantees.

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APPENDIX E:

ADULTHOOD PREPARATION SUBJECTS

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Table E.1. PREP performance measures related to preparation for adulthood

PREP performance measure related to preparation for adulthood	Adulthood preparation subject					
	Adolescent development	Healthy relationships	Healthy life skills	Educational and career success	Financial literacy	Parent-child communi-cation
Percentage of youth who were much more or somewhat more likely to						
Resist or say no to peer pressure	X	X	X			
Form friendships that keep you out of trouble	X	X	X			
Be respectful towards others	X	X				
Be the best that you can be	X		X	X		
Care about doing well in school	X		X	X		
Know to how manage stress	X		X			
Make healthy decisions about drugs and alcohol	X		X			
Share ideas or talk about things that really matter with a parent/guardian	X					X
Manage conflict without causing more conflict		X	X			
Make plans to reach your goals			X	X		
Get a steady job after you finish school				X	X	
Get more education after high school				X		
Manage money carefully, such as making a budget, saving, or investing					X	

PREP
The Personal Responsibility Education Program Evaluation

Exhibit 12

Health Education

Note: The Washington State Health Education K-12 Learning Standards are organized into six core ideas that reflect typical units of study. Each core idea organizes outcomes related to the eight learning standards. Each outcome is coded to the relevant learning standard (e.g., H3 for Health Education Standard 3), core idea and topic strand (e.g., N3 for Nutrition Topic Strand 3) and grade level (e.g., 4 for grade 4). For reference, each of the Health Education core ideas and learning standards are listed below.

Washington State Health Education K-12 Core Ideas:

Wellness (W)

Safety (Sa)

Nutrition (N)

Sexual Health (Se)

Social Emotional Health (So)

Substance Use and Abuse (Su)

Washington State Health Education K-12 Learning Standards:

Standard 1: Students will comprehend concepts related to health promotion and disease prevention to enhance health.

Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

Standard 3: Students will demonstrate the ability to access valid information and products and services to enhance health.

Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.

Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.

Standard 7: Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.

Health Education Core Idea: Wellness (W)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Dimensions of Health	Recognize meaning of healthy and unhealthy. H1.W1.K	Understand what it means to be healthy. H1.W1.1	Describe what it means to be healthy. H1.W1.2	Recognize dimensions of health. H1.W1.3	Identify dimensions of health. H1.W1.4	Describe dimensions of health. H1.W1.5
2. Hygiene	Recognize basic hygiene practices. H1.W2.Ka	Describe basic hygiene practices. H1.W2.1 Understand which elements of hygiene are essential to good health. H1.W2.Kb	Describe benefits of hygiene practices. H1.W2.2	Demonstrate effective hygiene practices. H7.W2.3	Describe personal hygiene needs associated with the onset of puberty. H1.W2.4	Explain how family, peers, media, and culture influence decision-making related to hygiene practices. H1.W2.5
3. Disease Prevention	Understand germs can cause diseases. H1.W3.Ka Identify ways germs are transmitted. H1.W3.Kb Describe symptoms that occur when a person is sick. H1.W3.Kc	Describe ways to prevent the spread of germs. H1.W3.1a Understand differences between communicable and noncommunicable diseases. H1.W3.1b	Understand bacteria and viruses are types of germs. H1.W3.2a Describe differences between communicable and noncommunicable diseases. H1.W3.2b	Identify ways pathogens enter the body. H1.W3.3a Identify common chronic diseases and allergies. H1.W3.3b Explain how common childhood illnesses are treated. H1.W3.3c	List ways to prevent debilitating or life-threatening diseases. H1.W3.4a Identify ways to keep the immune system strong. H1.W3.4b	Understand relationship between disease prevention and quality of life. H1.W3.5a Describe how heredity can affect personal health. H1.W3.5b
4. Analyzing Influences	Identify how family influences health practices and	Describe how family and friends influence health practices and	Understand how media influences health decisions and	Describe how media and technology influence health	Identify how culture influences health decisions and	Analyze how family, peers, media, culture, and technology

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Health Education Core Idea: Wellness (W)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
	behaviors. H2.W4.K	behaviors. H2.W4.1	behaviors. H2.W4.2	decisions and behaviors. H2.W4.3	behaviors. H2.W4.4	influence health decisions and behaviors. H2.W4.5
5. Access Valid Information	Identify trusted adults and professionals who can help promote health. H3.W5.K	Identify where to locate trusted adults who can help promote health. H3.W5.1	Identify characteristics of valid health information and services. H3.W5.2	Investigate resources from home, school, and community that provide valid health information. H3.W5.3	Investigate validity of health and wellness information, products, and services. H3.W5.4	Demonstrate how to access valid information, products, and services. H3.W5.5
6. Communication	Demonstrate healthy ways to express needs, wants, and feelings. H4.W6.K	Identify verbal and nonverbal communication. H1.W6.1 Demonstrate ways to respond to an unwanted, threatening, or dangerous situation. H4.W6.1	Demonstrate active listening skills to enhance communication. H4.W6.2a Identify skills for assertive communication. H4.W6.2b	Demonstrate effective refusal skills. H4.W6.3a Recognize how to ask for needs. H4.W6.3b	Demonstrate appropriate strategies to manage or resolve conflict. H4.W6.4 Recognize steps to a decision-making model. H5.W6.4	Demonstrate appropriate interpersonal communication skills. H4.W6.5
7. Decision-Making	Identify situations when a health-related decision is needed. H5.W7.K	Differentiate between situations when a health-related decision can be made individually and when assistance is needed. H5.W7.1	Identify healthy options for making a health-related decision. H5.W7.2	Predict potential short-term outcomes of a health-related decision. H5.W7.3	Predict potential long-term outcomes of a health-related decision. H5.W7.4	Apply decision-making skills to make a health-enhancing choice. H5.W7.5

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Health Education Core Idea: Wellness (W)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
8. Goal-Setting	Identify a personal health goal. H6.W8.K	Identify people who can support achievement of a personal health goal. H6.W8.1	Describe steps to achieve a personal health goal. H6.W8.2	Identify resources to support achievement of a personal health goal. H6.W8.3	Create a personal health goal and track progress toward achieving it. H6.W8.4	Analyze progress toward achieving a personal health goal. H6.W8.5

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Health Education Core Idea: Wellness (W)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Dimensions of Health	Describe interrelationships of dimensions of health. H1.W1.6	Assess personal health behaviors in relation to dimensions of health. H1.W1.7	Analyze interrelationships of personal dimensions of health. H1.W1.8	Analyze personal dimensions of health and design a plan to balance health. H1.W1.HS
2. Disease Prevention	Differentiate between communicable and noncommunicable diseases. H1.W2.6 Determine how hereditary factors and health behaviors impact health. H2.W2.6	Summarize lifestyle factors to prevent communicable and noncommunicable diseases. H7.W2.7a Explain benefits and consequences of various health behaviors. H7.W2.7b	Analyze how personal choices contribute to communicable and noncommunicable diseases. H7.W2.8a Assess personal health behaviors that reduce or prevent health risks. H7.W2.8b	Analyze prevention, lifestyle factors, and treatment of communicable and noncommunicable diseases. H2.W2.HSa Assess personal risk factors and predict future health status. H2.W2.HSb
3. Analyzing Influences	Explain factors that influence health decisions and behaviors. H2.W3.6	Describe how peers, culture, and family influence health decisions and behaviors. H2.W3.7	Describe how values, media, and technology influence health decisions and behaviors. H2.W3.8	Analyze how a variety of factors impact personal and community health. H2.W3.HS
4. Access Valid Information	Describe situations that call for expert health resources and services. H3.W4.6	Analyze validity and reliability of health and wellness information and products. H3.W4.7	Investigate local valid and reliable health and wellness information. H3.W4.8	Create a resource that outlines where and how students can access valid and reliable health information, products, and services. H3.W4.HS
5. Communication	Explain effective communication skills. H4.W5.6	Use communication skills effectively with family, peers, and others. H4.W5.7	Demonstrate communication skills to enhance health and avoid or reduce health risks. H4.W5.8	Demonstrate strategies to prevent, manage, or resolve interpersonal conflicts without harming self or others.

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Health Education Core Idea: Wellness (W)

Topic	Grade 6	Grade 7	Grade 8	High School
				H4.W5.HS
6. Decision-Making	Identify circumstances that help or hinder making healthy decisions related to personal health. H5.W6.6	Determine healthy alternatives for making a personal health decision. H5.W6.7	Demonstrate a decision-making model to make a personal health-enhancing choice. H5.W6.8	Predict potential short- and long-term outcomes of a personal health-related decision. H5.W6.HS
7. Goal-Setting	Describe how goals can enhance health. H6.W7.6	Describe components of goal-setting to enhance health. H6.W7.7	Describe various short- and long-term goals that can be used to enhance health. H6.W7.8	Implement strategies to achieve a personal health goal. H6.W7.HS

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Health Education Core Idea: Safety (Sa)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Injury Prevention	Identify safety hazards in the home. H1.Sa1.Ka Recognize bicycle, pedestrian, and transportation safety rules. H1.Sa1.Kb Identify fire, water, and sun safety rules. H1.Sa1.Kc Explain potential dangers of weapons. H1.Sa1.Kd	Identify safety hazards in the school. H1.Sa1.1a Understand bicycle, pedestrian, and transportation safety rules. H1.Sa1.1b Understand fire, water, and sun safety rules. H1.Sa1.1c Explain importance of reporting to an adult when seeing or hearing about someone having a weapon. H1.Sa1.1d	Identify safety hazards in the community. H1.Sa1.2a Describe bicycle, pedestrian, and transportation safety rules. H1.Sa1.2b Describe emergency, fire, and safety plans at home and at school. H1.Sa1.2c Understand importance of avoiding weapons when unsupervised. H1.Sa1.2d	Identify ways to prevent injuries at home, at school, and in the community. H1.Sa1.3a Create emergency, fire, and safety plans for home. H1.Sa1.3b	Identify ways to prevent injuries in recreational activities. H1.Sa1.4 Describe practices and behaviors that promote safety and reduce or prevent injuries. H7.Sa1.4	Identify dangerous or risky behaviors that might lead to injuries. H1.Sa1.5a Identify safety precautions for playing and working outdoors. H1.Sa1.5b Predict potential outcomes when making a decision related to injury prevention. H1.Sa1.5c
2. First Aid	Understand differences between emergency and nonemergency situations. H1.Sa2.Ka Identify people to ask for help in an	Identify people to ask for help in emergency situations. H1.Sa2.1a Explain and demonstrate how to call 911. H1.Sa2.1b	Recognize local emergency alert system. H1.Sa2.2a Identify people who can help when someone is injured or suddenly ill.	Describe safety rules to follow in a disaster. H1.Sa2.3a Identify basic first aid steps. H1.Sa2.3b	Describe how to prepare for an emergency. H1.Sa2.4a Understand basic first aid for minor injuries. H1.Sa2.4b	Explain how to respond to emergency situations. H1.Sa2.5

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Health Education Core Idea: Safety (Sa)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
	emergency situation at school. H1.Sa2.Kb Identify how to call 911 in emergency situations. H1.Sa2.Kc		H1.Sa2.2b			
3. Violence Prevention	Understand definition of violence and abuse. H1.Sa3.K	Recognize different types of violence and abuse. H1.Sa3.1	Describe different types of violence and abuse. H1.Sa3.2a Identify healthy and unhealthy group characteristics. H1.Sa3.2b	Identify potentially violent situations. H1.Sa3.3a Differentiate between gang, clique, and club. H1.Sa3.3b Understand impact of violent behavior on others. H1.Sa3.3c	Explain how potentially violent situations can be avoided. H1.Sa3.4a Explain importance of communicating and interacting safely when using electronic media. H1.Sa3.4b Identify influences on violence and violence prevention. H2.Sa3.4	Describe ways to prevent, reduce, and avoid violent situations. H1.Sa3.5a Analyze how violent behavior impacts self and others. H1.Sa3.5b Describe effective communication skills to prevent, reduce, and avoid violent situations in person or on electronic media. H4.Sa3.5

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Health Education Core Idea: Safety (Sa)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Injury Prevention	Identify guidelines related to bicycle, pedestrian, traffic, water, and recreation safety. H1.Sa1.6	Explain importance of being responsible for promoting safety and avoiding or reducing injury. H7.Sa1.7	Advocate for safety and injury prevention. H8.Sa1.8 Describe how some health risk behaviors influence safety and injury prevention practices. H2.Sa1.8	Analyze impact of decisions related to bicycle, pedestrian, traffic, water, and recreation safety. H5.Sa1.HS Describe how to prevent occupational injuries. H1.Sa1.HS Compare how family, peers, culture, media, technology, and other factors influence safety and injury prevention practices and behaviors. H2.Sa1.HS
2. First Aid	Understand basic first aid skills. H1.Sa2.6a Understand cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) procedures. H1.Sa2.6b	Explain basic first aid skills. H1.Sa2.7 Demonstrate CPR and AED procedures. H7.Sa2.7	Practice basic first aid skills. H7.Sa2.8a Demonstrate CPR and AED procedures. H7.Sa2.8b	Apply basic first aid skills. H7.Sa2.HSa Demonstrate CPR and AED procedures. H7.Sa2.HSb
3. Violence Prevention	Describe situations that could lead to violence. H1.Sa3.6a Demonstrate ways to resolve conflict to prevent, reduce, and avoid violence. H4.Sa3.6	Describe how risk of violence increases with presence of weapons. H1.Sa3.7a Demonstrate communication skills to prevent, reduce, and	Analyze causes and effects of violence on individuals, families, and communities. H1.Sa3.8a Differentiate between passive, aggressive, and assertive	Evaluate societal influences on violence. H2.Sa3.HS Demonstrate effective peer resistance, negotiation, and

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Health Education Core Idea: Safety (Sa)

Topic	Grade 6	Grade 7	Grade 8	High School
	Identify potential dangers of sharing personal information through electronic media. H1.Sa3.6b	avoid violent situations. H4.Sa3.7 Understand potential dangers of sharing personal information through electronic media. H1.Sa3.7b	communication. H4.Sa3.8 Explain how bystanders can help prevent, reduce, and avoid violence. H1.Sa3.8b Describe potential dangers of sharing personal information through electronic media. H1.Sa3.8c	collaboration skills to avoid potentially violent situations. H7.Sa3.HS Advocate for violence prevention. H8.Sa3.HS Analyze potential dangers of sharing personal information through electronic media. H1.Sa3.HS

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Health Education Core Idea: Nutrition (N)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Food Groups and Nutrients	Recognize food groups. H1.N1.Ka Identify healthy and unhealthy foods. H1.N1.Kb Recognize importance of eating breakfast. H1.N1.Kc	Match foods to food groups. H1.N1.1a Distinguish between healthy and unhealthy foods. H1.N1.1b Understand importance of eating breakfast and lunch. H1.N1.1c	Understand how to create a balanced meal. H1.N1.2a Describe how each food group contributes to a healthy body. H1.N1.2b Understand importance of eating meals throughout the day. H1.N1.2c	Create a balanced meal. H1.N1.3a Define nutrient. H1.N1.3b List six nutrients: carbohydrates, fats, proteins, vitamins, minerals, water. H1.N1.3c	Create a balanced daily food plan. H1.N1.4a Classify nutrients found in foods. H1.N1.4b Describe how each nutrient contributes to a healthy body. H1.N1.4c	Analyze a food journal to create a more balanced food plan. H5.N1.5
2. Beverages	Identify daily recommended water intake. H1.N2.Ka Identify healthy and unhealthy beverages. H1.N2.Kb	Recognize importance of drinking water. H1.N2.1	Identify benefits of drinking recommended intake of water. H1.N2.2	Explain importance of choosing healthy beverages. H1.N2.3	Identify impact of high-sugar and high-caffeine drinks. H1.N2.4	Compare beverages to make a healthy choice. H5.N2.5
3. Label Literacy	*Developmentally appropriate outcomes first appear in grade 1.*	Identify location of a Nutrition Facts label. H1.N3.1	Identify purpose of a Nutrition Facts label. H3.N3.2	Identify types of information on a Nutrition Facts label. H1.N3.3a	Explain how to use information found on a Nutrition Facts label. H1.N3.4	Differentiate between healthy and unhealthy foods according to Nutrition Facts

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Health Education Core Idea: Nutrition (N)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
				Understand importance of reading a Nutrition Facts label. H1.N3.3b	Compare and contrast Nutrition Facts labels for nutrition information. H3.N3.4	labels. H3.N3.5
4. Caloric Intake and Expenditure	Describe body signals that tell a person when they are hungry and when they are full. H1.N4.K	Understand food provides energy for the body. H1.N4.1	Identify healthy eating patterns that provide energy and help the body grow and develop. H1.N4.2	Distinguish between different energy sources: proteins, fats, carbohydrates. H1.N4.3a Understand the relationship between caloric intake and expenditure. H1.N4.3b	Describe why individuals have different caloric needs. H1.N4.4a Identify ways to balance caloric intake and expenditure. H1.N4.4b	Describe how the body's function and composition are affected by food consumption. H1.N4.5
5. Disease Prevention	Understand that food choices affect health. H1.N5.K	Understand that food choices can contribute to a healthy body. H1.N5.1	Understand that food choices can put individuals at risk for some health problems. H1.N5.2	Identify foods that are high in sodium and added sugars. H1.N5.3a Describe benefits of limiting consumption of sodium and added sugars. H1.N5.3b Describe benefits of	Identify foods that are high in fat and low in fat. H1.N5.4a Describe benefits and consequences of consuming fats. H1.N5.4b Describe how vitamins and	Analyze how healthy eating reduces health risks and promotes growth. H1.N5.5a Explain importance of eating in moderation to promote health. H1.N5.5b

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Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
				consuming fruits, vegetables, and whole grains. H1.N5.3c	minerals contribute to disease prevention. H1.N5.4c	Describe how fiber contributes to disease prevention. H1.N5.5c
6. Nutritional Planning	Identify influences on food and beverage choices and eating behaviors. H2.N6.K	Identify how family influences food and beverage choices and eating behaviors. H2.N6.1	Identify how family, school, and community influence food and beverage choices and eating behaviors. H2.N6.2 Recognize decision-making or refusal skills that could help when making food choices. H5.N6.2	Identify how peers, media, and technology influence food and beverage choices and eating behaviors. H2.N6.3 Identify reliable resources that promote healthy eating. H3.N6.3 Develop a healthy eating goal. H6.N6.3 Demonstrate effective refusal skills to limit unhealthy food choices and promote healthy eating. H4.N6.3	Describe how family, school, community, peers, media, and technology influence food and beverage choices and eating behaviors. H2.N6.4 Identify resources that can help achieve a healthy eating goal. H3.N6.4 Develop a plan to achieve a healthy eating goal. H6.N6.4	Analyze how community, peers, media, technology, and culture influence decision-making related to food and beverage choices and eating behaviors. H2.N6.5 Demonstrate how to effectively ask for help to improve personal food choices and promote healthy eating. H4.N6.5 Assess progress toward achieving a healthy eating goal. H7.N6.5

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Health Education Core Idea: Nutrition (N)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Food Groups and Nutrients	Identify functions of the six nutrients: carbohydrates, fats, proteins, vitamins, minerals, water. H1.N1.6a Understand differences between reliable and unreliable sources of nutrition information. H3.N1.6 Describe consequences of skipping meals. H1.N1.6b	Classify foods by food groups and nutrients. H1.N1.7a Summarize benefits of eating a variety of food from all food groups. H1.N1.7b Determine availability of valid and reliable nutrition information, products, and services. H3.N1.7	Compare and contrast nutritional value of fresh versus processed foods. H1.N1.8a Explain effects of eating patterns on growth and development, and on physical, mental, and academic performance. H1.N1.8b Investigate valid and reliable nutrition information, products, and services. H3.N1.8	Predict impact of consuming adequate or inadequate amounts of nutrients. H1.N1.HS Evaluate resources for accessing valid and reliable information, products, and services for healthy eating. H3.N1.HS Collaborate with others to advocate for healthy eating at home, in school, or in the community. H8.N1.HS
2. Beverages	Summarize importance of staying hydrated. H1.N2.6 Identify beverages that should be limited and provide evidence to support limiting intake. H3.N2.6	Evaluate nutritional content for a variety of beverages and describe benefits and consequences of intake. H1.N2.7	Develop a message to persuade someone to make healthy beverage choices. H8.N2.8	Analyze the impact of school rules and community and federal laws on beverage availability and choice. H2.N2.HS

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Health Education Core Idea: Nutrition (N)

Topic	Grade 6	Grade 7	Grade 8	High School
3. Label Literacy	Explain how different components of a Nutrition Facts label can be used to guide food and beverage choices. H3.N3.6a Distinguish between serving size and portion size. H3.N3.6b	Demonstrate how to use Nutrition Facts labels to make healthier choices. H3.N3.7 Demonstrate how to calculate nutritional value based on serving sizes. H1.N3.7	Draw conclusions from Nutrition Facts labels and make recommendations for healthy choices. H3.N3.8	Cite evidence from Nutrition Facts labels useful for making informed and healthy choices. H5.N3.HS Analyze trends in portion size as compared to recommended serving sizes. H3.N3.HS
4. Caloric Intake and Expenditure	Distinguish between nutrient-dense and empty-calorie foods and identify examples of each. H1.N4.6a Compare and contrast caloric expenditure for a variety of physical activities. H1.N4.6b	Explain relationship of caloric intake and expenditure to weight management. H1.N4.7a Investigate strategies for healthy weight management. H1.N4.7b	Conduct a personal caloric needs assessment, based on age, gender, activity levels, and specific health requirements, to develop an eating plan. H7.N4.8	Demonstrate how to balance caloric intake with caloric expenditure to maintain, gain, or reduce weight in a healthy manner. H7.N4.HS
5. Disease Prevention	Identify diseases often caused by nutritional choices. H1.N5.6	Describe impact of nutritional choices in relation to disease prevention. H1.N5.7	Evaluate a variety of eating plans and determine potential short-term and long-term consequences based on nutritional intake. H1.N5.8	Analyze and describe the relationship between nutritional choices, physical activity, and chronic diseases. H1.N5.HS

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Topic	Grade 6	Grade 7	Grade 8	High School
6. Nutritional Planning	Develop a SMART (specific, measurable, attainable, realistic, and timely) goal to improve eating behaviors. H6.N6.6 Identify circumstances that influence healthy decision-making related to food choices and eating behaviors. H2.N6.6	Create a daily food plan with adequate amounts of each nutrient. H6.N6.7a Assess barriers to achieving a personal goal to improve healthy eating behaviors. H6.N6.7b Describe how peers, culture, and family influence nutritional choices. H2.N6.7	Assess personal food and beverage intake based on recommended individual needs. H7.N6.8 Create short- and long-term goals to establish healthy eating patterns. H6.N6.8 Investigate strategies to overcome barriers to achieving a personal goal to improve healthy eating behaviors. H3.N6.8 Draw conclusions regarding how society, culture, and economics influence nutrition choices. H2.N6.8	Design, monitor, and adjust a personal nutrition plan, considering cost, availability, access, nutritional value, balance, freshness, and culture. H7.N6.HS Apply strategies to overcome barriers to achieving a personal goal to improve healthy eating behaviors. H6.N6.HS

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Health Education Core Idea: Sexual Health (Se)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Anatomy and Physiology	Understand boys and girls have some body parts that are the same and some that are different. H1.Se1.K	Identify medically accurate names for body parts, including external reproductive anatomy. H1.Se1.1	Use medically accurate names for body parts, including external reproductive anatomy. H1.Se1.2	Recognize medically accurate names for body parts, including internal and external reproductive anatomy. H1.Se1.3	Label medically accurate names for body parts, including internal and external reproductive anatomy. H1.Se1.4	Understand functions of reproductive systems. H1.Se1.5
2. Growth and Development	Understand living things grow and mature. H1.Se2.K	Describe how living things grow and mature. H1.Se2.1	Understand physical changes are part of growth and development. H1.Se2.2	Understand puberty is part of the process of growth and development. H1.Se2.3	Understand physical, social, and emotional changes occur during puberty. H1.Se2.4a Recognize puberty and physical development can vary considerably. H1.Se2.4b	Identify ways to manage physical, social, and emotional changes that occur during puberty. H7.Se.2.5 Describe how puberty and physical development can vary considerably. H1.Se2.5
3. Reproduction	*Developmentally appropriate outcomes first appear in grade 2.*	*Developmentally appropriate outcomes first appear in grade 2.*	Understand living things can reproduce. H1.Se3.2	Understand humans can reproduce. H1.Se3.3	Understand reproductive organs allow living things to reproduce. H1.Se3.4	Recognize puberty prepares the body for reproduction. H1.Se3.5
4. HIV Prevention	*Developmentally appropriate outcomes first appear in grade 4.*	*Developmentally appropriate outcomes first appear in grade 4.*	*Developmentally appropriate outcomes first appear in grade 4.*	*Developmentally appropriate outcomes first appear in grade 4.*	Understand how communicable diseases are transmitted. H1.Se4.4	Define human immunodeficiency virus (HIV). H1.Se4.5a

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Health Education Core Idea: Sexual Health (Se)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
						Identify methods of transmission and prevention of HIV. H1.Se4.5b
5. Self-Identity	Understand there are many ways to express gender. H1.Se5.K	Explain that there are many ways to express gender. H1.Se5.1	Understand there is a range of gender roles and expression. H1.Se5.2a Understand importance of treating others with respect regarding gender expression. H1.Se5.2b	Explain that gender roles can vary considerably. H1.Se5.3a Understand importance of treating others with respect regarding gender identity. H1.Se5.3b	Identify how friends and family can influence ideas regarding gender roles, identity, and expression. H2.Se5.4 Demonstrate ways to show respect for all people. H4.Se5.4 Define sexual orientation. H1.Se5.4	Describe how media, society, and culture can influence ideas regarding gender roles, identity, and expression. H2.Se5.5a Promote ways to show respect for all people. H8.Se5.5 Identify trusted adults to ask questions about gender identity and sexual orientation. H2.Se5.5b
6. Healthy Relationships	Recognize characteristics of a friend. H1.Se6.Ka	Describe characteristics of a friend. H1.Se6.1a	Identify characteristics and benefits of healthy friendships.	List characteristics of healthy and unhealthy friendships. H1.Se6.3a	Describe characteristics of healthy friendships and other	Differentiate between healthy and unhealthy relationships.

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Health Education Core Idea: Sexual Health (Se)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
	Recognize ways to express feelings. H1.Se6.Kb Identify safe and unwanted touch. H1.Se6.Kc Recognize people have the right to refuse giving or receiving unwanted touch. H1.Se6.Kd	Identify healthy ways to express feelings. H1.Se6.1b Explain safe and unwanted touch. H1.Se6.1c Describe how to tell a trusted adult about unwanted touch. H4.Se6.1	H1.Se6.2a Describe healthy ways for family members and friends to express feelings toward each other. H4.Se6.2a Explain why unwanted touches should be reported to a trusted adult. H1.Se6.2b Demonstrate how to tell trusted adults about unwanted touch until action is taken. H4.Se6.2b	Identify trusted adults to communicate with about relationships. H4.Se6.3a Identify positive ways to communicate differences of opinion while maintaining relationships. H4.Se6.3b Understand that a child is not at fault if an unwanted touch occurs. H1.Se6.3b	relationships. H1.Se6.4 Explain importance of communicating with trusted adults about relationships. H2.Se6.4a Demonstrate positive ways to communicate differences of opinion and feelings while maintaining relationships. H4.Se6.4 Understand ways family, friends, and peers can have a positive or negative influence on relationships. H2.Se6.4b	H1.Se6.5a Explain importance of using social media safely, legally, and respectfully. H1.Se6.5b Understand how to support a peer to recognize healthy and unhealthy relationships. H8.Se6.5 Define sexual abuse. H1.Se6.5c

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Health Education Core Idea: Sexual Health (Se)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Anatomy, Reproduction, and Pregnancy	Identify parts of the reproductive systems. H1.Se1.6	Describe reproductive systems including body parts and functions. H1.Se1.7a Describe the stages of a pregnancy from fertilization to birth. H1.Se1.7b	Summarize reproductive systems and their functions, including the path of an egg during ovulation and the path of sperm during ejaculation. H1.Se1.8a Identify physical, emotional, and social effects of sexual activity. H1.Se1.8b	Summarize fertilization, fetal development, and childbirth. H1.Se1.HSa Explain the role hormones play in sexual behavior and decision-making. H5.Se1.HS Describe emotional, social, physical, and financial effects of being a teen or young adult parent. H1.Se1.HSb Describe behaviors that impact reproductive health. H1.Se1.HSc Describe steps of testicular self-exam and the importance of breast self-awareness. H7.Se1.HS
2. Puberty and Development	Identify physical, social, mental, and emotional changes that occur during puberty. H1.Se2.6	Recognize that there are individual differences in growth and development. H1.Se2.7	Describe the physical, social, mental, and emotional changes that occur during adolescence. H1.Se2.8	Explain the physical, social, mental, and emotional changes associated with being a young adult. H1.Se2.HSa Describe how sexuality and

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Health Education Core Idea: Sexual Health (Se)

Topic	Grade 6	Grade 7	Grade 8	High School
				sexual expression change throughout the life span. H1.Se2.HSb
3. Self-Identity	Understand the range of gender roles, identity, and expression across cultures. H2.Se3.6	Distinguish between biological sex, gender identity, gender expression, and sexual orientation. H1.Se3.7	Recognize external influences that shape attitudes about gender identity, gender expression, and sexual orientation. H2.Se3.8	Evaluate how culture, media, society, and other people influence our perceptions of gender roles, sexuality, relationships, and sexual orientation. H2.Se3.HS
4. Prevention	Define abstinence and explain why it is the most effective method to prevent pregnancy and sexually transmitted infections (STDs), including HIV. H1.Se4.6a Explain how STDs are transmitted and prevented. H1.Se4.6b Identify examples of protective factors and risk behaviors. H1.Se4.6c	List and describe commonly used methods of birth control, including abstinence. H1.Se4.7a Describe methods to prevent the transmission of STDs/HIV, including abstinence. H1.Se4.7b Understand that all STDs are treatable and many are curable. H1.Se4.7c Identify medically accurate information about STDs. H3.Se4.7 Identify a decision-making model that can be used to make	Summarize ways to prevent pregnancy and STDs. H1.Se4.8a List steps to using a condom correctly. H7.Se4.8 Identify medically accurate resources about contraceptive methods, STDs/HIV, and pregnancy. H3.Se4.8 Summarize signs, symptoms, potential impact, and treatment of STDs. H1.Se4.8b Use a decision-making model to make a health-related decision. H5.Se4.8	Evaluate the effectiveness of abstinence, condoms, and other contraceptives in preventing pregnancy and STDs/HIV. H1.Se4.HSa Demonstrate steps to using a condom correctly. H7.Se4.HS Identify local youth-friendly sexual health services. H3.Se4.HS Understand that people can choose abstinence at different times in their lives. H1.Se4.HSb Advocate for STD testing and

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Health Education Core Idea: Sexual Health (Se)

Topic	Grade 6	Grade 7	Grade 8	High School
		a health-related decision. H5.Se4.7 Describe factors that contribute to or protect against engaging in risk behaviors. H1.Se4.7d	Compare and contrast potential outcomes of risk behaviors and protective factors. H1.Se4.8c Describe personal role in protecting one's own sexual and reproductive health. H7.Se4.8	treatment for sexually active youth. H8.Se4.HS Use a decision-making model to make a sexual health-related decision. H5.Se4.HS
5. Healthy Relationships	Explain importance of talking with a family member and other trusted adults about relationships. H3.Se5.6 Identify ways to communicate effectively in a variety of relationships. H1.Se5.6a Recognize that everyone has the right to set boundaries based on personal values. H1.Se5.6b	Describe characteristics of healthy and unhealthy relationships. H1.Se5.7 Demonstrate communication skills that foster healthy relationships. H4.Se5.7a Explain importance of setting personal boundaries and showing respect for the boundaries and values of others. H4.Se5.7b	Explain how to build and maintain healthy family, peer, and dating relationships. H1.Se5.8a Define sexual consent and identify ways that consent can be communicated and accepted. H1.Se5.8b Analyze the impact of technology and social media on friendships and relationships. H2.Se8.8. Develop a plan to communicate and maintain personal boundaries and values. H6.Se5.8	Differentiate between affection, love, commitment, and sexual attraction. H1.Se5.HSa Compare and contrast characteristics of healthy and unhealthy romantic and sexual relationships. H1.Se5.HSb Demonstrate effective ways to communicate with a partner about healthy sexual decisions and consent. H4.Se5.HS Analyze factors that can affect the ability to give or recognize consent to sexual activity. H2.Se5.HS Identify ways to access accurate

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Health Education Core Idea: Sexual Health (Se)

Topic	Grade 6	Grade 7	Grade 8	High School
				information and resources for survivors of sexual offenses. H3.Se5.HS
6. Washington State Laws	Understand which sexual health care services are available to youth. H1.Se6.6a Understand that there are behaviors that constitute sexual offenses. H1.Se6.6b Understand that it is illegal to send or post sexually explicit images or messages electronically. H1.Se6.6c	Identify laws related to accessing sexual health care services. H1.Se6.7a Define sexual offenses as they relate to state law. H1.Se6.7b Identify consequences of sharing sexually explicit pictures or messages. H1.Se6.7c	Understand laws related to accessing sexual health care services. H1.Se6.8a Understand importance of personal responsibility for sexual decisions. H7.Se6.HS Identify state laws related to sexual offenses, including when a minor is involved. H1.Se6.8b Explain consequences of sharing sexually explicit pictures or messages. H1.Se6.8c	Describe laws related to accessing sexual health care services. H3.Se6.HS Understand importance of personal and social responsibility for sexual decisions. H7.Se6.HS Examine laws and consequences related to sexual offenses, including when a minor is involved. H1.Se6.HSa Identify laws and concerns related to sending or posting sexually explicit pictures or messages. H1.Se6.HSb

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Health Education Core Idea: Social Emotional Health (So)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Self-Esteem	Understand positive self-talk. H1.So1.K	Compare and contrast positive and negative self-talk. H1.So1.1	Identify personal strengths and challenges. H1.So1.2a Recognize that practice develops confidence. H1.So1.2b	Define self-esteem. H1.So1.3a Identify characteristics of healthy self-esteem. H1.So1.3b Understand self-esteem can be enhanced by working through challenges. H1.So1.3c	Compare and contrast high and low self-esteem. H1.So1.4a Understand the connection between self-esteem and healthy decision-making. H1.So1.4b	Explain how high self-esteem is a sign of emotional well-being. H1.So1.5a Recognize how self-esteem is impacted by family and peers. H1.So1.5b
2. Body Image	*Developmentally appropriate outcomes first appear in grade 2.*	*Developmentally appropriate outcomes first appear in grade 2.*	Understand body size, shape, and appearance are partially determined by genetics. H1.So2.2	Identify positive and negative influences on body image. H2.So2.3	Understand influences of family, culture, and media on body image. H2.So2.4	Describe influence of peers and social media on body image. H2.So2.5
3. Stress Management	Identify characteristics of stress. H1.So3.K	Recognize positive and negative effects of stress. H1.So3.1 Identify basic stress management techniques. H7.So3.1	Identify causes of stress. H1.So3.2a Describe stress management techniques. H1.So3.2b	Explain how the body reacts to stress. H1.So3.3a Identify personal stressors. H1.So3.3b Identify strategies to manage personal	Explain emotional reactions to stress. H1.So3.4a Describe relationship between attitude and stress. H1.So3.4b Explain how stress	List ways to support others in stressful situations. H8.So3.5 Compare healthy and unhealthy ways to manage stress. H7.So3.5

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Health Education Core Idea: Social Emotional Health (So)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
				stress. H7.So3.3	management techniques positively impact health. H1.So3.4c	
4. Expressing Emotions	Identify different kinds of emotions. H1.So4.Ka Identify appropriate ways to express and manage emotions. H1.So4.Kb	Describe appropriate ways to express emotions. H1.So4.1a Recognize importance of being sensitive to others' feelings. H1.So4.1b	Demonstrate appropriate ways to express emotions. H4.So4.2 Understand relationship between emotions and behaviors. H1.So4.2	Describe importance of being aware of one's own feelings. H1.So4.3a Identify characteristics of self-control. H1.So4.3b	Explain how expression of emotions may impact others. H4.So4.4a Understand how to express empathy. H4.So4.4b	Understand ways to manage difficult emotions. H1.So4.5a Identify resources for managing emotions. H1.So4.5b
5. Harassment, Intimidation, and Bullying	Recognize bullying and teasing. H1.So5.K Recognize ways to respond appropriately to bullying and teasing. H4.So5.K	Distinguish between bullying and teasing. H1.So5.1a Discuss harmful effects of bullying and teasing. H1.So5.1b List ways to respond appropriately to bullying and teasing. H4.So5.1	Define bystanders and interveners related to bullying. H1.So5.2 Identify strategies to intervene safely when someone is being bullied or teased. H8.So5.2	Demonstrate how to respond appropriately to bullying or teasing. H4.So5.3 Identify benefits of intervening and disadvantages of being a bystander. H8.So5.3 Recognize harassment and intimidation. H1.So5.3	Compare and contrast bullying, teasing, harassment, and intimidation. H1.So5.4 Demonstrate how to respond appropriately to bullying, harassment, and intimidation. H4.So5.4	Explain how bullying, intimidation, and harassment affect individuals. H1.So5.5a Advocate for self and others to prevent bullying, harassment, and intimidation. H8.So5.5 Define sexual harassment.

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Health Education Core Idea: Social Emotional Health (So)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
						H1.So5.5b Understand cyber-bullying. H1.So5.5c

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Health Education Core Idea: Social Emotional Health (So)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Self-Esteem	Describe factors that can influence self-esteem. H1.So1.6a Understand how to improve one's self-esteem. H1.So1.6b	Explain how self-esteem influences personal health choices. H1.So1.7 Describe personal choices that can positively impact self-esteem. H7.So1.7	Compare characteristics of high and low self-esteem and impacts on health. H1.So1.8 Demonstrate ability to make choices that positively impact self-esteem. H7.So1.8	Assess self-esteem and determine its impact on personal dimensions of health. H1.So1.HSa Understand changes in self-esteem can occur as people mature. H1.So1.HSb
2. Body Image and Eating Disorders	Describe how self-esteem and body image are related. H1.So2.6a Explain importance of a positive body image. H1.So2.6b	Explain how peers and media influence body image. H2.So2.7	Explain how body image influences eating disorders. H2.So2.8 Identify signs, symptoms, and consequences of eating disorders. H1.So2.8	Explain why people with eating disorders need support services. H3.So2.HS Identify supportive services for people with eating disorders. H1.So2.HS Describe how to support someone who has symptoms of an eating disorder. H8.So2.HS
3. Stress Management	Define stressor, eustress, and distress. H1.So3.6a Explain causes and effects of stress. H1.So3.6b Understand stress management	Differentiate between eustress and distress. H1.So3.7 Compare healthy and unhealthy ways of dealing with stress. H7.So3.7	Analyze effects of eustress and distress. H1.So3.8 Evaluate personal stress management techniques. H7.So3.8	Identify physical and psychological responses to stressors. H1.So3.HS Develop a personal stress management plan. H7.So3.HS

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Health Education Core Idea: Social Emotional Health (So)

Topic	Grade 6	Grade 7	Grade 8	High School
	techniques. H7.So3.6			
4. Expressing Emotions	Explain importance of understanding other perspectives when resolving interpersonal conflicts. H1.So4.6a Summarize characteristics of empathy and compassion. H1.So4.6b Investigate resources for support when dealing with difficult emotions. H3.So4.6	Describe ways to manage interpersonal conflict. H1.So4.7a Explain how expressing emotions or feelings can influence others. H1.So4.7b	Demonstrate ways to manage or resolve interpersonal conflict. H4.So4.8 Compare and contrast the influence of family, culture, and media on how emotions are expressed. H2.So4.8	Advocate for ways to manage or resolve interpersonal conflict. H8.So4.HS Summarize strategies for coping with difficult emotions, including defense mechanisms. H1.So4.HS Demonstrate effective communication skills to express emotions. H4.So4.HS
5. Harassment, Intimidation, and Bullying	Describe different types of harassment, intimidation, and bullying. H1.So5.6a Analyze harmful effects of harassment, intimidation, and bullying. H1.So5.6b	Determine strategies for responding to harassment, intimidation, and bullying. H5.So5.7 Explain how harassment, intimidation, and bullying affect individuals, families, and communities. H1.So5.7	Describe possible consequences of harassment, intimidation, and bullying. H1.So5.8a Advocate for a bully-free school and community environment. H8.So5.8 Understand connection between bullying and harmful behaviors including suicide. H1.So5.8c	Analyze strategies to prevent and respond to different types of harassment, intimidation, and bullying. H1.So5.HS Compare and contrast the influence of family, peers, culture, media, technology, and other factors on harassment, intimidation, and bullying. H2.So5.HS

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Health Education Core Idea: Social Emotional Health (So)

Topic	Grade 6	Grade 7	Grade 8	High School
6. Emotional, Mental, and Behavioral Health	Identify signs and symptoms of depression and anxiety. H1.So6.6a Describe situations that call for professional emotional and mental and behavioral health services. H3.So6.6 Identify reasons individuals may want to harm themselves. H1.So6.6b Understand that emotional and mental and behavioral health and well-being are as important as physical health and well-being. H1.So6.6c Define stigma related to mental and behavioral health. H1.So6.6d	Identify different emotional and mental and behavioral health disorders. H1.So6.7a Identify valid and reliable emotional and mental and behavioral health services. H3.So6.7 Identify risk factors associated with self-harm and/or suicide. H1.So6.7b Recognize how culture and media impact access to mental and behavioral health services. H2.So6.7 Demonstrate supportive responses to people who may be experiencing mental and behavioral health disorders. H4.So6.7 Identify how individuals experience stigma related to mental and behavioral health. H1.So6.7c	Explain causes, symptoms, and effects of emotional and mental and behavioral health disorders. H1.So6.8a Identify valid and reliable emotional and mental and behavioral health supports and services available to youth age 13 and older. H3.So6.8 Recognize signs that someone may be at risk of suicide. H1.So6.8b Recognize stigma as it relates to emotional and mental and behavioral health. H1.So6.8d	Compare and contrast emotional and mental and behavioral illness, mental well-being, and concurrent disorders. H1.So6.HSa Describe how self-harm or suicide impacts other people. H1.So6.HSb Explain how to help someone who is thinking about attempting suicide. H1.So6.HSc Identify school and community resources that can help a person with emotional and mental and behavioral health concerns. H3.So6.HSa Describe laws related to minors accessing mental health care. H3.So6.HSb Advocate for reducing stigma associated with emotional and mental and behavioral health. H8.So6.HS

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Health Education Core Idea: Substance Use and Abuse (Su)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1. Use and Abuse	Understand how medicines are used correctly. H1.Su1.Ka Recognize differences between medicines and harmful drugs. H1.Su1.Kb Identify trusted adults at home and school who administer prescriptions and over-the-counter medicines. H3.Su1.Kc	Understand differences between safe and unwanted medicine use. H1.Su1.1a Identify different medicines and harmful drugs. H1.Su1.1b Understand tobacco and alcohol are harmful drugs. H1.Su1.1c	Understand differences between prescription medicines, over-the-counter medicines, and harmful drugs. H1.Su1.2a Understand commonly used terms for tobacco and alcohol. H1.Su1.2b	Compare and contrast prescription and over-the-counter medicines with harmful drugs. H1.Su1.3a Understand commonly used terms for marijuana. H1.Su1.3b Identify how family, school, and community influence decisions related to tobacco, alcohol, and marijuana. H2.Su1.3	Understand differences between medically accurate use and abuse of prescriptions and over-the-counter medicines. H1.Su1.4a Understand tobacco, alcohol, and marijuana are illegal for minors. H1.Su1.4b Describe reasons people use tobacco, alcohol, and other drugs. H1.Su1.4c Identify how peers, media, and technology influence decisions related to tobacco, alcohol, and marijuana. H2.Su1.4	Identify reliable sources of information about tobacco, alcohol, and other drugs. H3.Su1.5 Identify a variety of tobacco, alcohol, and marijuana products. H1.Su1.5a Recognize that tobacco, alcohol, and other drugs can be addictive. H1.Su1.5b Describe how family, school, community, peers, media, and technology influence decisions related to use of tobacco, alcohol, marijuana, and other drugs. H2.Su1.5
2. Effects	*Developmentally appropriate outcomes*	Recognize effects of medicines used	Understand effects of tobacco and alcohol.	Describe effects of tobacco, secondhand	Describe harmful effects of medicines,	Recognize substances are more addictive and

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Health Education Core Idea: Substance Use and Abuse (Su)

Topic	Kindergarten	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
	first appear in grade 1.	incorrectly. H1.Su2.1	H1.Su2.2	smoke, alcohol, and marijuana. H1.Su2.3	tobacco, alcohol, and marijuana. H1.Su2.4	harmful during growth and development. H1.Su2.5a Explain how substance abuse can affect family and friends. H1.Su2.5b
3. Prevention	Understand importance of using medicines only with supervision of a trusted adult. H1.Su3.K	Recognize how to tell a trusted adult when offered nonprescribed medicine or harmful drugs. H4.Su3.1 Recognize importance of avoiding tobacco, secondhand smoke, and alcohol. H1.Su3.1	Describe how to use refusal skills when offered nonprescribed medicine or harmful drugs. H4.Su3.2 Identify benefits of being tobacco- and alcohol-free. H1.Su3.2 Demonstrate refusal skills in different situations. H1.Su3.2	Describe verbal and nonverbal communication skills to avoid tobacco, alcohol, and marijuana. H4.Su3.3 Identify situations and potential outcomes of decisions related to tobacco, alcohol, and marijuana. H5.Su3.3	Describe how to ask for help to avoid situations in which others are using tobacco, alcohol, or marijuana. H4.Su3.4 Determine benefits of abstaining from or discontinuing use of tobacco, alcohol, and marijuana. H1.Su3.4	Demonstrate ways to resist peer pressure to use substances. H4.Su3.5 Identify healthy alternatives for decisions related to substance use. H5.Su3.5

Health education teachers should provide a variety of age-appropriate and grade-level opportunities for students to demonstrate skill development and competency. They should not, however, use the standards to compare students. The standards and outcomes consider differences in cultural norms and access to resources outside of school and include alternative activities to engage students. Health education teachers may modify terminology when implementing the standards to ensure that students understand the concepts. The Health Education Glossary contains definitions for many of the terms used in the standards and outcomes.

Health Education Core Idea: Substance Use and Abuse (Su)

Topic	Grade 6	Grade 7	Grade 8	High School
1. Use and Abuse	Explain differences between appropriate use, misuse, and abuse of substances. H1.Su1.6a Understand stages of addiction. H1.Su1.6b Describe how peers and family influence substance use and abuse. H2.Su1.6	Distinguish between substance use, misuse, abuse, dependency, and addiction. H1.Su1.7 Describe how peers and media influence substance use and abuse. H2.Su1.7	Analyze factors that influence substance use and abuse. H2.Su1.8 Compare and contrast sources of information on substance use. H3.Su1.8 Explain classifications of substances. H1.Su1.8	Analyze why individuals choose to use or not use substances. H1.Su1.HSa Differentiate classifications of substances. H1.Su1.HSb Analyze validity of information on substance use. H3.Su1.HSa Describe laws related to minors accessing substance abuse treatment. H3.Su1.5b
2. Effects	Understand short- and long-term effects of substance abuse on physical and mental health. H1.Su2.6	Explain short- and long-term effects of substance abuse on dimensions of health. H1.Su2.7	Describe how substance abuse affects dimensions of health. H1.Su2.8	Summarize short- and long-term effects of substance abuse on dimensions of health. H1.Su2.HSa Analyze how addiction and dependency impact individuals, families, and society. H1.Su2.HSb
3. Prevention	Identify how to use refusal skills to avoid substance use. H1.Su3.6 Identify scenarios in which	Demonstrate use of refusal skills to avoid substance use. H7.Su3.7a	Apply refusal skills to avoid substance use. H7.Su3.8a Demonstrate behaviors and	Predict how a drug-free lifestyle will support achievement of short- and long-term goals. H6.Su3.HS

Health education teachers should provide a variety of age-appropriate and grade-level opportunities for students to demonstrate skill development and competency. They should not, however, use the standards to compare students. The standards and outcomes consider differences in cultural norms and access to resources outside of school and include alternative activities to engage students. Health education teachers may modify terminology when implementing the standards to ensure that students understand the concepts. The Health Education Glossary contains definitions for many of the terms used in the standards and outcomes.

Health Education Core Idea: Substance Use and Abuse (Su)

Topic	Grade 6	Grade 7	Grade 8	High School
	substances may be present and determine strategies to avoid exposure and use. H7.Su3.6 Promote benefits of abstaining from or discontinuing substance use. H8.Su3.6	Assess scenarios in which substances may be present and determine strategies to avoid exposure and use. H7.Su3.7b Construct a message describing benefits of being drug-free. H8.Su3.7	practices to prevent substance use and improve the health of oneself and others. H7.Su3.8b Create a drug-free message for school. H8.Su3.8	Design a drug-free message for a community beyond school. H8.Su3.HS
4. Treatment	Identify valid and reliable substance abuse services. H3.Su4.6	Describe situations that call for professional treatment for substance abuse. H3.Su4.7	Investigate local services for those affected by substance abuse. H3.Su4.8	Analyze valid and reliable information to prevent or treat substance dependency and addiction. H3.Su4.HS Understand how codependency relates to substance use and abuse. H1.Su4.HS
5. Legal Consequences	Identify legal and illegal substances. H1.Su5.6	Understand school policies related to substance possession and use. H1.Su5.7	Describe short- and long-term legal consequences of substance use and the effects on personal goals. H6.Su5.8	Compare and contrast school, local, state, and federal laws related to substance possession and use. H1.Su5.HS

Health education teachers should provide a variety of age-appropriate and grade-level opportunities for students to demonstrate skill development and competency. They should not, however, use the standards to compare students. The standards and outcomes consider differences in cultural norms and access to resources outside of school and include alternative activities to engage students. Health education teachers may modify terminology when implementing the standards to ensure that students understand the concepts. The Health Education Glossary contains definitions for many of the terms used in the standards and outcomes.

Exhibit 13

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501WAPREP
FAIN# 2501WAPREP
Federal Award Date: August 6, 2025

Recipient Information

1. Recipient Name
HEALTH, WASHINGTON STATE DEPARTMENT OF
PO Box 47880

OLYMPIA, WASHINGTON 98504 7880

2. Congressional District of Recipient
*See Remarks

3. Payment Account Number and Type
*See Remarks

4. Employer Identification Number (EIN)
1911444603A1

5. Data Universal Numbering System (DUNS)
808883128

6. Recipient's Unique Entity Identifier
C16SP2HBR123

7. Project Director or Principal Investigator
Mary Clark

Mary.Clark@doh.Wa.Gov
360-236-3940

8. Authorized Official
*See Remarks

Federal Agency Information

9. Awarding Agency Contact Information
David Lee
Grants Management Officer
david.lee@acf.hhs.gov
202-401-5461

10. Program Official Contact Information
Debbie Powell
Deputy Associate Commissioner
ACYF - Family and Youth Services Bureau
debbie.powell@acf.hhs.gov
(202) 205 2360

Federal Award Information

11. Award Number
2501WAPREP

12. Unique Federal Award Identification Number (FAIN)
2501WAPREP

13. Statutory Authority
Section 513 of the Social Security Act

14. Federal Award Project Title
*See Remarks

15. Assistance Listing Number
93.092

16. Assistance Listing Program Title
Personal Responsibility Education Program

17. Award Action Type
Supplement

18. Is the Award R&D?
*See Remarks

Summary Federal Award	Financial Information
19. Budget Period Start Date 10-01-2024	**End Date** 09-30-2027
20. Total Amount of Federal Funds Obligated by this Action	$712,515.00
20a. Direct Cost Amount	*See Remarks
20b. Indirect Cost Amount Administrative Offset	*See Remarks
21. Authorized Carryover	*See Remarks
22. Offset	*See Remarks
23. Total Amount of Federal Funds Obligated this budget period	$1,133,232.00
24. Total Approved Cost Sharing or Matching, where applicable	*See Remarks
25. Total Federal and Non-Federal Approved	*See Remarks
26. Project Period Start Date 10-01-2024 -	**End Date** 09-30-2027
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching	*See Remarks

28. Authorized Treatment of Program Income
*See Remarks

29. Grants Management Officer – Signature

E-sign
David Lee
Grants Management Officer

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501WAPREP
FAIN# 2501WAPREP
Federal Award Date: August 6, 2025

Recipient Information
HEALTH, WASHINGTON STATE DEPARTMENT OF
PO Box 47880
OLYMPIA, WASHINGTON 98504 7880
Employer Identification Number (EIN): 1911444603A1
Data Universal Numbering System (DUNS): 808883128
Recipient's Unique Entity Identifier: C16SP2HBR123
Object Class: 41.15

Financial Information

Appropriation	CAN	Allotment	Award this action	Cumulative Grant Award to Date	Document Number	Funding Type
75-X-1512	2025,G99SU25	$1,133,232.00	$712,515.00	$1,133,232.00	2501WAPREP	Formula

Terms and Conditions

This grant award represents an obligation for the ACF Family and Youth Services Bureau State Personal Responsibility Education Program. Funds are subject to the requirements of Section 513 of Social Security Act.
This award is subject to the requirements listed in the terms and conditions. The use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions. The electronic copy of Terms and Conditions to support this program can be found on the website at: https://acf.gov/grants/manage-grant/grant-award/award-terms.
Recipients are prohibited from including gender ideology in any program or service that is funded with this award. The statutory authority for the PREP program under which this grant has been awarded, at 42 U.S.C. § 713, does not authorize teaching students that gender identity is distinct from biological sex or boys can identify as girls and vice versa, or that there is a vast spectrum of genders that are disconnected from one's sex. Therefore, gender ideology is outside of the scope of the statutory authority for this award. In addition, any costs associated with gender ideology are not allowable expenditures of federal grant funds or maintenance-of-effort funds for this grant because they are not necessary, reasonable, or allocable for the performance of this award. See 45 C.F.R. §§ 75.403-405.

Remarks

* This field is intended to be included in the standardized Notice of Award and will be displayed in subsequent quarters.

Recipients are prohibited from including gender ideology in any program or service that is funded with this award. Please refer to Additional Term and Condition section of the Supplemental Terms and Conditions for more information on this requirement.

Exhibit 14

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501MNSRAE
FAIN# 2501MNSRAE
Federal Award Date: August 6, 2025

Recipient Information

1. Recipient Name
MINNESOTA DEPARTMENT OF HEALTH
85 East Seventh Place
Suite 220

ST PAUL, MINNESOTA 55164

2. Congressional District of Recipient
*See Remarks

3. Payment Account Number and Type
*See Remarks

4. Employer Identification Number (EIN)
1416007162B3

5. Data Universal Numbering System (DUNS)
804887321

6. Recipient's Unique Entity Identifier
DHQVY2WCVHC5

7. Project Director or Principal Investigator
Emily McDowell
Project Director
emily.mcdowell@state.mn.us

8. Authorized Official
*See Remarks

Federal Agency Information

9. Awarding Agency Contact Information
David Lee
Grants Management Officer
david.lee@acf.hhs.gov
202-401-5461

10. Program Official Contact Information
Jerry Milner
Program Authorizing Official
ACYF - Family and Youth Services Bureau
Milner.Jerry@acf.hhs.gov
111-111-1111

Federal Award Information

11. Award Number
2501MNSRAE

12. Unique Federal Award Identification Number (FAIN)
2501MNSRAE

13. Statutory Authority
The Bipartisan Budget Act of 2018, Title V, Section 2954, Public Law 113-93, 42 US Code 710

14. Federal Award Project Title
*See Remarks

15. Assistance Listing Number
93.235

16. Assistance Listing Program Title
Sexual Risk Avoidance Education (SRAE)

17. Award Action Type
Supplement

18. Is the Award R&D?
*See Remarks

Summary Federal Award	Financial Information
19. Budget Period Start Date 10-01-2024	**End Date** 09-30-2026
20. Total Amount of Federal Funds Obligated by this Action	$447,776.00
20a. Direct Cost Amount	*See Remarks
20b. Indirect Cost Amount Administrative Offset	*See Remarks
21. Authorized Carryover	*See Remarks
22. Offset	*See Remarks
23. Total Amount of Federal Funds Obligated this budget period	$660,122.00
24. Total Approved Cost Sharing or Matching, where applicable	*See Remarks
25. Total Federal and Non-Federal Approved	*See Remarks
26. Project Period Start Date 10-01-2024 -	**End Date** 09-30-2026
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching	*See Remarks

28. Authorized Treatment of Program Income
*See Remarks

29. Grants Management Officer – Signature

David Lee
Grants Management Officer

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2501MNSRAE
FAIN# 2501MNSRAE
Federal Award Date: August 6, 2025

Recipient Information
MINNESOTA DEPARTMENT OF HEALTH
85 East Seventh Place
Suite 220
ST PAUL, MINNESOTA 55164
Employer Identification Number (EIN): 1416007162B3
Data Universal Numbering System (DUNS): 804887321
Recipient's Unique Entity Identifier: DHQVY2WCVHC5
Object Class: 41.15

Financial Information

Appropriation	CAN	Allotment	Award this action	Cumulative Grant Award to Date	Document Number	Funding Type
75-25-1512	2025,G990597	$660,122.00	$447,776.00	$660,122.00	2501MNSRAE	Formula

Terms and Conditions

This grant award represents an obligation for the ACF Family and Youth Services Bureau State Sexual Risk Avoidance Education Program. Funds are subject to the requirements of Section 510 of Social Security Act.
This award is subject to the requirements listed in the terms and conditions. The use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions. The electronic copy of Terms and Conditions to support this program can be found on the website at: https://acf.gov/grants/manage-grant/grant-award/award-terms.
Recipients are prohibited from including gender ideology in any program or service that is funded with this award. The statutory authority for the SRAE program under which this grant has been awarded, at 42 U.S.C. § 710, does not authorize teaching students that gender identity is distinct from biological sex or boys can identify as girls and vice versa, or that there is a vast spectrum of genders that are disconnected from one's sex. Therefore, gender ideology is outside of the scope of the statutory authority for this award. In addition, any costs associated with gender ideology are not allowable expenditures for this grant because they are not necessary, reasonable, or allocable for the performance of this award. See 45 C.F.R. §§ 75.403-405.

Remarks

* This field is intended to be included in the standardized Notice of Award and will be displayed in subsequent quarters.

Recipients are prohibited from including gender ideology in any program or service that is funded with this award. Please refer to Additional Term and Condition section of the Supplemental Terms and Conditions for more information on this requirement.

Exhibit 15

Federal Fiscal Year 2025

SUPPLEMENTAL TERMS and CONDITIONS

The **Standard Terms and Conditions** apply to all non-discretionary programs. These Supplemental Terms and Conditions (T&Cs) are additional requirements applicable to the program named below.

By acceptance of awards for this program, the recipient agrees to comply with the requirements included in both the General and Supplemental Terms and Conditions for this program.

Administration on Children, Youth, and Families (ACYF)
Family and Youth Services Bureau (FYSB)

State Personal Responsibility Education Program (PREP)
Assistance Listing No. 93.092

EFFECTIVE PERIOD

The supplemental T&Cs are effective on the date shown in the footer at the bottom of the respective pages and applies to awards and award modifications that add funding which are issued on or after that date (including any supplements to awards and competing and non-competing continuation awards). For recipients of such awards, the T&Cs supersede all previous similar T&Cs and will remain in effect until updated for subsequent awards. All T&Cs will be updated and reissued, as needed.

APPLICABLE LEGISLATION, STATUTE, REGULATIONS

1. The administration of this program is authorized under Title V, Section 513, of the Social Security Act (the Act).

2. The program is codified at 42 U.S.C. §713.

3. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards located under 2 CFR Parts 200 and 300). In accordance with 2 CFR §200.101, Applicability, this program must comply with 2 CFR 200 in its entirety. No exceptions were identified.

4. Additional applicable regulations and requirements can be found in the ACF Standard Terms and Conditions.

ADDITIONAL TERM AND CONDITION

5. Recipients are prohibited from including gender ideology in any program or service that is funded with this award. The statutory authority for the PREP program under which this grant has been awarded, at 42 U.S.C. §713, does not authorize teaching students that gender identity is distinct from biological sex or boys can identify as girls and vice versa, or that there is a vast spectrum of genders that are disconnected from one's sex. Therefore, gender ideology is outside of the scope of the statutory authority for this award. In addition, any costs associated with gender ideology are not allowable expenditures of federal grant funds or maintenance-of-effort funds for this grant because they are not necessary, reasonable, or allocable for the performance of this award. *See* 45 C.F.R. §§ 75.403-405.

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

6. This program has a Maintenance of Effort (MOE) requirement per Section 513(a)(5) of the Act (42 U.S.C. §713(a)(5)). No payment shall be made from the allotment awarded under 513(a)(4), if the non-federal expenditure is less than the amount expended by the state, organization, or entity for such programs or initiatives for fiscal year 2023 (or the fiscal year amended by subsequent Public Laws).

7. MOE is a statutory requirement where the state, local organization, or entities awarded under this program is required, as a condition of eligibility for federal funding, to maintain its financial contribution to the program. MOE must be used to supplement not supplant federal funds with existing non-federal funds. State, local organizations or entities under this award may not replace or supplant federal funds to meet program requirements.

FINANCIAL REPORTING

8. Federal funds awarded under this grant must be expended for the purposes for which they were awarded and within the time period allotted.

9. The OMB approved Financial Reporting form for this program is the Federal Financial Report SF-425. The SF-425 is due annually and no later than December 30, which is 90 days after the end of each reporting period.

    a. Submission Methodology: All periodic SF-425 financial reports for all grant programs must be submitted electronically through the Payment Management System (PMS). Recipients must not submit duplicate copies either by mail, by fax or as an email attachment of any reports submitted.

    b. Submission Schedule: Annual. Each annual financial report must be submitted within 90 days (i.e., no later than December 30) following the end of each Federal Fiscal Year (FFY).

        i. An interim financial report (covering Year 1 of the project period) is due 90 days following the end of Federal Fiscal Year 1.
        ii. An interim financial report (covering Year 2 of the project period) is due 90 days following the end of the Federal Fiscal Year 2.
        iii. A final financial report (cumulative, covering the entire 3-year project period) is due 120 days following the end of Federal Fiscal Year 3.

10. Obligation Deadline:

    a. In accordance with Section 503(b) of the Act (42 U.S.C. §703(b)), the State Personal Responsibility Education program has a 3-year project/obligation period starting from the first day of the FFY for which these funds were awarded through the last day of the next FFY. (i.e., October 1, Federal Fiscal Year 1 through September 30, Federal Fiscal Year 3). Any Federal funds not obligated by the end of the obligation period will be recouped by this Department.

11. Liquidation Deadline:

    a. In accordance with 2 CFR § 200.344(b), a recipient must liquidate all obligations incurred under the award no later than 120 days after the end of the funding/obligation period (i.e., December 30 following the end of Federal Fiscal Year 3). Any Federal funds from this award not liquidated by this date will be recouped by this Department.

PROGRAM REPORTING AND REQUIREMENTS

12. The OMB approved Program Report form for this program is the Performance Progress Report (PPR). Semi-annual narrative program performance reports must describe the program activities carried out, including an assessment of the effectiveness of those activities in achieving the purposes of this award. Each report covers the preceding 6-month period and is due 30 days following the end of the 2nd and 4th quarters (i.e., no later than April 30 and October 30, respectively). Please refer to the general terms and conditions for electronic submission guidance.

13. All recipients and subrecipient(s), including their implementation sites, will be required to collect and report information on program implementation and program outcomes through a common set of performance measures. This requirement applies to any community partners that agree to host a site or recruit program participants (e.g., school districts, non-profits). Recipients must collect and report on these measures twice a year.

14. Recipients will be expected to check local and state laws, policies, and procedures to ensure that the collection of performance measures data is feasible and obtain any necessary permissions (e.g., formal agreements with partners, Institutional Review Board (IRB) approval, copies of school district approvals) to collect these data. Recipients are responsible for ensuring all subrecipients and implementation sites collect and submit the PREP performance measures. Recipients may develop additional indicators of program performance, as needed, including adding items to the entry or exit surveys. However, all FYSB OMB-approved items must be administered first, in the order presented in the approved survey, before any additional items are added. Any additional survey items should be added at the end of the OMB-approved survey and should not be submitted to ACF.

15. Additional program conditions:

    a. Have the project fully functioning and serving youth within at least 90 days following the issuance of the Notice of Award.

    b. Formally train facilitators/educators in the evidence-based effective program model or elements of the effective program model by professionals who can provide follow-up technical assistance to facilitators.

    c. Provide PREP programming to youth populations who are the most high-risk or vulnerable for pregnancies and sexually transmitted infections, including HIV/AIDS, youth in or aging out of foster care or adjudication systems; youth who are victims of trafficking; youth who have runaway or left home without permission; youth experiencing homelessness; and other vulnerable or underserved youth populations.

    d. Send at least two key staff persons to the Adolescent Pregnancy Prevention (APP) Program Grantee Training if held during the project period. A minimum of two staff persons are to attend at least one of two topical training sessions offered each year of the project in areas such as Washington, DC; Phoenix, AZ; and Boston, MA.

    e. Collect and report on all OMB cleared federal PREP performance measures (recipient, partners, and subrecipients). PREP Performance Measures are currently approved under OMB # 0970-0497, expiration date 07/31/2026.

    f. For states and subrecipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.

    g. Submit curricula and programmatic materials to FYSB, as requested, for a medical accuracy review and provide a plan to comply with making any required modifications.

PROPERTY REPORTING

16. The OMB approved property reporting forms are the following:

    h. Real Property Reports (SF-429s). The SF-429 Real Property forms are not applicable to this program. Purchase, construction, and major renovation are not an allowable activity or expenditure under this program. For more information, see the ACF Standard Terms and Conditions.

    i. Tangible Property Report (SF-428s). The SF-428 Tangible Personal Property forms must be submitted as described in the Standard Terms and Conditions.

POINTS OF CONTACT

17. Points of contact for additional information or questions concerning either the operation of the program or related financial matters can be found on the Notice of Award.

a. Program Office:
Sierra Baker
Program Specialist
330 C St., SW.
Washington, DC 20201
Sierra.Baker@acf.hhs.gov
202-401-4663

b. Office Grants Management:
David Lee
Grants Management Officer
330 C St., SW.
Washington, DC. 20201
David%20Lee@acf.hhs.gov
202-401-5461

Exhibit 16

FISCAL YEAR 2025

SUPPLEMENTAL TERMS and CONDITIONS

The ***ACF Standard Terms and Conditions*** applies to all ACF awards and is located on the **Award Terms and Conditions** (T&C) page. The *Supplemental Terms and Conditions* herein are additional requirements applicable to the program named below.

By acceptance of awards for this program, the recipient agrees to comply with the requirements included in both the *Standard* and *Supplemental Terms and Conditions* for this program.

Administration on Children, Youth, and Families (ACYF)
Family and Youth Services Bureau (FYSB)

Title V State Sexual Risk Avoidance Education (SRAE) Program

Assistance Listing No. 93.235

EFFECTIVE PERIOD

The supplemental T&Cs are effective on the date shown in the footer at the bottom of the respective pages and applies to awards and award modifications that add funding which are issued on or after that date (including any supplements to awards and competing and non-competing continuation awards). For recipients of such awards, the T&Cs supersede all previous similar T&Cs and will remain in effect until updated for subsequent awards. All T&Cs will be updated and reissued, as needed.

APPLICABLE LEGISLATION, STATUTE, REGULATIONS

1. The administration of this program is authorized under Title V, Section 510, of the Social Security Act (the Act).

2. The program is codified at 42 U.S.C. §710.

3. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards located under 2 CFR Parts 200 and 300. In accordance with 2 CFR §200.101, Applicability, this program must comply with 2 CFR 200 in its entirety. No exceptions were identified.

4. Additional program and applicable regulation and requirements include:

    a. The Notice of Funding Opportunity (NOFO) found here: HHS-2024-ACF-ACYF-SRAE-0044
    b. The ACF Standard Terms and Conditions

ADDITIONAL TERM AND CONDITION

5. Recipients are prohibited from including gender ideology in any program or service that is funded with this award. The statutory authority for the SRAE program under which this grant has been awarded, at 42 U.S.C. §710, does not authorize teaching students that gender identity is distinct from biological sex or boys can identify as girls and vice versa, or that there is a vast spectrum of genders that are disconnected from one's sex. Therefore, gender ideology is outside of the scope of the statutory authority for this award. In addition, any costs associated with gender ideology are not allowable expenditures of federal grant funds or maintenance-of-effort funds for this grant because they are not necessary, reasonable, or allocable for the performance of this award. *See* 45 C.F.R. §§ 75.403-405.

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

6. The Title V State SRAE does not require a match.

FINANCIAL MANAGEMENT AND REPORTING

7. Federal funds awarded under this grant must be expended for the purposes for which they were awarded and within the time period allotted.

8. The OMB approved Financial Reporting form for this program is the Federal Financial Report SF-425. The SF-425 is due annually and no later than December 30, which is 90 days after the end of each reporting period.

    a. Submission Methodology: All periodic SF-425 financial reports for all grant programs must be submitted electronically through the Payment Management System (PMS). Recipients must not submit duplicate copies either by mail, by fax or as an email attachment of any reports submitted.

    b. Submission Schedule: Annual. Each annual financial report must be submitted within 90 days (i.e., no later than December 30) following the end of each Federal Fiscal Year (FFY).

        i. An interim financial report (covering Year 1 of the project period) is due 90 days following the end of Federal Fiscal Year 1.
        ii. A final financial report (cumulative, covering the entire 2-year project period) is due 120 days following the end of Federal Fiscal Year 2.

9. Obligation Deadline:

    a. In accordance with Section 503(b) of the Act (42 U.S.C. §703(b)), the Title V State Sexual Risk Avoidance Education program has a 2-year project/obligation period starting from the first day of the FFY for which these funds were awarded through the last day of the next FFY. (i.e., October 1, Federal Fiscal Year 1 through September 30, Federal Fiscal Year 2). Any Federal funds not obligated by the end of the obligation period will be recouped by this Department.

10. Liquidation Deadline:

    a. In accordance with 2 CFR §200.344(b), a recipient must liquidate all obligations incurred under the award no later than 120 days after the end of the funding/obligation period (i.e., January 30 following the end of Federal Fiscal Year 2). Any Federal funds from this award not liquidated by this date will be recouped by this Department.

PROGRAM MANAGEMENT AND REPORTING

11. The OMB approved Program Report form for this program is the Performance Progress Report (PPR). Semi-annual narrative program performance reports must describe the program activities carried out,

including an assessment of the effectiveness of those activities in achieving the purposes of this award. Each report covers the preceding 6-month period and is due 30 days following the end of the 2nd and 4th quarters (i.e., no later than April 30 and October 30, respectively). Please refer to the general terms and conditions for Electronic Submission guidance.

12. All recipients and subrecipient(s), including their implementation sites, will be required to collect and report information on program implementation and program outcomes through a common set of performance measures. This requirement applies to any community partners that agree to host a site or recruit program participants (e.g., school districts, non-profits). SRAE performance measures will be distributed to funded recipients, that will be required to collect and report on these measures approximately twice a year. ACF has defined measures at the recipient, provider, and program levels.

13. Recipients will be expected to check local and state laws, policies, and procedures to ensure that the collection of performance measures data is feasible and obtain any necessary permissions (e.g., formal agreements with partners, Institutional Review Board (IRB) approval, copies of school district approvals) to collect these data. Recipients are responsible for ensuring all subrecipients and implementation sites collect and submit the SRAE performance measures. Recipients may develop additional indicators of program performance, as needed, including adding items to the entry or exit surveys. However, all FYSB OMB-approved items must be administered first, in the order presented in the approved survey, before any additional items are added. Any additional survey items should be added at the end of the OMB-approved survey and should not be submitted to ACF.

14. Additional program conditions:

    a. Have the project fully functioning and serving youth within at least 90 days following the issuance of the Notice of Award.

    b. Formally train facilitators/educators in the evidence-based effective program model or elements of the effective program model by professionals who can provide follow-up technical assistance to facilitators.

    c. Provide SRAE programming that demonstrates the incorporation of positive youth development (PYD) and meaningful youth engagement.

    d. Send at least two key staff persons to the Adolescent Pregnancy Prevention (APP) Program Grantee Training, if held during the project period. A minimum of two staff persons are to attend at least one of two topical training sessions offered each year of the project in areas such as Washington, DC; Phoenix, AZ; and Boston, MA.

    e. Collect and report on all OMB cleared federal SRAE performance measures (recipient, partners, and subrecipients). SRAE Performance Measures are currently approved under OMB # 0970-0536, expiration date 12/31/2025.

    f. For states and subrecipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.

    g. Submit curricula and programmatic materials to FYSB, as requested, for a medical accuracy review and provide a plan to comply with making any required modifications.

    h. Agree to participate in the National Evaluation, if selected.

PROPERTY REPORTING

15. The OMB approved property reporting is the following:

    a. Real Property Reports (SF-429s). The SF-429 Real Property forms are not applicable to this program. Purchase, construction, and major renovation are not an allowable activity or expenditure under this award. For more information, see the *ACF Standard Terms and Conditions*.

    b. Tangible Property Report (SF-428s). The SF-428 Tangible Personal Property forms must be submitted as described in the *ACF Standard Terms and Conditions*.

POINTS OF CONTACT

16. Points of contact for additional information or questions concerning either the operation of the program or related financial matters can be found on the *Notice of Award*.

    a. Program Office
    MeGan Hill
    Program Specialist
    330 C Street, S.W.
    Washington, D.C. 20201
    E-mail: megan.hill@acf.hhs.gov
    Phone: (301) 348-3565

    b. Office of Grants Management
    David Lee
    Supervisory Grant Management Specialist
    330 C Street, S.W.
    Washington, D.C. 20201
    E-mail: david.lee@acf.hhs.gov
    Phone: (202) 401-5461

Exhibit 17

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

August 21, 2025

Sydney Armendariz
California State Personal Responsibility Education Program (PREP)
Division Chief, Maternal Child, and Adolescent Health Division
CA Dept of Public Health/Maternal Child, and Adolescent Health Division
1615 Capitol Avenue, MS 8306
Sacramento, CA 95814

Matthew Green
Deputy Director, Center for Family Health
California Department of Public Health
1615 Capitol Avenue
Sacramento, CA 95814

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (Grant # 2301CAPREP), 2024 (Grant #2401CAPREP) & 2025 (Grant # 2501CAPREP)

Dear Ms. Armendariz and Mr. Green:

Pursuant to 45 Code of Federal Regulations (C.F.R.) §§ 75.371(c), 75.372(a)(1), and 75.373(a), this letter constitutes official notification that the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Family and Youth Services Bureau (FYSB)'s, Division of Positive Youth Development, is hereby terminating all California State Personal Responsibility Education Program (PREP) awards and suspending the funding effective August 21, 2025. The effect of this termination is to shorten the duration of the current budget and project periods without the possibility of additional support under the above-referenced grant awards. California shall not incur new obligations after the effective date of the termination and shall take steps to cancel as many outstanding obligations as possible.

ACF is taking this action for two reasons: (1) the grant is not being administered consistent with the authorizing statute because the funded programs and services include gender ideology which is outside the scope of the statute; and (2) California has failed to modify its State PREP content to remove all references to gender ideology consistent with the additional conditions imposed by ACF. As a result, California failed to demonstrate that the grant and maintenance-of-effort funds are being used on allowable costs, which violates the terms and conditions of the state's three current grant awards. For these reasons, ACF is terminating each of the grants awarded under the California State PREP.

Summary of Findings

On March 27, 2025, ACF requested that California submit all State PREP curricula and programmatic material for a medical accuracy review, in accordance with the terms and conditions of California's three State PREP grants. *See* March 27, 2025 letter; *California State PREP Terms and Conditions, Other Terms and Conditions Section under Program Reporting and Requirements*. California was given three business days from receipt of the letter to provide its curricula and programmatic materials. California submitted its State PREP content on April 1, 2025.

While preparing California's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that falls outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, ACF identified multiple examples of gender ideology content, including lessons teaching students that gender identity is distinct from biological sex and that boys can identify as girls and vice versa.

On June 20, 2025, ACF sent a letter to California that imposed additional grant conditions instructing California to remove all content concerning gender ideology from its State PREP curricula, program materials and any other aspects of its program delivery within 60 days of receipt of the letter and to provide a copy of the modified materials to ACF for approval. *See* June 20, 2025 letter. The letter included specific examples of content in California's State PREP curricula and programmatic materials that constituted unallowable gender ideology teachings that are outside the scope of the authorizing statute and needed to be removed. *Id.* All responsive materials were due on August 19, 2025.

California submitted a response to ACF dated August 19, 2025. California responded, "CDPH will not make any such modifications at this time for several reasons." The listed reasons were: 1) PREP materials had already been reviewed and approved by ACF; 2) the materials are medically accurate; 3) the gender ideology content is relevant to purposes identified in the authorizing statute, specifically the adult preparation subjects listed at 42 U.S.C. § 713(b)(2)(C); and 4) ACF does not have authority to take an enforcement action. *See* August 19, 2025 California letter.

ACF addresses each argument below, but begins here with ACF's authority to terminate California State PREP. The authorizing statute, 42 U.S.C. § 713, and applicable HHS grant regulations at 45 C.F.R. Part 75 establish requirements to which all funded projects must comply or be subject to enforcement actions.

Basis for Termination

ACF is taking this enforcement action under 45 C.F.R. §§ 75.371(c), 75.372(a)(1) and 75.373(a). California's areas of noncompliance are detailed as follows:

1. California State PREP is noncompliant with the federal authorizing statute.

   As explained in the June 20, 2025 letter, gender ideology content is outside the scope of PREP's authorizing statute. The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42

U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2). 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects:

(i) Healthy relationships, including marriage and family interactions
(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects
(iii) Financial literacy
(iv) Parent-child communication
(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity
(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C). The statute does not require, support, or authorize teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute. Applicable regulations require Federal grant recipients to comply with Federal statutes, regulations, and the terms and conditions of the Federal awards, which would include a requirement to comply with the PREP authorizing statute. *See* 45 C.F.R. § 75.303(b). Similarly, Standard Terms and Conditions that are incorporated by reference in each Notice of Award requires grant recipients to comply with "requirements of statutes and regulations applicable to the program under which the award is funded, including authorizing statutes, appropriations statutes, generally applicable statutes, and any regulations related thereto." *See* ACF Standard Terms and Conditions, *Federal Financial Award Assistance*, at 4 (applicable to NOA for Grant #2301CAPREP, NOA for Grant #2401CAPREP, and NOA for Grant # 2501CAPREP).

In its August 19th response, California maintains that gender ideology is authorized under the PREP authorizing statute, specifically under the adult preparation subjects at 42 U.S.C. 713(b)(2)(C). In addition to the fact that gender ideology is not relevant to abstinence and contraception education, gender ideology is also not relevant to the adult preparation subjects listed in the statute. Furthermore, gender ideology is not supported by the weight of science, and thus cannot inform the adult preparation subjects that California refers to such as healthy relationships, healthy attitudes and values about adolescent growth and development, or healthy life skills.

In addition, in its response, California maintains that gender ideology is medically accurate. However, California has not met its statutory obligation to demonstrate that gender ideology is medically accurate. The authorizing statute at 42 U.S.C. § 713(e)(2) defines "medically accurate and complete" as:

> verified or supported by the weight of research conducted in compliance with accepted scientific methods and—
>
> (A) published in peer-reviewed journals, where applicable; or
>
> (B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

This is a very high statutory burden to meet, and ACF notes that California, as with other arguments within its response, simply makes a conclusory statement (claiming medical accuracy).

Because California State PREP's gender ideology content is unauthorized by the PREP program statute, the inclusion of any such content in a program or service that is funded with a State PREP grant violates the statute. The gender ideology content in California's program, including but not limited to the examples listed in the June 20 letter, are wholly unrelated to the statutory requirements and exceed the statutory authority. While we realize that ACF previously approved gender ideology content in the curricula and other programmatic materials, that decision was made in error because such approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress.

Moreover, gender ideology content does not comply with the applicable HHS regulations that limit the expenditure of grant and maintenance-of-effort funds to allowable costs, because such content is not necessary, reasonable, or allocable for the performance of this award. *See* 45 C.F.R. §§ 75.403(a), 75.404(b), and 75.405(a).

2. California failed to adhere to ACF's additional conditions imposed for noncompliance.

California has failed to correct the deficiencies in its State PREP grant and notify ACF accordingly when given an opportunity to do so.[1] ACF's June 20, 2025 letter requested that California remedy its noncompliance within 60 days of receipt of the letter by providing a copy of the modified materials to ACF for approval. *See* June 20, 2025 letter. ACF's instructions constituted an additional condition on California's State PREP grant imposed to remedy noncompliance under 45 C.F.R. § 75.371. California has responded that it will not comply with the imposed conditions, writing "CDPH will not make any

[1] In its response, California asserts that "the materials fully comply with state law, and ACF's proposed modifications may prevent PREP materials from use by California school districts." Neither the prior correspondence nor this enforcement letter concern any wholly state-funded program.

such modifications at this time for several reasons." *See* August 19, 2025 California letter.

It is a fundamental principle of grants law that a grantee bears the burden of demonstrating the allowability and allocability of costs for which it received federal funding. ACF imposed additional conditions that would enable it to show that funds are being used for allowable costs and California, as a PREP grantee, has an obligation to comply in order to meet its burden of demonstrating allowability.

Given the bases outlined above, termination of all California State PREP grants is now appropriate. *See* 45 C.F.R. § 75.371.

Summary of Violations

The above stated facts demonstrate that California is in violation of 42 U.S.C. § 713, 45 C.F.R. § 75.303(b), 45 C.F.R. §§ 75.403(a), 75.404(b), and 75.405(a) and the terms and conditions of the State PREP grant awards. California has demonstrated an unwillingness to modify its State PREP award to adhere to the PREP authorizing statute. Despite receiving an opportunity to correct the identified deficiencies, California has refused to make ACF's requested modifications. Therefore, the Administration for Children and Families has concluded that all California State PREP grants must be terminated.

Please note that this letter does not foreclose ACF from exercising its authority to pursue any other enforcement remedies that are authorized, such as disallowances, pursuant to 45 CFR § 75.371.

Next Steps

ACF will respond separately to drawdown requests that California PREP has submitted through the Payment Management System (PMS) for costs resulting from obligations that occurred prior to August 20, 2025, and any subsequent such requests received from California State PREP within the closeout period. Upon receipt of this letter, California State PREP must take the necessary steps to close out project operations, consistent with the requirements of 45 CFR § 75.381. Per 45 CFR § 75.471, certain costs associated with the termination of an award may be allowable to the award.

Communication will be issued in the coming weeks regarding the process for submitting those costs for approval for payment. Additional un-issued approved funding may be made available during the closeout period of the award for approved costs.

Appeal

This is the final decision of the Administration for Children and Families. It shall be the final decision of the Department unless, within 30 days after receiving this decision, you submit a notice of appeal to the Departmental Appeals Board (DAB), in accordance with 45 C.F.R. § 16.7.

The notice of appeal should note that you intend an appeal, state the amount in dispute, and briefly state why you think the decision is incorrect. Please attach a copy of this decision to your

notice of appeal. Appeals may be filed electronically using the Departmental Appeals Board's e-filing system, DAB E-File, at https://dab.efile.hhs.gov. To use E-File, you or your representative must become a registered user. Detailed instructions can be found on the DAB E-File homepage. Submissions are considered made on the date successfully transmitted via DAB E-File. The DAB will notify you of further procedures.

When submitting your appeal to the DAB, please send a copy of your notice of appeal to David Lee, Grants Management Officer, Office of Grants Management: david.lee@acf.hhs.gov.

Inasmuch as this Notice is sent on August 21, 2025 by Certified Mail, electronic mail, and facsimile, it shall be deemed received by California State PREP as of August 21, 2025 and will be effective August 21, 2025 Eastern Standard Time.

If you have questions regarding the information provided in this letter, please contact Mousumi Banikya, Director, Division of Positive Youth Development, at mousumi.banikya@acf.hhs.gov or Resa Matthew, Deputy Associate Commissioner, Family and Youth Services Bureau at resa.matthew@acf.hhs.gov.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

cc: Drew Brereton, Chief Counsel, California Department of Public Health
Drew.Brereton@cdph.ca.gov

Exhibit 18

CDPH
Health and Human Services Agency
California Department of Public Health

Erica Pan, MD, MPH
Director and State Public Health Officer

Gavin Newsom
Governor

August 19, 2025

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families
Department of Health and Human Services
330 C Street, S.W., Suite 4034
Washington, D.C. 20201

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (Grant # 2301CAPREP), 2024 (Grant #2401CAPREP) & 2025 (Grant # 2501CAPREP)

Dear Mr. Gradison,

On June 20, 2025, the Administration for Children and Families (ACF) requested that the California Department of Public Health (CDPH) remove all content concerning "gender ideology" from curriculum and program materials utilized by Personal Responsibility Education Program (PREP) implementing agencies, and provide a copy of the modified materials to ACF by August 19, 2025.

CDPH will not make any such modifications at this time for several reasons. First, as noted in ACF's request, all materials that a California PREP implementing agency may use have been previously reviewed and approved by your agency. For good reason: the materials are medically accurate and directly relevant to the purposes of personal responsibility education programs set out in the authorizing statute. These include educating youth about "abstinence and contraception for the prevention of pregnancy and sexually transmitted infections" and "adulthood preparation subjects" such as "healthy relationships," "adolescent development, such as the development of healthy attitudes . . . about adolescent growth and development, body image, . . . and other related subjects," and "healthy life skills." 42 U.S.C. § 713(b)(2)(B), (C).

Second, there is no federal law or regulation that authorizes ACF to take any "enforcement action" described in the June 20, 2025 letter. Indeed, consistent with ACF's prior approval of the materials at issue, the materials comply with all federal laws and regulations. And finally, the materials fully comply with state law, and ACF's proposed modifications may prevent PREP materials from use by California school districts. *See* Cal. Educ. Code § 51933(d)(6).

In short, CDPH will continue to comply with federal and California law regarding personal responsibility and sexual health education of youth and pupils in the state.

CDPH reserves the right to challenge any adverse action that ACF or any other federal agency may take as a result of this inability to comply with ACF's request to modify the curriculum and program materials for PREP available to implementing agencies. Thank you for your attention to this matter, and please be sure to copy our Department's Chief Counsel, Drew Brereton, on any responses or follow-up questions. Mr. Brereton can be reached at Drew.Brereton@cdph.ca.gov.

Sincerely,

Matthew Green
Deputy Director, Center for Family Health
California Department of Public Health
1615 Capitol Avenue
Sacramento, CA 95814

Exhibit 19

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

June 20, 2025

Sydney Armendariz
California State Personal Responsibility Education Program (PREP)
Division Chief, Maternal Child, and Adolescent Health Division
CA Dept of Public Health/Maternal Child, and Adolescent Health Division
1615 Capitol Avenue, MS 8306
Sacramento, CA 05899

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (Grant # 2301CAPREP), 2024 (Grant #2401CAPREP) & 2025 (Grant # 2501CAPREP)

Dear Ms. Armendariz:

On March 27, 2025, the Administration for Children and Families (ACF) requested that California provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing California's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from California's PREP curricula and program materials:[1]

Rights, Respect, Responsibility

- Middle School Lesson 1, Page 3: "We've been talking during class about messages people get on how they should act as boys and girls—but as many of you know, there are also people who don't identify as boys or girls, but rather as transgender or gender queer. This means that even if they were called a boy or a girl at birth and may have body parts

[1] ACF initiated a medical accuracy review to determine if California's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, California will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

that are typically associated with being a boy or a girl, on the inside, they feel differently."

- Teachers Guide, Page 23: "Gender Identity: A person's deep-seated, internal sense of who they are as a gendered being – specifically, the gender as which they identify. All people have a gender identity. An adjective used to describe a person whose gender identity is incongruent with (or does not "match") the biological sex they were assigned at birth is "transgender." An adjective used to describe a person whose gender identity is congruent (or "matches") the biological sex they were assigned at birth is "cisgender." Other gender identities may include non-binary, agender, bigender, genderfluid, and genderqueer."

Making Proud Choices 5th Edition Facilitator Curriculum California

- Page 279: "Transgender refers to a person's gender identity. Gender identity is your inner sense of your gender—Do you feel like a guy? Do you feel like a girl? Do you feel like something different than a guy or a girl? Often gender identity matches a person's body—someone with a girl's body feels like a girl on the inside or someone with a boy's body feels like a boy on the inside—but not always. Transgender is when a person's inner feelings about gender identity don't match the body."

Teen Talk High School

- Page 38: "Remind students that some men are born with female anatomy, some women are born with male anatomy."

- Page 85: "Gender Identity describes the way a person feels internally and socially. This is essentially a social status defined by a community's expectations for behavior."

- Page 87: "Genderqueer, gender non-conforming, and gender expansive are more terms that people use to describe their experience of being non-binary. Each person's experience of being non-binary is unique, in the same ways that each person's experience of being a man or of being a woman is unique."

- Page 86: "Trans is an umbrella category that describes anyone whose sex assigned at birth does NOT match their gender identity. Some trans people may choose to transition in any combination of the following ways:
    - Social transitioning: may include telling others about their gender identity, changing their name, asking others to address them using a new name and/or gender pronouns, and changing their gender expression to better reflect their identity.
    - Medical transitioning: altering their body by going through hormone therapy (using testosterone or estrogen) or having gender-affirming surgeries. Common

surgeries include top surgery (adding or removing breast tissue) and bottom surgery (transforming the genitals)."

Teen Talk Middle School

- Page 82: "If someone's sex assigned at birth does not match with their gender identity, or how they feel inside, they might identify as "transgender." For example: if someone is born with female body parts, hormones, and DNA, and inside they feel like a man."[2]

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2). The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[3] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. *See* 45 C.F.R. §§ 75.403-405. We are aware that this curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. California's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. *See* 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable).

ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. *See* 45 C.F.R. § 75.371. **Therefore, ACF instructs California to remove all content concerning gender ideology from its**

[2] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact Federal Project Officer, Latanya Bispham-Robinson at Latanya.Bispham-robinson@acf.hhs.gov.

[3] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval. The content flagged on the first page of this letter provides examples of gender ideology content that does not adhere to the PREP statute; California is directed to remove these and all similar language throughout their curricula and program materials. Should California fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. *See* 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than August 19, 2025, at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison

Acting Assistant Secretary
Administration for Children and Families

Exhibit 20

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Thomas Miller
Alabama State Personal Responsibility Education Program (PREP)
Alabama Dept. of Public Health
201 Monroe Street, Suite 1350
Montgomery, AL 36104-3735

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301ALPREP), 2024 (#2401ALPREP), and 2025 (#2501ALPREP).

Dear Mr. Miller:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Alabama provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Alabama's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Alabama's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Alabama's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Alabama will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Making Proud Choices! 5th Edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B Procedure. Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "Respect Diversity: Let's keep in mind that there's diversity in society and in this group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they chose to; others may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender. All of these differences make us unique. Regardless of how you see yourself, your background, previous relationships or experience, each of you has a place in this group. This will be safe place for everyone."

Making Proud Choices! Adaptation for Youth in Out-of-Home-Care Facilitator curriculum

- Page 50 (Module 1, Activity C, Talking Circle, Facilitator's Note): "Asking participants to tell you their preferred pronouns is a way of creating safe space for any transgender or gender nonconforming youth. Model what you want participants to say by giving your own preferred pronouns. Some transgender youth might prefer typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Preferred pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting preferred pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Alabama's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Alabama to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Alabama is directed to remove these and all similar language throughout their curricula and program materials. Should Alabama fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60)

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Sierra Baker at sierra.baker@acf.hhs.gov.

days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Hannah Guzzi, Adolescent Health Program Specialist
Alaska Department of Health & Social Services
3601 C Street, Suite 322
Anchorage, AK 99503

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301AKPREP), 2024 (#2401AKPREP), and 2025 (#2501AKPREP).

Dear Alaska Department of Health & Social Services:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Alaska provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Alaska PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Alaska's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Alaska's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Alaska will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

The Fourth R, Teacher Manual and Curriculum

- Unit 3: Human Development and Sexual Health, pages 218-19: "Gender Identity- A person's own sense of identification as male or female. Not necessarily the same as an individual's biological identity.

  Transgender – A term for a person whose gender identity does not match society's expectations for someone with their physical sex characteristics.

  Two Spirited – A term used in some Native American communities. This refers to people having both a male and female spirit. This can include ideas of both sexual orientation and gender identity.

  Pansexual – People who are physically and/or emotionally attracted to members of any sexual orientation or gender identity. Their attraction is not limited to any specific group.

  Transsexual – A person who experiences intense personal and emotional discomfort with his or her birth gender and may undergo treatment to transition gender.

  Gender Expression – The way in which people express their gender identity to others. This may be the stereotypical expressions of male or female; it may also be a combination of the two genders or a mixed or multiple model of male and female expressions."

- Page 230: "Explain to students that being in high school presents many challenges and is often a difficult time for many students. Furthermore, students who may be questioning their gender identity or sexual orientation or for students who don't feel like they fit into what society expects of them in terms of gender roles or relationships are presented with additional pressures and challenges."

Healthy Relationships Plus, Teacher Manual and Curriculum

- Page 36: "Language Matters. It is important to use gender neutral language while facilitating the sessions. Every effort has been made in these sessions to use language that is gender neutral. We want to provide a space where all students feel welcome and safe, therefore the proper use of language is a key component for consideration."

- Page 49: "Do you think there is any difference in how someone chooses their friend/partner if they are LGBTQ (lesbian, gay, bisexual, trans*, two spirited, queer)?"

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute

defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Alaska's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Alaska to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Alaska is directed to remove these and all similar language throughout their curricula and program materials. Should Alaska fail to make the appropriate modifications to its PREP curricula and program materials, ACF

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Jessica Lopez
Arizona Department of Health Services
150 N 18th Ave., Suite 500
Phoenix, AZ 85007

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (2301AZPREP), 2024 (2401AZPREP), and 2025 (2501AZPREP).

Dear Ms. Lopez:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Arizona Health Department provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Arizona Health Department's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Arizona Health Department's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if the Arizona Health Department's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, the Arizona Health Department will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Making Proud Choices! 5th Edition, Facilitator Manual

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone under understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Teen Outreach Program (TOP), Curriculum

- LAM-SU-A2, "Defining Sexuality" chapter, page 80:

  "**Facilitator Tip**: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

  Circle 'Sex' in 'Sexuality'

  Ask
  - How much of our Word Web is about 'having sex' or 'sex' as a physical behavior?

  Share
  - Sexuality is more than physical behavior.

  Add
  - Besides physical behavior, what else do you think could be part of a person's sexuality?

  If participants do not identify in the following, add
  - Sexual and reproductive anatomy
  - Body Image
  - Biological sex
  - Gender Including gender identity, gender expression and gender roles
  - Sexual orientation
  - Desires, pleasure, intimacy and reproduction
  - Beliefs, attitudes and values about sexuality

  Share
  - Sexuality can include some or all these things.
  - Sexuality is a personal experience and will be different for everyone.

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148:

  "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress.

Arizona Health Department's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs the Arizona Health Department to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Shakira Williams, shakira.williams@acf.hhs.gov.

The Arizona Health Department is directed to remove these and all similar language throughout their curricula and program materials. Should Arizona fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Minna Castillo Cohen
Colorado Department of Human Services
1575 Sherman Street
Denver, CO 80203

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301COPREP), 2024 (#2401COPREP), and 2025(#2501COPREP).

Dear Ms. Cohen:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Colorado provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Colorado's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Colorado's PREP curricula and program materials:[1]

All 4 You 2, 2nd Edition, Facilitator Manual

[1] ACF initiated a medical accuracy review to determine if Colorado's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Colorado will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

- Page 128 (Lesson 6, Activity 6.5): "Educator Note: Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively."

Be Proud Be Responsible! 5th Edition, Facilitator Manual

- Page 15: "Demonstrate acceptance and respect for all participants, regardless of personal characteristics, including race, cultural background, religion, social class, sexual orientation or gender identity."

- Page 20: "In addition, during the roleplay practice, participants may roleplay sexual pressure situations with someone of a different or the same gender. This may be awkward for straight teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively."

Draw the Line/Respect the Line, 2nd Edition, Facilitator Manual, Grades 6-8

- Page 6: "While some young people may feel more comfortable or be able to be more honest when discussing sexuality-related issues in single-gender groups, we do not recommend dividing the class in this way, as it can cause trauma for transgender, gender non-conforming, and non-binary youth.

  The use of integrated, mixed-gender groups is considered best practice for current-day classrooms and youth groups, * and is something sexuality educators are trained to facilitate. Use of mixed-gender groups can help promote gender equity, build understanding of different perspectives, and increase inclusivity for transgender, gender nonconforming, and non-binary youth."

- Page 59, Lesson 1, Teacher's Note:

  "During the roleplay practice, youth may roleplay pressure situations with a partner of a different or the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively. Here are some tips:

  Explain the situation in a matter-of-fact way. Let youth know that they may be doing the roleplays with a partner of a different or the same gender."

Making Proud Choices, 5th Edition, Facilitator Manual

- Page 36 (Module 1, Activity B, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

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  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both

abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Colorado's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Colorado to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Colorado is directed to remove these and all similar language throughout their curricula and program materials. Should Colorado fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt at arlisa.britt@acf.hhs.gov.

(allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Marc Camardo, State PREP Coordinator
Connecticut Department of Public Health
401 Capital Avenue, MS #111MAT
Hartford, CT 06134

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301CTPREP), 2024 (#2401CTPREP), and 2025 (#2501CTPREP).

Dear Connecticut Department of Public Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Connecticut provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Connecticut's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Connecticut's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Connecticut's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Connecticut will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Making Proud Choices! 5th Edition, Facilitator Guide

- Page 36: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 39: **"Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender. All of these differences make us unique. Regardless of how you see yourself, your background, previous relationships or experience, each of you has a place in this group. This will be a safe space for everyone."

- Page 39-40: **"Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Be Proud Be Responsible! 5th Edition Facilitator Guide

- Page 15: "Demonstrate acceptance and respect for all participants, regardless of personal characteristics, including race, cultural background, religion, social class, sexual orientation or gender identity."

- Page 20: "In addition, during the roleplay practice, participants may roleplay sexual pressure situations with someone of a different or the same gender. This

may be awkward for straight teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

Here are some tips:

- Explain the situation in a matter-of-fact way. Let participants know that they may be doing the roleplays with someone of a different or the same gender.
- Emphasize that they are playing roles. Doing the roleplay to practice the skill doesn't say anything about the sexual orientation of the people doing the roleplay or mean that anyone is expressing a real-life attraction toward the other person in the roleplay.
- Explain that they need to take their roles seriously because teens of all sexual orientations and gender identities need to learn how to resist sexual pressure and negotiate condom use to protect themselves. This will help ensure that they all get the most out of the roleplay activities."

Reducing the Risk, 5th Edition, Facilitator Guide

- Page 14: "Be sure your reading of the roleplay allows for inclusivity and does not reinforce one view of gender identity or gender stereotypes. You can do this by introducing Lee and Lee as a couple without specifying their genders, by not differentiating the two Lees' lines using stereotypical male and female voices, and by leaving it open as to which Lee is pressuring and which does not want to have sex."

- Page 71: "Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:

  - Explain the situation in a matter-of-fact way. Let students know that every student in the class will, at some point, be doing a roleplay with a classmate of a different gender and with a classmate of the same gender. Most likely, they will do this several times."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B);

and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Connecticut's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Connecticut to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Connecticut is directed to remove these and all similar language throughout their curricula and program materials. Should Connecticut fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Mariel Edge
District of Columbia Department of Health
899 North Capitol St. NE, 5th Floor
Washington, DC 20002

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2101DCPREP), 2024 (#2201DCPREP), and 2025 (#2301DCPREP).

Dear Ms. Edge:

On April 14, 2025, the Administration for Children and Families (ACF) requested that District of Columbia provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing District of Columbia's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from District of Columbia's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if District of Columbia's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, District of Columbia will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Sexual Wellness Advocacy by Teens (SWAT, 2011)

- Module 2, Facilitator Guide, Page 1: "Learning Objectives: By the end of the workshop, participants will be able to . . .
    - Define what each of the letters in the acronym LGBTQIA+ stand for
    - Distinguish between terms used for gender and sexual orientation
    - Name the different kinds of discriminations and barriers in health care experienced by LGBTQIA+ youth.
    - Challenge homophobia, biphobia and transphobia.
    - Advocate and become an ally to the LGBTQIA+ community."

    - Pages 2-3 (Under activity "Discrimination LBGTQIA+ people experience"): "Mention that there are 20 states where there are no explicit laws against discrimination based on sexual orientation or gender identity in state law. This means, for example, you can be fired if you are part of the LGBTQIA+ community. Which states do you think they are?"

- Module 2, PowerPoint Slides:

    "**Transgender:** term of gender identity fora person whose gender identity does not correspond with their gender assigned at birth. Trans people can be straight, gay, bisexual, queer, or any other sexual orientation.
    Queer: encompassing term for people who do not conform to heterosexual norms of sexuality or gender. . . .
    Pansexual: attraction towards people regardless of their sex or gender identity.
    Cisgender: the term of gender identity for a person whose gender identity corresponds with their gender assigned at birth. Cis people can be straight, gay, bisexual, queer or any other sexual orientation.
    Non-binary/genderqueer: Someone who does not fit into conventional gender distinction and identifies with neither, both, or a combo of male and female genders. Gender expansive: people who feel that they exist between genders, as on a spectrum, or beyond the notion of the man/woman binary.
    ALLY: A person who fights for the rights of a disadvantage group they are not a part of. For example, an ally can support:
        - equal civil rights
        - gender equality
        - LGBTQ+ social movements
        - challenges homophobia, biphobia, and transphobia

    Stigmas (unconscious and conscious) against people who identify as queer--specifically gay/lesbian, bisexual, and trans."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B);

and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. District of Columbia's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs District of Columbia to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] District of Columbia is directed to remove these and all similar language throughout their curricula and program materials. Should District of Columbia fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Steve Blessings, Director
Delaware Health and Social Services
417 Federal Street
Dover, DE 19901

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2302DEPREP), 2024 (#2402DEPREP), and 2025 (#2502DEPREP).

Dear Delaware Health and Social Services:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Delaware provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Delaware's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Delaware's PREP curricula and program materials.[1]

Making Proud Choices! 5th Edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is

[1] ACF initiated a medical accuracy review to determine if Delaware's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Delaware will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 39-40 (Module 1, Activity C Procedure): **"Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

LGBT+ Inclusion APS for Middle School

- Slide 7: "'Sex assigned at birth' is the **label a doctor gives to a baby when it is born. Sex assigned at birth is about the** private parts (genitals) we are born with–it doesn't consider how we feel inside about our gender."

- Slide 9: "Transgender or 'trans'
    - Sometimes, a person's inner feelings about their gender doesn't match their body parts.
    - For example, they have a penis, and know, 'I'm female.'
    - This is called 'transgender' or just 'trans.'
    - Sometimes a person's gender feels fluid and changing. They might call themselves 'non-binary.'"

Be Proud Be Responsible! 5th Edition Facilitator Curriculum

- Page 15 (Facilitator Information): "Demonstrate acceptance and respect for all participants, regardless of personal characteristics, including race, cultural background, religion, social class, sexual orientation or gender identity."
- Page 20 (Teaching Strategies): "In addition, during the roleplay practice, participants may roleplay sexual pressure situations with someone of a different or the same gender. This may be awkward for straight teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

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teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Delaware's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Delaware to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Delaware is directed to remove these and all similar language throughout their curricula and program materials. Should Delaware fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

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ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Erika Dennis
Georgia Human Resources, Division of Family and Children Services
2 Peachtree Street, 26th Floor
Atlanta, GA 30303

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#1601GAPREP), 2024 (#1601GAPREP), and 2025 (#1601GAPREP)

Dear Ms. Dennis:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Georgia provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Georgia's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Georgia's PREP curricula and program materials:[1]

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Making Proud Choices! 5th Edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

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We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Georgia's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Georgia to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Wendy Jefferson at wendy.jefferson@acf.hhs.gov.

all similar language throughout their curricula and program materials. Should Georgia fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Kenneth Swanson
Guam Department of Education
500 Mariner Ave.
Barrigada, GU 96913

RE: Personal Responsibility Education Program grants for Fiscal Years 2023 (2301GUPREP), 2024 (2402GUPREP), and 2025 (2502GUPREP).

Dear Guam Department of Education:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Guam provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing the territory's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from your PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if Guam's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, your territory will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity**: Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  'I want to be sure everyone understands some of the terms we use when talking about diversity.'

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states and territories to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the

requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).” 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency’s authority to administer the program consistent with the authorizing legislation as enacted by Congress. The commonwealth’s current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Guam to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged in this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Cheri Thompson at cheri.thompson@acf.hhs.com.

Guam is directed to remove these and all similar language throughout their curricula and program materials. Should Guam fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: “(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.”

C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Matthew Shim, Chief
Hawaii State Department of Health
1250 Punchbowl
Honolulu, HI 96813

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2302HIPREP), 2024 (#2402HIPREP), and 2025 (#2502HIPREP).

Dear Mr. Shim:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Hawaii provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Hawaii's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Hawaii's PREP curricula and program materials:[1]

Teen Outreach Program (TOP) Curriculum, Second Edition

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to

[1] ACF initiated a medical accuracy review to determine if Hawaii's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Hawaii will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

understand it broadly and to have different views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Circle 'Sex in 'Sexuality.'

Ask
- How much of our Word Web is about 'having sex' or 'sex as a physical behavior?

Share
- Sexuality is more than physical behavior.

Ask
- Besides physical behavior, what else do you think could be part of a person's sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body Image
- Biological sex
- Gender including gender identity, gender expression and gender roles
- Sexual orientation
- Desires, pleasure, intimacy and reproduction
- Beliefs, attitudes and values about sexuality"

- LAM-SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted

infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Hawaii's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Hawaii to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Hawaii is directed to remove these and all similar language throughout their curricula and program materials. Should Hawaii fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Mary White
Illinois Dept. of Human Services
10 South Grand Avenue East, 3rd Floor
Springfield, IL 62762

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301ILPRPEP), 2024 (#2401ILPREP), and 2025 (#2501ILPREP).

Dear Ms. White:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Illinois provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Illinois' PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Illinois' PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, Teacher Manual

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if Illinois' approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Illinois will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B);

and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Illinois' current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Illinois to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Illinois is directed to remove these and all similar language throughout their curricula and program materials. Should Illinois fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, MeGan Hill at MeGan.Hill@acf.hhs.gov.

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Ken Sharp
Iowa Department of Public Health
Lucas State Office Building
321 E 12th Street
Des Moines, IA 50319

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301IAPREP), 2024 (#2401APPREP), and 2025 (2501IAPREP).

Dear Iowa Department of Public Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Iowa provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Iowa s PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Iowa's PREP curricula and program materials:[1]

Teen Outreach Program (TOP), Second Edition, Facilitator Manual

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to

[1] ACF initiated a medical accuracy review to determine if Iowa's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Iowa will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

understand it broadly and to have different views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Circle 'Sex' in 'Sexuality.'

Ask
- How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

Share
- Sexuality is more than physical behavior.

Ask (add response to Word Web)
- Besides physical behavior, what else do you think could be part of a person's sexuality? If participants do not identify in the following, add
  - Sexual and reproductive anatomy
  - Body image
  - Biological sex
  - Gender including gender identity, gender expression and gender roles
  - Sexual orientation
  - Desires, pleasure, intimacy and reproduction
  - Beliefs, attitudes and values about sexuality"

- LAM-SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

Wise Guys: Healthy Relationships Curriculum (2021), Facilitator Manual

- Introduction to Level I, page 6: "LGBTQ Inclusive Language: Wise Guys Educators should use language in the classroom that includes and affirms LGBTQ students' identities and experiences. Additionally, it's important to separate gender identity from body parts; in other words, someone who identifies as

> female may have a penis and someone who identifies as male may have a vagina; someone may not identify as male or female. The use of gender-neutral language when discussing anatomy and physiology helps to ensure that transgender or gender non-conforming students are respected, included and gain an understanding of their bodies too."
>
> Page 7: "The new phrasing in inclusive of gender and body diversity; it does not assume all females have vaginas and all males have penises and acknowledges that some people's genders are non-binary, and they may not identify as male OR female."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Iowa's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

Therefore, ACF instructs Iowa to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt at arlisa.britt@acf.hhs.gov.

Iowa is directed to remove these and all similar language throughout their curricula and program materials. Should Iowa fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Jan Bright
Kentucky Cabinet for Health and Families
275 East Main Street, HS1WF
Frankfort, KY 40621

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#1601KYPREP), 2024 (#1601KYPREP,) and 2025 (#1601KYPREP)

Dear Ms. Bright:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Kentucky provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Kentucky's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Kentucky's PREP curricula and program materials:[1]

Teen Outreach Program (TOP) Curriculum

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to

[1] ACF initiated a medical accuracy review to determine if Kentucky's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Kentucky will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

understand it broadly and to have different views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Circle 'Sex' in 'Sexuality.'

Ask
- How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

Share
- Sexuality is more than physical behavior

Add
- Besides physical behavior, what else do you think could be part of a person's sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body Image
- Biological sex
- Gender Including gender identity, gender expression and gender roles
- Sexual orientation
- Desires, pleasure, intimacy and reproduction
- Beliefs, attitudes and values about sexuality"

- LAM-SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted

infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Kentucky's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Kentucky to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Kentucky is directed to remove these and all similar language throughout their curricula and program materials. Should Kentucky fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Wendy Jefferson at wendy.jefferson@acf.hhs.gov.

(allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Samuel Burgess
Louisiana Office of Public Health, HIV/AIDS Program
1450 Poydras Street, Suite 2136
New Orleans, LA 70112

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (#2301LAPREP), 2024 (#2401LAPREP), and 2025 (#2501LAPREP).

Dear Mr. Burgess:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Louisiana provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Louisiana s PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Louisiana's PREP curricula and program materials:[1]

Making Proud Choices! Facilitator Manual, 5th Edition

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if Louisiana's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Louisiana will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  - **Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.
  - **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.
  - **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Wise Guy: Healthy Relationship Curriculum (2021)

- Introduction to Level I, page 6: "**LGBTQ Inclusive Language:** Wise Guys Educators should use language in the classroom that includes and affirms LGBTQ students' identities and experiences. Additionally, it's important to separate

> gender identity from body parts; in other words, someone who identifies as female may have a penis and someone who identifies as male may have a vagina; someone may not identify as male or female. The use of gender-neutral language when discussing anatomy and physiology helps to ensure that transgender or gender non-conforming students are respected, included and gain an understanding of their bodies too."
>
> Page 7: "The new phrasing in inclusive of gender and body diversity; it does not assume all females have vaginas and all males have penises and acknowledges that some people's genders are non-binary, and they may not identify as male OR female."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Louisiana's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

Therefore, ACF instructs Louisiana to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Louisiana is directed to remove these and all similar language throughout their curricula and program materials. Should Louisiana fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Tecia Sellers at tecia.sellers@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Bethany Hamm, Deputy Commissioner, DHHS
State of Maine Department of Health and Human Services
221 State Street
Augusta, ME 04330

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301MEPREP), 2024 (#2401MEPREP), and 2025 (#2501MEPREP)

Dear State of Maine Department of Health and Human Services:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Maine provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Maine's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Maine's PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, California Edition, Teacher Manual

- Page 279: "Transgender refers to a person's gender identity. Gender identity is your inner sense of your gender—Do you feel like a guy? Do you feel like a girl?

[1] ACF initiated a medical accuracy review to determine if Maine's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Maine will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Do you feel like something different than a guy or a girl? Often gender identity matches a person's body— someone with a girl's body feels like a girl on the inside or someone with a boy's body feels like a boy on the inside—but not always. Transgender is when a person's inner feelings about gender identity don't match the body."

- Pages 353-54:

  "CISGENDER: A term for people who identify as or feel themselves to be the gender that matches the sex they were assigned at birth.

  GENDER EXPRESSION: How a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics.

  GENDER IDENTITY: Peoples' inner understanding of what gender they identify with. It may be male, female, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person."

Sexuality for All Abilities, 2nd Edition, Instructor Manual

- Page 97, chapter on gender: "Key Messages:

  - Gender is how you feel. Some people identify as she, he or they. Some people have other ways of identifying.
  - Sometimes a person's gender identity doesn't match the gender that caregivers assign them.
  - Sometimes a person's gender expression also doesn't match their assigned gender.
  - In our society, we have stereotypes of what it means to be a man or a woman. Many people do not fit into this stereotype because we are all different, and that is okay."

- Glossary of Terms, page 133:

  "GENDER– A word that refers to how a person feels on the inside in regards to being male, female or a different gender.

  GENDER EXPRESSION– How a person represents or expresses their identity to the world. Sometimes this matches their assigned sex, sometimes not.

  GENDER FLUIDITY– The flexibility of gender expressions and identities that may change over time or even from day to day. A gender fluid person may feel male on some days, female on others, both male and female, or neither. A gender fluid person might also identify as genderqueer.

> GENDER IDENTITY– How a person identifies gender inside of themselves. Sometimes this matches their assigned sex, sometimes not.
>
> GENDER NONCONFORMING– When a person's gender expression doesn't fit inside traditional male or female categories (sometimes called the gender binary).
>
> GENDERQUEER– A term for people who don't identify as a man or a woman or whose identity lies outside the traditional gender binary of male and female. Some people use genderqueer, gender non-conforming, and non-binary interchangeably, but others don't. Genderqueer has a political history, so many use the term to identify their gender as non-normative in some way. For example, someone could identify as both cisgender female and gender queer."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Maine's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Maine to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Maine is directed to remove these and all similar language throughout their curricula and program materials. Should Maine fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Shelly Choo, Director
Maryland Department of Health and Mental Hygiene
201 West Preston Street, 5th Floor
Baltimore, MD 21201

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301MDPREP), 2024 (#2401MDPREP), and 2025 (#2501MDPREP).

Dear Maryland Department of Health and Mental Hygiene:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Maryland provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Maryland's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Maryland's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Maryland's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Maryland will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Rights, Respect, Responsibility, Lesson Plan (Updated 2023)

- Pages 8, 19, 26, 32, 57, & 78: "A NOTE ABOUT LANGUAGE: Language is really important and we've intentionally been very careful about our language throughout this curriculum. You may notice language throughout the curriculum that seems less familiar- using the pronoun 'they' instead of 'her' or 'him,' using gender neutral names in scenarios and role-plays and referring to 'someone with a vulva' vs. a girl or woman. This is intended to make the curriculum inclusive of all genders and gender identities. You will need to determine for yourself how much and how often you can do this in your own school and classroom and should make adjustments accordingly."

- Pages 39-40 (bolded content denotes gender ideology): "Sexual Orientation: Myth or Fact? You can change your BEHAVIORS, **you can change your IDENTITY** – but you can't change your ORIENTATION, or how you feel. Feelings of attraction are discovered, not chosen. It isn't something a person can turn on and off like a light switch. We don't choose who we are attracted to. Now, sometimes we can discover new feelings of attraction **– for example, always being attracted to one gender, and then finding someone or others of a different gender attractive later in life**. That is different from sitting down and trying to change the way you feel – or from going to therapy or to church to try to influence your feelings. It doesn't work, and can end up doing real psychological and emotional harm."

- Power Point, page 44 (bolded content denotes gender ideology): "What is 'Sexual Orientation'?
  - **The gender(s) of the people to whom we are attracted, physically and romantically.**
  - **Can include more than one gender.**
  - Includes love: can know one's orientation without necessarily doing something sexual with another person."

- Power Point, page 46 (bolded content denotes gender ideology):
  - "Orientation–Who we're attracted to
  - Behavior–How we behave sexually
  - **Identity–What we call ourselves"**

Making Proud Choices, 5th Edition, Facilitator's Guide

- Page 36 (Module 1, Activity B Procedure: "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or

> zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."
>
> Pages 39-40 (Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.
>
> Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .
>
> Define terms related to diversity as needed.
>
> I want to be sure everyone understands some of the terms we use when talking about diversity.
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> **Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another. **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from(transgender)the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects

described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress.

Maryland's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Maryland to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Maryland is directed to remove these and all similar language throughout their curricula and program materials. Should Maryland fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60)

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Jill Clark
Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (2301MAPREP), 2024 (#2401MAPREP), and 2025 (#2501MAPREP).

Dear Ms. Clark:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Commonwealth of Massachusetts provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Massachusetts's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Massachusetts's PREP curricula and program materials:[1]

Making Proud Choices! 5th edition

- Page 36: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns

[1] ACF initiated a medical accuracy review to determine if Massachusetts's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Massachusetts will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40: **"Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.
  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.
  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Rights, Respect, Responsibilities (the 3Rs), Middle School Curriculum

- Pages 2-3: "Being Respectful about Gender Identity: Pronouns and Practice!

  A NOTE ABOUT LANGUAGE:

  Language is extremely important. It is one way you can be explicitly inclusive around often underrepresented and not as commonly acknowledged sexual orientations and gender identities. We've intentionally been very thoughtful about our language throughout this curriculum. You may notice language that seems less familiar, for example, using the pronoun 'they' instead of 'her' or 'him', and simply referring to the body parts and processes we are teaching about rather than unnecessarily gendering them. We have also explicitly included scenarios and role plays that use a variety of names typically coded to certain genders, as well as ones that are not as readily coded to assumptions about gender. We have also used a variety of gendered and gender-neutral pronouns and names to be sure we are actively including various gender identities, sexual orientations, and relationships in our activities and discussions. This commitment to inclusiveness across our lessons is aimed at building new habits within our classrooms related to actively and more seamlessly representing a broader range of genders, orientations, and lived experiences.

  NOTE TO THE TEACHER: *Being prepared to teach about gender identity and expression may be new skills for some teachers. Preparation can include checking out some of the links below, talking with colleagues who have taught these topics before, and taking a minute to practice new phrases or use of*

pronouns. You have transgender young people in your classes, you always have! Your preparation to actively acknowledge and include them can be lifesaving!

- **I Think I Might Be Transgender, Advocates for Youth** – Written by transgender youth, this pamphlet provides answers for young people who find that the gender to which they were born, or assigned at birth, does not fit them.

- **Developing LGBTQ-Inclusive Classroom Resources, GLSEN** – Educator guide on creating an inclusive curriculum, responding to anti-LGBTQ behavior and implementing social emotional learning in the classroom.

- **Framework for Gender-Inclusive Schools, Gender Spectrum** – Background on the four entry points for the intentional development of gender-inclusive school settings and resources to approach each.

- **Schools in Transition: A Guide for Supporting Transgender Students in K-12 Schools, ACLU** – Handbook on providing safe environments for transgender high school students that is targeted toward administrators, teachers and parents.

- **Pronoun Guide, GLSEN** – Guide for members of the school community to learn how to use people's correct pronouns.

- **Gender Support Checklist for Transgender and Non-Binary Students, Welcoming Schools** – Set of questions for educators to confirm they have the answers and resources necessary to best support gender-nonconforming students."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2). The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2]

The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Massachusetts. current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Massachusetts to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Sierra Baker, sierra.baker@acf.hhs.gov.

Massachusetts is directed to remove these and all similar language throughout their curricula and program materials. Should Massachusetts fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Dan Lance
Michigan Department of Health and Human Services
235 South Grand Avenue, Suite 800
Lansing, MI 48933

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301MIPREP), 2024 (#2401MIPREP), and 2025 (#2501MIPREP).

Dear Mr. Lance:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Michigan provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Michigan's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Michigan's PREP curricula and program materials:[1]

Making Proud Choices! 5th edition

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if Michigan's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Michigan will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

Define terms related to diversity as needed.

I want to be sure everyone understands some of the terms we use when talking about diversity.

Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.
Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender)or different from(transgender)the ex they were assigned at birth. Gender identity is unique for each person.
Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Teen Outreach Program (TOP), 2nd Edition, Facilitator Manual

- LAM-HW-F1, "Introduction to Reproductive Anatomy," page 142: "Share:
  - During our discussion today, when we say 'male' and 'female,' we will be referring to biological sex, or people born with a penis or vulva.
  - Biological sex is different than gender. Gender is how people identify and express themselves.

- However someone identifies and expresses themselves, they should feel safe, respected and included in our TOP club."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

- LAM-HW-F6, "Abstinence and Expressing Affection," page 196: "Share
  - When people think of sexuality, they often just think of sex.
  - However, sex is only one part of sexuality.
  - Sexuality also includes our bodies and how we feel about them, our desires and attractions to others, our relationships, our beliefs and values about sexuality, how we can love and affection and how we identity and express our gender."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Michigan's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Michigan to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Michigan is directed to remove these and all similar language throughout their curricula and program materials. Should Michigan fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Nakia Martin-Wright, nakia.martin-wright@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Emily McDowell, PREP/SRAE Grant Manager
Minnesota Department of Health
625 Robert Street North
St. Paul, MN 55164

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301MNPREP), 2024 (#2401MNPREP), and 2025 (#2501MNPREP).

Dear Ms. McDowell:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Minnesota provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Minnesota's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Minnesota's PREP curricula and program materials:[1]

In Clued, In-Person Youth Curriculum

- Page 5: "Introductions and Warm-Up: Facilitators introduce themselves, the IN·clued workshop agenda and Essential Questions, and facilitate participant

[1] ACF initiated a medical accuracy review to determine if Minnesota's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Minnesota will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

introductions. Participants commit to group agreements to maximize physical, emotional, and psychological safety during the learning experience. The Peer Educators read a welcoming poem depicting diverse sexual and gender identities to create a supportive environment for workshop participants. Participants spend time exploring their IN·clued zines."

- Page 13: "Gather everybody's attention and thank participants for being there. Introduce yourself with your name, pronouns (if you wish), your role, and why you care about LGBTQ+ sexual health. Introduce the purpose of the workshop.

  'We want to thank everybody for taking the time to be here today—we're really excited to be working with you for the next few hours, and are grateful to be with you in this space. IN·clued is a program just for LGBTQ+ youth to learn about how to get the sexual health information and services they need and have the right to. We know that sometimes lesbian, gay, bisexual, transgender, and queer or questioning young people don't have access to information and services that is for them. That's why we're here, to spend some time together talking about LGBTQ+ sexual healthcare in particular.'"

- Page 24: "It's not because this is the only way to have sex or the right way to have sex. Sex is often defined this way because our society is heteronormative; meaning that heterosexual/cisgender is considered the norm. It doesn't usually acknowledge genderqueer, non-binary, intersex, or transgender identities. It also assumes that sex is only for reproduction and leaves out any conversation about pleasure. This biased perspective shapes the messages and information we get about sex in school, from the media, and even from our friends and family. And it often leads to incomplete and inaccurate information. But we know that 'sex' is so much more than penis-in-vagina intercourse, and we know there are many more identities out there than heterosexual and cisgender!"

Live IT, Second Edition, Facilitator's Manual

- Page 22: "Two-spirited people were held in high regard, and they decided which of the female or male societies they joined and were respectfully included in the discussion regardless of gender of the society (i.e. male joining the female society or female joining the male society).

  European contact and the US Government interrupted and banned our way of life, our family systems, our clans, our ceremonies, and our societies thereby bringing new ways of talking about and viewing sex, sexuality, and relationships. These topics began to be influenced by religion, shame and guilt. Soon many of our people adopted the religion and left behind the ways of life that insured the development of healthy, balanced human beings. Giving up our way of life was not voluntary. To continue our way of life, our family systems, our clans, our ceremonies, and our societies meant negative governmental consequences that impacted our families and our communities."

- Page 32: "Settler colonialism is a distinct type of colonialism that functions through the replacement of indigenous populations with an invasive settler society. Settler colonialism 'destroys to replace.' Their goal was to gain total control and possession of the land. It is a structural system, not an event in history. In this sense, settler colonialism does not ever 'end.' As a result, Indigenous People's entire societies, lifeways, languages, cultures, and connection to lands were almost completely destroyed. Indigenous life and society was replaced with European lifeways, including heteropatriarchal gender roles. Heteropatriarchal means the dominance by the heterosexual and patriarchy, or, in other words, cisgendered white men. Settler colonialism erased Indigenous lifeways and replaced them with Western Culture, including ways in which we view gender and relationships among humans. Colonization resulted in forced assimilation to heteropatriarchal gender norms that continue to oppress and erase Indigenous Two-Spirit and LGBTQ+ peoples. Tribal communities have been forced to define human relationships based on this heteropatriarchal gender normativity, which has resulted in the oppression of gender and sexual identities that don't fit this norm."

Making Proud Choices! 5th Edition, Curriculum Manual

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

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  Define terms related to diversity as needed.

I want to be sure everyone understands some of the terms we use when talking about diversity.
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Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Sexuality for All Abilities, 2nd Edition, Instructor Manual

- Page 91: "Key Messages:

  - Gender is how you feel. Some people identify as she, he or they. Some people have other ways of identifying.
  - Sometimes a person's gender identity doesn't match the gender that caregivers assign them.
  - Sometimes a person's gender expression also doesn't match their assigned gender.
  - In our society, we have stereotypes of what it means to be a man or a woman. Many people do not fit into this stereotype because we are all different, and that is okay."

Teen Outreach Program (TOP), 2nd Edition

- LAM SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
When we use body parts to describe people, we're talking about "biological sex," or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Minnesota's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Minnesota to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Minnesota is directed to remove these

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

and all similar language throughout their curricula and program materials. Should Minnesota fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Mary Currier
Mississippi State Dept. of Health
570 East Woodrow Willson
Jackson, MS 39215

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (#2301MSPREP), 2024 (#2401MSPREP), and 2025 (#2501MSPREP).

Dear Ms. Currier:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Mississippi provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Mississippi's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Mississippi's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Mississippi's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Mississippi will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Draw the Line Respect the Line, Facilitator Manual

- Page 6 ("How to Use the Curriculum"): "While some young people may feel more comfortable or be able to be more honest when discussing sexuality-related issues in single-gender groups, we do not recommend dividing the class in this way, as it can cause trauma for transgender, gender non-conforming, and non-binary youth.

  Rather, we suggest building a safe and inclusive environment in which all youth feel affirmed and included in the lessons. The use of integrated, mixed-gender groups is considered best practice for current-day classrooms and youth groups, and is something sexuality educators are trained to facilitate. Use of mixed-gender groups can help promote gender equity, build understanding of different perspectives, and increase inclusivity for transgender, gender nonconforming, and non-binary youth."

- Page 59 (Activity 4.5, Youth Roleplays): "Teacher Note: During the roleplay practice, youth may roleplay pressure situations with a partner of a different or the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:
  - Explain the situation in a matter-of-fact way. Let youth know that they may be doing the roleplays with a partner of a different or the same gender."

Making Proud Choices! 5th Edition

- Page 36 (Module 1, Activity B Procedure): "Facilitator Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships;

> others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.
>
> Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .
>
> Define terms related to gender diversity as needed.
>
> I want to be sure everyone understands some of the terms we use when talking about diversity.
>
> **Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another. **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Reducing the Risk, 5th ed., Curriculum

- Class 4, "Roleplay in Small Groups: Note to the Teacher" page 71: "Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively. Here are some tips:

  - Explain the situation in a matter-of-fact way. Let students know that every student in the class will, at some point, be doing a roleplay with a classmate of a different gender and with a classmate of the same gender. Most likely, they will do this several times."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B);

and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Mississippi's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Mississippi to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Mississippi is directed to remove these and all similar language throughout their curricula and program materials. Should Mississippi fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Sierra Baker at sierra.baker@acf.hhs.gov.

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Chad Ridder
Missouri Department of Health and Senior Services
P.O. Box 570
Jefferson City, MO 65102-0570

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023, 2024 and 2025 (#2201MOPREP).

Dear Mr. Ridder:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Missouri Department of Health & Senior Services provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing the Missouri Department of Health & Senior Services' PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Missouri Department of Health & Senior Services' PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Missouri Department of Health & Senior Services' approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Missouri Department of Health & Senior Services will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Making Proud Choices! 5th Edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): **"Respect diversity**: Let's keep in mind that there's diversity in society and in this group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they chose to; others may have had sex against their will. Some may identity as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another. **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender)or different from(transgender)the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Making Proud Choices! Adaptation for Youth in Out-of-Home-Care, Facilitator curriculum

- Page 50 (Module 1, Activity C, Talking Circle, Facilitator's Note): "Asking participants to tell you their preferred pronouns is a way of creating safe space for any transgender or gender nonconforming youth. Model what you want participants to say by giving your own preferred pronouns. Some transgender youth might prefer typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Preferred pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting preferred pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

Teen Outreach Program (TOP), 2nd Edition, Facilitator Manual

- LAM-HW-F1, "Introduction to Reproductive Anatomy," page 142: "Share:
  - During our discussion today, when we say 'male' and 'female,' we will be referring to biological sex, or people born with a penis or vulva.
  - Biological sex is different than gender. Gender is how people identify and express themselves.
  - However someone identifies and expresses themselves, they should feel safe, respected and included in our TOP club."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

- LAM-HW-F6, "Abstinence and Expressing Affection," page 196: "Share
  - When people think of sexuality, they often just think of sex.
  - However, sex is only one part of sexuality.
  - Sexuality also includes our bodies and how we feel about them, our desires and attractions to others, our relationships, our beliefs and values about sexuality, how we can love and affection and how we identity and express our gender."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B);

and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Missouri Department of Health & Senior Services' current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs the Missouri Department of Health & Senior Services to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Se'an Bournes, Sean.Bournes@acf.hhs.gov.

Missouri Department of Health & Senior Services is directed to remove these and all similar language throughout their curricula and program materials. Should Missouri Department of Health & Senior Services fail to make the appropriate modifications to its

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer, Se'an Bournes at Sean.Bournes@acf.hhs.gov if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Darla Dexter, Community Health Section Supervisor
Montana Department of Public Health and Human Services
14 East Broadway, Room A116
Helena, MT 59601

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (#2301MTPREP), 2024 (#2401MTPREP), and 2025 (#2501MTPREP).

Dear Montana Department of Public Health and Human Services:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Montana provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Montana's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Montana's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Montana's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Montana will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Draw the Line/Respect the Line

- Page 6 ("How to Use the Curriculum"): "While some young people may feel more comfortable or be able to be more honest when discussing sexuality-related issues in single-gender groups, we do not recommend dividing the class in this way, as it can cause trauma for transgender, gender non-conforming, and non-binary youth. . . .

  The use of integrated, mixed-gender groups is considered best practice for current-day classrooms and youth groups, and is something sexuality educators are trained to facilitate. Use of mixed-gender groups can help promote gender equity, build understanding of different perspectives, and increase inclusivity for transgender, gender nonconforming, and non-binary youth."

- Lesson 1, Activity 4.5 (page 59) and Lesson 4, Activity 4.4 (page 92):

  Teacher's Note
  During the roleplay practice, youth may roleplay pressure situations with a partner of a different or the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:
  - Explain the situation in a matter-of-fact way. Let youth know that they may be doing the roleplays with a partner of a different or the same gender.
  - Emphasize that they are playing roles. Doing the roleplay to practice the skill doesn't say anything about the sexual attraction of the people doing the roleplay or mean that anyone is expressing a real-life attraction toward the other person in the roleplay.
  - Explain that they need to take their role seriously because teens of all sexual orientations and gender identities need to learn how to draw the line to resist sexual pressure and protect themselves. This will help ensure that they and their classmates get the most out of the roleplay activities.

Making Proud Choices!

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a

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Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60)

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt at arlisa.britt@acf.hhs.gov.

days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Jennifer Severe-Oforah
Nebraska Dept. of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#1601NEPREP), 2024 (#2301NEPREP), and 2025 (#2301NEPREP).

Dear Ms. Severe-Oforah:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Nebraska provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Nebraska's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Nebraska's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Nebraska's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Nebraska will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Teen Outreach Program (TOP), 2nd Edition, Facilitator Manual

- LAM-SU-A2, "Defining Sexuality," page 80:

  "**Facilitator Tip**: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to each other, and make sure dialogue remains respectful and inclusive.

  Circle 'Sex' in 'Sexuality.'

  Ask:
  - How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

  Share:
  - Sexuality is more than physical behavior.

  Ask (add responses to Word Web)
  - Besides physical behavior, what else do you think could be part of a person's sexuality?

  If participants do not identify in the following, add
  - Sexual and reproductive anatomy
  - Body image
  - Biological sex
  - Gender including gender identity, gender expression and gender roles
  - Sexual orientation
  - Desires, pleasure, intimacy and reproduction
  - Beliefs, attitudes and values about sexuality"

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 147-48:

  "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both

abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Nebraska's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Nebraska to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Nebraska is directed to remove these and all similar language throughout their curricula and program materials. Should Nebraska fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

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(allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Vickie Ives
Nevada State Health Division
4150 Technology Way, Suite 210
Carson City, NV 89706

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301NVPREP), 2024 (#2401NVPREP), and 2025 (#2501NVPREP).

Dear Ms. Ives:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Nevada provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Nevada's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Nevada's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Nevada's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Nevada will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

In Clued, 2nd edition, In-Person Youth Curriculum (For Adult Facilitators & Peer Educators), Updated 2024

- Page 5 (Curriculum Overview): "Introductions and Warm-Up (20 minutes)

  Facilitators introduce themselves, the IN·clued workshop agenda and Essential Questions, and facilitate participant introductions. Participants commit to group agreements to maximize physical, emotional, and psychological safety during the learning experience. The Peer Educators read a welcoming poem depicting diverse sexual and gender identities to create a supportive environment for workshop participants. Participants spend time exploring their IN·clued zines."

- Page 10 (Youth Workshop, Overview): "Call LGBTQ+ youth group facilitator to ask about:
  - Community-specific group language use (e.g. 'Queer youth,' 'LGBTQ+ youth,' 'Gender-expansive youth,' etc.)
  - Group structure (meeting times, locations, number of youth, etc.)
  - Already established group norms/agreements, if they have any
  - Prior activities/experiences the group has had around sexual health education or accessing sexual healthcare
  - Facilities—room set up, A/V equipment, room for breakout groups, etc.
  - Group dynamics that would be useful to know"

- Page 13 (Youth Workshop, Section 1): "ADULT FACILITATOR: Gather everybody's attention and thank participants for being there. Introduce yourself with your name, pronouns (if you wish), your role, and why you care about LGBTQ+ sexual health. Introduce the purpose of the workshop.

  'We want to thank everybody for taking the time to be here today—we're really excited to be working with you for the next few hours, and are grateful to be with you in this space. IN·clued is a program just for LGBTQ+ youth to learn about how to get the sexual health information and services they need and have the right to. We know that sometimes lesbian, gay, bisexual, transgender, and queer or questioning young people don't have access to information and services that is for them. That's why we're here, to spend some time together talking about LGBTQ+ sexual healthcare in particular.'"

- Page 18 (Youth Workshop): "ADULT FACILITATOR: Explain the purpose of the IN·clued zine and how it will be used throughout the workshop.

  This is the IN·clued zine. It's a handy resource that we'll be using throughout the workshop. This is for you to keep and take home if you want to look at later. For those of you who have never heard of a zine, zines have historically been used by marginalized or oppressed groups as a way to distribute information. They are frequently photocopied in small batches with a focus on raising awareness about important issues. Does anyone know what I mean by marginalized or oppressed?

Sample answer: Being marginalized means being pushed to the side or not being treated fairly because of things like race, gender, or beliefs. Oppression is when someone or institutions treat others unfairly or cruelly, making it hard for them to have the same rights or opportunities."

- Page 24 (Youth Workshop, Section 2: LGBTQ+ Sexual Health): "It's not because this is the only way to have sex or the right way to have sex. Sex is often defined this way because our society is heteronormative; meaning that heterosexual/cisgender is considered the norm. It doesn't usually acknowledge genderqueer, non-binary, intersex, or transgender identities. It also assumes that sex is only for reproduction and leaves out any conversation about pleasure. This biased perspective shapes the messages and information we get about sex in school, from the media, and even from our friends and family. And it often leads to incomplete and inaccurate information. But we know that 'sex' is so much more than penis-in-vagina intercourse, and we know there are many more identities out there than heterosexual and cisgender!"

- Page 43 (Youth Workshop, Section 3): "ADULT FACILITATOR: Tell participants what services are available in their community, differentiating between laws for those who are minors/under 18 and those who are 18+. Be sure to include the following: age of consent for sex, access to sexual and reproductive healthcare (including STI testing, birth control, emergency contraception, condoms, PrEP, and abortion), and gender affirming care, (including puberty blockers and hormone therapy)."

Making Proud Choices! 5th Edition, Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity**: Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will.

> Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.
>
> Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .
>
> Define terms related to diversity as needed.
>
> 'I want to be sure everyone understands some of the terms we use when talking about diversity.'
>
> **Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.
>
> **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.
>
> **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

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Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

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ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Nancy Scotto-Rosato
New Jersey Department of Health and Senior Services
50 East State Street, 6th Floor
PO Box 364
Trenton, NJ 08625

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (2301NJPREP), 2024 (2401NJPREP), 2025 (2501NJPREP).

Dear Ms. Scotto-Rosato:

On April 14, 2025, the Administration for Children and Families (ACF) requested that New Jersey provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing New Jersey's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from New Jersey's PREP curricula and program materials:[1]

High School FLASH, Third Edition, Educator Manual

- Implementation Toolkit, Page 13: "Sexual orientation and gender identity concepts

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- Everyone has a sexual orientation and a gender identity.
- A person knows their sexual orientation because of who they feel attracted to.
- A person knows their gender identity because they feel like a boy, a girl, both, neither or somewhere in between.
- People of all sexual orientations and gender identities need to know how to prevent pregnancy and STOs, either for themselves or to help a friend."

- Implementation Toolkit, Page 14-15: "Teaching about sexual orientation and gender identity creates better understanding and respect among all students and creates a climate where discrimination is unwelcome. It also provides a necessary protection for lesbian, gay, bisexual, trans, and queer (LGBTQ) students. The FLASH curriculum has been shown through rigorous evaluation to significantly reduce homophobia and transphobia among high school students (Kesler et al., 2023). It is important for educators to routinely teach inclusively, as every classroom will likely have students who identify (or will later identify) as LGBTQ, as well as students with family and friends who identify as LGBTQ."

FLASH

- Lesson 4, Page 4: "1. Let's start with **assigned sex**.
  - When a baby is born, the doctor usually says the baby is male or female, depending on the appearance of the baby's genitals. This is the baby's assigned sex.
  - The assigned sex of babies with a vagina, clitoris, and XX chromosomes is usually female.
  - The assigned sex of babies with a penis, scrotum, and XY chromosomes is usually male.
  - Some babies are born with variations in their genitals, reproductive organs, or chromosomes. This is called intersex. The doctor will usually assign a sex of male or female, although people may identify differently as they get older.

  If someone asked you to summarize assigned sex, what would you say? Who is it assigned by? Right, it's when the doctor says, 'It's a boy' or 'It's a girl,' depending on the baby's genitals. Good job. Any questions.

  2. Let's move on to gender identity. While assigned sex is based on the body parts the doctor sees at birth, gender identity has nothing to do with body parts.

  - Gender identity is a deep feeling people have about whether they are a guy, a girl, both, neither, or somewhere in between.
  - People often know their gender identity when they are very little, before they start kindergarten, although everyone is different and some people will know when they are younger or older.

- Cisgender is when a person's gender identity is the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'Yes, I am a girl.'
- Transgender is when a person's gender identity is not the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'No, I'm not a girl.' People may also identify as nonbinary, genderqueer, or some other gender identity.

So how is gender identity different than assigned sex? Correct, gender identity is based on a deep feeling that a person has about themselves."

Teen Outreach Program (TOP), 2nd Edition, Curriculum

- LAM-SU-A2, "Defining Sexuality," page 80: "**Facilitator Tip**:
Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

  Circle 'Sex' in 'Sexuality.'

  Ask
  - How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

  Share
  - Sexuality is more than physical behavior.

  Ask
  - Besides physical behavior, what else do you think could be part of a person's sexuality?

  If participants do not identify in the following, add
  - Sexual and reproductive anatomy
  - Body image
  - Biological sex
  - Gender including gender identity, gender expression and gender roles
  - Sexual orientation
  - Desires, pleasure, intimacy and reproduction
  - Beliefs, attitudes and values about sexuality"

- LAM-SI-F1, "This Is Me. Who Are You? page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148: **"Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

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We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. New Jersey's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

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Therefore, ACF instructs New Jersey to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

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Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

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ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Kate Daniel
New Mexico Department of Health
1190 South Street Francis Drive, Suite N4100
Sante Fe, NM 87502

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#1601NMPREP), 2024 (#1601NMPREP), and 2025 (#1601NMPREP).

Dear Ms. Daniel:

On April 14, 2025, the Administration for Children and Families (ACF) requested that New Mexico provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing New Mexico's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from New Mexico's PREP curricula and program materials:[1]

Teen Connection Project, 1st Edition

- Training and Facilitation Guide, Page 26: "Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) youth face a variety of unique obstacles

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facilitators must be aware of. Youth that identify or are perceived as LGBTQ are more likely to be victims of harassment, bullying and violence, especially at school, causing them to feel uncomfortable and unsafe in environments where they may be targeted."

- Page 26, facilitation tips:
  - "Foster an environment that is accepting of sexual and gender diversity, starting with you. Explore your own values and biases related to sexual orientation and gender identity and take time to learn about how society represents and receives LGBTQ people. Consider how bias and judgements may spill over into your group atmosphere or facilitation and take purposeful steps to mitigate them.
  - Don't assume you will be able to tell what a teen's sexual orientation or gender identity is, even if you have known them a long time.
  - Don't pressure anyone to share their personal identity with the group or to be the "spokesperson" for the LGBTQ population.
  - Try to use gender-neutral language such as 'they/them' instead of 'him/her' or 'he/she' and 'partner' instead of 'boyfriend/girlfriend' whenever possible.
  - Avoid characterizing heterosexual sex or sex between two cisgender individuals as "normal" and instead try to use neutral and inclusive language when talking about sex and anatomy.
  - At all times, make it clear that offensive language, stereotypes and stigmatization will not be tolerated. Encourage open discussion about sexual orientation, gender identity and healthy relationships of all kinds as a part of learning about human development."

- Page 27: "Cultural and Human Diversity Awareness and Inquiry
  - Cultural and Human Diversity Awareness and Inquiry
  - Relationship and Communication Sensitive to Cultural and Human Diversity
  - Practice Methods Sensitive to Cultural and Human Diversity"

Teen Outreach Program (TOP), 2nd Edition

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip:

  Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

  Circle 'Sex' in 'Sexuality.'

  Ask

- How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

Share
- Sexuality is more than physical behavior.

Ask
- Besides physical behavior, what else do you think could be part of a person's sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body image
- Biological sex
- Gender including gender identity, gender expression and gender roles
- Sexual orientation
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- LAM-SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

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The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. New Mexico's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs New Mexico to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] New Mexico is directed to remove these and all similar language throughout their curricula and program materials. Should New Mexico fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Se'an Bournes, sean.bournes@acf.hhs.gov.

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Kate Daniel
New Mexico Department of Health
1190 South Street Francis Drive, Suite N4100
Sante Fe, NM 87502

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#1601NMPREP), 2024 (#1601NMPREP), and 2025 (#1601NMPREP).

Dear Ms. Daniel:

On April 14, 2025, the Administration for Children and Families (ACF) requested that New Mexico provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing New Mexico's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from New Mexico's PREP curricula and program materials:[1]

Teen Connection Project, 1st Edition

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Tuesday, August 26, 2025

Mr. Jonathan Fanning
New York State Department of Health
Empire State Plaza
Corning Tower Room 859
Albany, NY 12237

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301NYPREP), 2024 (#2401NYPREP), and 2025 (#2502NYPREP).

Dear: Mr. Fanning:

On April 14, 2025, the Administration for Children and Families (ACF) requested that New York provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

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Be Proud Be Responsible! 5th Edition, Facilitator Manual

- Page 15 (Facilitator Information): "Demonstrate acceptance and respect for all participants, regardless of personal characteristics, including race, cultural background, religion, social class, sexual orientation or gender identity."

- Page 20 (Teaching Strategies on Roleplaying): "In addition, during the roleplay practice, participants may roleplay sexual pressure situations with someone of a different or the same gender. This may be awkward for straight teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively."

Making Proud Choices, 5th Edition, Facilitator Manual

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

> **Gender** refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.
>
> **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.
>
> **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

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ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Mandy Cohen
North Carolina Dept. of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301NCPREP), 2024 (#2401NCPREP), and 2025 (#2501NCPREP).

Dear Ms. Cohen:

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Middle School FLASH, Grade 6-8, 2nd Edition (2020)

- Page 40, Lesson 1, Developing a Local Sexual Health Resources List, Teacher Guide: "FLASH recommends referring young people to clinics and agencies that

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are teen and LGBT friendly, culturally competent, supportive of all pregnancy options, and that consider the teen to be their primary client. When creating your local resource sheet, keep these criteria in mind."

- Pages 59-60 (Lesson 2, Sexual Orientation and Gender Identity, page 2), "FLASH Key Concepts: Everyone has a sexual orientation and a gender identity.

  A person knows their sexual orientation because of who they feel attracted to, not because of who they have sex with.

  A person knows their gender identity because they feel like a boy, a girl, both, neither or somewhere in between, not because of their body parts.

  People of all sexual orientations and gender identities need to know how to prevent pregnancy and STDs, either for themselves or to help a friend."

- Page 67 (Lesson 2, page 9): "What if I don't know someone's sexual orientation or sexual identity? What should I call them?

  Every person has the right to name their own identities. It is polite to ask someone how they identify their sexual orientation and gender identity, and what words they would like you to use when talking to them. It is important to respectfully use the terms and pronouns people have asked others to use."

- Page 72 (Lesson 2): "Sexual Orientation and Gender Identity Definitions

  Gender Identity: How a person identifies their gender

Female	a person who identifies as a woman
Male	a person who identifies as a man
Transgender	When a person's gender identity doesn't match the sex (male or female) the doctor said they were when they were born
Cisgender	When a person's gender identity matches the sex (male or female) the doctor said they were when they were born
Gender Queer	Usually means a person doesn't feel exactly like a boy or a girl, at least not all of the time"

High School FLASH, 3rd Edition, Teacher Manual

- Page 105 (Sexual Orientation and Gender Identity Lesson 4, Page 6) "**Gender Identity**

- Gender Identity is a deep feeling people have about whether they are a guy, a girl, both, neither or somewhere in between.
- People often know their gender identity when they are very little, before they start kindergarten, although everyone is different and some people will know when they are younger or older.
- When a person's gender identity is the same as their assigned sex, it is usually called cisgender.
- When a person's gender identity is not the same as their assigned sex, it is often called transgender. People may also identify as gender queer, gender fluid or some other gender identity."

Rights Respect Responsibilities (the 3Rs), Grade 6

- Pages 1, 37, 44, 55: "A NOTE ABOUT LANGUAGE: Language is really important and we've intentionally been very careful about our language throughout this curriculum. You may notice language throughout the curriculum that seems less familiar- using the pronoun 'they' instead of 'her' or 'him', using gender neutral names in scenarios and role-plays and referring to 'someone with a vulva' vs. a girl or woman. This is intended to make the curriculum inclusive of all genders and gender identities. You will need to determine for yourself how much and how often you can do this in your own school and classroom, and should make adjustments accordingly."

Rights Respect Responsibility (the 3Rs), High School

- Page 4: "Note to the Teacher: If two cisgender, heterosexual boys end up randomly being assigned to each other, it is possible they will have a homophobic response that could include refusing to do the work or speaking or making gestures that mimic their understanding of gay male stereotypes. Some boys may be fine doing the role plays, but someone from another group might make a homophobic comment about it. Should this happen in your class, it's important to stop what you are doing, notice the interaction, and ask for the class members to reflect on what's happening and why. Direct the students back to your class ground rules and reinforce the agreement to be respectful – and that making homophobic comments is not respectful."

Teen Outreach Program (TOP), Second Edition, Facilitator Manual

- LAM-HW-F6, "Abstinence and Expressing Affection," page 196: "Write 'Sexuality' on the board/chart paper.

  Share
  - Becoming more aware and interested in sexuality is a normal and natural part of adolescence.

  Ask (write responses on board/chart paper)

- When you see and hear the word 'sexuality," what comes to mind?
- What do you think influences our views of sexuality?

Circle the word 'sex' within 'sexuality' on the board/chart paper.

Share

- When people think of sexuality, they often just think of sex
- However, sex is only one part of sexuality.
- Sexuality also includes our bodies and how we feel about them, our desires and attractions to others, out relationships, our beliefs and values about sexuality, how we should love and affection and how we identify and express our gender
- While some people choose to express their sexuality through sex, others choose to practice abstinence."

- LAM-HW-F1, Facilitator Resource, page 147-48: "**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. North Carolina's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs North Carolina to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] North Carolina is directed to remove these and all similar language throughout their curricula and program materials. Should North Carolina fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Sierra Baker at sierra.baker@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Glenn Muna
CNMI Public School System
P.O. Box 501370
Saipan, MP, 96950-1370

RE: Personal Responsibility Education Program grants for Fiscal Years 2023 (2301MPPREP), 2024 (2401MPPREP), and 2025 (2501MPPREP).

Dear CNMI Public School System:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Northern Mariana Islands provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing the territory's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from your PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, Curriculum

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if the Northern Mariana Islands' approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, your territory will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity**: Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  'I want to be sure everyone understands some of the terms we use when talking about diversity.'

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states and territories to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the

requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).” 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency’s authority to administer the program consistent with the authorizing legislation as enacted by Congress. The commonwealth’s current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs the Northern Mariana Islands to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged in this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Tecia Sellers at tecia.sellers@acf.hhs.gov.

The Northern Mariana Islands is directed to remove these and all similar language throughout the territory’s curricula and program materials. Should the commonwealth fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: “(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.”

withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Chris Freeman
Ohio Department of Youth Services
4545 Fisher Rd.
Columbus, OH 43228

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301OHPREP), 2024 (#2401OHPREP), and (#2501OHPREP).

Dear Chris Freeman:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Ohio provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Ohio's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Ohio's PREP curricula and program materials:[1]

Making Proud Choices! 5th edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender

[1] ACF initiated a medical accuracy review to determine if Ohio's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Ohio will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 39-40 (Module 1, Activity C, Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity.

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Ohio's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Ohio to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Ohio is directed to remove these and all similar language throughout their curricula and program materials. Should Ohio fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Sierra Baker at sierra.baker@acf.hhs.gov.

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Alicia Lincoln
Oklahoma State Dept. of Health
123 Robert S Kerr Ave.
Oklahoma City, OK 73117

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (#2301OKPREP), 2024 (#2401OKPREP), and 2025 (#2501OKPREP).

Dear Ms. Lincoln:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Oklahoma provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Oklahoma's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Oklahoma's PREP curricula and program materials:[1]

It's that Easy: A Guide to Raising Sexually Healthy Children (Resource Manual)

- Page 10 (Glossary):

[1] ACF initiated a medical accuracy review to determine if Oklahoma's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Oklahoma will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

"Gender: The set of meanings assigned by a culture or society to someone's perceived biological sex. Gender has three components: gender identity, physical markers and gender expression.

Gender Identity: An individual's internal sense of their gender. Gender identities may include male, female, transgender, non-binary, agender, bigender, genderfluid and genderqueer. For example, a person whose gender identity does not align with the biological sex they were assigned at birth is 'transgender' and a person whose gender identity aligns with the biological sex they were assigned at birth is 'cisgender.

Gender Expression: A person's outward gender presentation, usually comprised of personal style, clothing, hairstyle, makeup, jewelry, vocal inflection and body language. Gender expression is typically categorized as masculine, feminine, or androgynous, and there are many shades in between all of these. Gender expression may change throughout a person's life or in different situations and may or may not conform to a person's gender identity."

- Page 115 (Healthy Sexual Development: Ages 15-18): "Make sure that your children get information that makes sense for them. Remember that sexual identity and sexual behavior don't always match up. Gay, lesbian, transgender or bisexual youth may need different resources and support. Parents can help them find it."

Making a Difference, 5th Edition, Facilitator Curriculum

- Page 36 (Module 1, Activity B, Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Page 38-39 (Module 1, Activity C, Procedure): "Be sure to cover confidentiality, right to pass and respecting diversity. . . . **Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some

> may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.
>
> Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Oklahoma's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Oklahoma to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Oklahoma is directed to remove these and all similar language throughout their curricula and program materials. Should Oklahoma fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, MeGan Hill at megan.hill@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 27, 2025

Nadia Davidson, Chief Financial Officer
Oregon Health Authority
800 NE Oregon Street Ste 805
Portland, OR 97232

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301ORPREP), 2024 (#2401ORPREP), and 2025 (#2501ORPREP).

Dear Oregon Health Authority:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Oregon provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Oregon's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Oregon's PREP curricula and program materials:[1]

Friendships and Dating Program (2008-2017), Curriculum Manual, Sessions 1-20

- Section 5: Types of Relationships, page 37:

[1] ACF initiated a medical accuracy review to determine if Oregon's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Oregon will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

"Facilitator Tip: You may want to explore LGBT support organizations in your community. While it is a brief conversation, if participants have additional questions or need more in-depth coverage, you will be able to comfortably and knowledgeably point them to additional resources.

Ask participants if they know what sexual orientation and gender identity mean.

- Allow for peer interaction and opportunity for participants to lead this discussion.

Help the group understand sexual orientation is the term used to describe what gender(s) someone is sexually or romantically attracted to. Gender identity is the term used to describe how someone views their gender.

Use the Genderbread Person handout found on the FDP Website to discuss differences in gender identity, gender expression, biological sex, and sexual orientation (optional).

Ask participants if they know what the term straight or heterosexual means.

- People who are attracted to members of the other sex often call themselves straight or heterosexual.

Ask participants if they are familiar with the term LGBTQ. Allow participants to give answers, praise responses. Explain what each letter stands for. You may want to write LGBTQ on the board and write what each letter stands for.

- L = Lesbian – Women who are attracted to other women. Some people may prefer the term gay or gay women.

- G = Gay – People who are attracted to other people of the same sex. It is often used to describe males attracted to males, but is also used by lesbians.

- B = Bisexual – People who are attracted to both men and women often call themselves bisexual.

- T = Transgender – People who feel that their gender expression and gender identity are different from what people told them they were based on biological sex (body parts). For example, a person might be transgendered if when they were born their doctor and parents said they were a boy, but as the person grew up if felt like they were a girl.

- Q = Questioning – People who are unsure about their sexual orientation my call themselves questioning or curious.

- Asexual – People who don't experience any sexual attraction for anyone may call themselves asexual.

Follow up by asking how you can tell someone's sexual orientation. Explain you can't tell a person's sexual orientation by the way they look, their job, interests or hobbies. The only way to know is if they tell you."

Sexuality for All Abilities, 2nd edition, Instructor Manual

- Page 91 (Gender Chapter): "Key Messages:
  - Gender is how you feel. Some people identify as she, he or they. Some people have other ways of identifying.
  - Sometimes a person's gender identity doesn't match the gender that caregivers assign them.
  - Sometimes a person's gender expression also doesn't match their assigned gender.
  - In our society, we have stereotypes of what it means to be a man or a woman. Many people do not fit into this stereotype because we are all different, and that is okay.

- Page 93 (Gender Chapter): "Learning Activities

  What is gender?

  a. Ask participants: What do you think of when you hear the word gender? Possible responses: male/female, boy/girl, non-binary, who I am as a person, etc.

  b. Read the Gender social story found on the flash drive. Discuss the following key points.
    - Gender is how society thinks we should look, think, and act as girls and women and boys and men.
    - It can also refer to how a person feels on the inside in regards to being male, female or a different
    - gender.
    - Gender identity is how you feel inside and how you show your gender through clothing, behavior, and personal appearance. Each person gets to name for themselves what their gender identity is.
    - Sometimes this matches the assigned sex, and sometimes it does not.
    - When a new baby is born, one of the first questions almost everyone asks is, "Is it a boy or a girl?" This is the sex assigned to you at birth: male or female.
    - Assigned Sex: how a person is identified at birth by one's primary sex organ (penis/ vagina).
    - Gender Expression: how people express and present themselves to the world. We can get clues to someone's gender identity by their gender expression, but we shouldn't assume we can tell someone's gender identity by their gender expression. It's important to ask someone what

their gender identity is if you need to know. Sometimes this matches the assigned sex, and sometimes it does not.
    - Transgender: A term that describes a person whose gender identity does not match that person's sex assigned at birth. This may include someone who was assigned female at birth who feels male, vice versa, or something else altogether. Transgender people may use hormones, have surgery, both, or neither.
    - Nonbinary: a gender identity that is outside the binary of girl/woman or boy/man.
    - Gender Nonconforming: people who do not follow other people's ideas or stereotypes about how they should look or act. These stereotypes are based on the female or male sex they were assigned at birth.
    - Gender Pronouns: used to refer to a person in place of using their name. Some pronouns people use include: he, she, they, zie, per, and others.
    - Everyone gets to name their own gender identity and pronouns, including changing the name they use to describe their gender identity. It is important to note that a person's gender identity and pronouns may change over time, and that's ok.
    - Sexual Orientation: who a person is romantically attracted to. Gender and Sexual Orientation are different.

- Page 127 (under Glossary of Terms):

  "GENDER– A word that refers to how a person feels on the inside in regards to being male, female or a different gender.
  GENDER EXPRESSION– How a person represents or expresses their identity to the world. Sometimes this matches their assigned sex, sometimes not.
  GENDER FLUIDITY– The flexibility of gender expressions and identities that may change over time or even from day to day. A gender fluid person may feel male on some days, female on others, both male and female, or neither. A gender fluid person might also identify as genderqueer.
  GENDER IDENTITY– How a person identifies gender inside of themselves. Sometimes this matches their assigned sex, sometimes not.
  GENDER NONCONFORMING– When a person's gender expression doesn't fit inside traditional male or female categories (sometimes called the gender binary).
  GENDERQUEER– A term for people who don't identify as a man or a woman or whose identity lies outside the traditional gender binary of male and female. Some people use genderqueer, gender non-conforming, and non-binary interchangeably, but others don't. Genderqueer has a political history, so many use the term to identify their gender as non-normative in some way. For example, someone could identify as both cisgender female and gender queer.

- Page 130 (under Glossary of Terms):
  "TWO-SPIRIT– An umbrella term for gender used by Native American and First Nation tribes; refers to people who have both masculine and feminine identity and are treated as a third gender in some tribes. Two-spirit individuals also tend to have same-sex and/or same-gender relationships. Many Native American and First Nation LGBTQ+ individuals identify with the term two-spirit."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Oregon's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Oregon to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Oregon is directed to remove these and all similar language throughout their curricula and program materials. Should Oregon fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Ida Kilcullen
Republic of Palau
P.O. Box 189
Koror, Palau 96940

RE: Personal Responsibility Education Program for Fiscal Years 2023 (#2301 PWPREP), 2024 (#2401 PWPREP), and 2025 (#2501 PWPREP).

Dear Ms. Kilcullen,

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Republic of Palau provide current curricula and programmatic materials in use or in any way relevant to your Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Palau's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Palau's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Palau's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Palau will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Draw the Line/Respect the Line

- Page 6 ("How to Use the Curriculum"): "While some young people may feel more comfortable or be able to be more honest when discussing sexuality-related issues in single-gender groups, we do not recommend dividing the class in this way, as it can cause trauma for transgender, gender non-conforming, and non-binary youth. . . .

  The use of integrated, mixed-gender groups is considered best practice for current-day classrooms and youth groups, and is something sexuality educators are trained to facilitate. Use of mixed-gender groups can help promote gender equity, build understanding of different perspectives, and increase inclusivity for transgender, gender nonconforming, and non-binary youth."

- Lesson 1, Activity 4.5 (page 59) and Lesson 4, Activity 4.4 (page 92):

  Teacher's Note
  During the roleplay practice, youth may roleplay pressure situations with a partner of a different or the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:
  - Explain the situation in a matter-of-fact way. Let youth know that they may be doing the roleplays with a partner of a different or the same gender.
  - Emphasize that they are playing roles. Doing the roleplay to practice the skill doesn't say anything about the sexual attraction of the people doing the roleplay or mean that anyone is expressing a real-life attraction toward the other person in the roleplay.
  - Explain that they need to take their role seriously because teens of all sexual orientations and gender identities need to learn how to draw the line to resist sexual pressure and protect themselves. This will help ensure that they and their classmates get the most out of the roleplay activities.

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects

described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress.

The Republic of Palau's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs the Republic of Palau to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged in this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Tecia Sellers at tecia.sellers@acf.hhs.gov.

The Republic of Palau is directed to remove these and all similar language throughout their curricula and program materials. Should Palau fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Kathy Jo Stence, Director
Pennsylvania Department of Health
7th Floor East, Health & Human Services Building
625 Forster Street
Harrisburg, PA 17120

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301PAPREP), 2024 (#2401PAPREP), and 2025 (#2501PAPREP).

Dear Pennsylvania Department of Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Commonwealth of Pennsylvania provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing the Commonwealth's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Pennsylvania's PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, Facilitator Curriculum California

- Page 31, Pre-Module, Setting the Stage: Sexual Diversity and Healthy Relationship (Learning Objectives):

[1] ACF initiated a medical accuracy review to determine if Pennsylvania's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Pennsylvania will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

- "Explain how gender identity, gender expression, sex assigned at birth, sexual and emotional attraction, and sexual behavior are related to sexual identity.
- Describe their own identity using affirming terms.
- Explain how understanding sexual identity and diversity can positively impact all individuals and decrease the harms caused by stigma and shame."

- Page 32: "This pre-module sets a tone that welcomes diversity of sexual identity and creates a respectful space for all participants. They learn the distinctions between gender identity, gender expression, sex assigned at birth, sexual attraction/orientation and sexual behavior with the help of a visual aid. They apply this learning to understanding their own sexual identity, and discuss how stereotypes, stigma and shame can impact LGBTQ+ individuals."

- Page 55 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 58-59 (Module 1, Activity C Procedure): **"Respect diversity**: Let's keep in mind that there's diversity in society and in this group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they chose to; others may have had sex against their will. Some may identity as male, female or transgender.

  Your people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender)or different from(transgender)the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Be Proud! Be Responsible! Facilitator Manual

- Page 17: "Demonstrate acceptance and respect for all participants, regardless of personal characteristics, including race, cultural background, religion, social class, sexual orientation or gender identity."

- Page 21: "In addition, during the roleplay practice, participants may roleplay sexual pressure situations with someone of a different or the same gender. This may be awkward for straight teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:

  Explain the situation in a matter-of-fact way. Let participants know that they may be doing the roleplays with someone of a different or the same gender.

  Emphasize that they are playing roles. Doing the roleplay to practice the skill doesn't say anything about the sexual orientation of the people doing the roleplay or mean that anyone is expressing a real-life attraction toward the other person in the roleplay.

  Explain that they need to take their roles seriously because teens of all sexual orientations and gender identities need to learn how to resist sexual pressure and negotiate condom use to protect themselves. This will help ensure that they all get the most out of the roleplay activities."

Friendships and Dating Program, First Edition (2008-2017), Curriculum Manual

- Section 5: Types of Relationships, page 37: "Facilitator Tip: You may want to explore LGBT support organizations in your community. While it is a brief conversation, if participants have additional questions or need more in-depth coverage, you will be able to comfortably and knowledgeably point them to additional resources.

  Ask participants if they know what sexual orientation and gender identity mean.

- Allow for peer interaction and opportunity for participants to lead this discussion.

Help the group understand sexual orientation is the term used to describe what gender(s) someone is sexually or romantically attracted to. Gender identity is the term used to describe how someone views their gender.

Use the Genderbread Person handout found on the FDP Website to discuss differences in gender identity, gender expression, biological sex, and sexual orientation (optional).

Ask participants if they know what the term straight or heterosexual means.

- People who are attracted to members of the other sex often call themselves straight or heterosexual

Ask participants if they are familiar with the term LGBTQ. Allow participants to give answers, praise responses. Explain what each letter stands for. You may want to write LGBTQ on the board and write what each letter stands for.

- L = Lesbian – Women who are attracted to other women. Some people may prefer the term gay or gay women.

- G = Gay – People who are attracted to other people of the same sex. It is often used to describe males attracted to males, but is also used by lesbians.

- B = Bisexual – People who are attracted to both men and women often call themselves bisexual.

- T = Transgender – People who feel that their gender expression and gender identity are different from what people told them they were based on biological sex (body parts). For example, a person might be transgendered if when they were born their doctor and parents said they were a boy, but as the person grew up if felt like they were a girl.

- Q = Questioning – People who are unsure about their sexual orientation my call themselves questioning or curious.

- Asexual – People who don't experience any sexual attraction for anyone may call themselves asexual.

Follow up by asking how you can tell someone's sexual orientation. Explain you can't tell a person's sexual orientation by the way they look, their job, interests or hobbies. The only way to know is if they tell you."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Pennsylvania's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Pennsylvania to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Pennsylvania is directed to remove

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

these and all similar language throughout their curricula and program materials. Should Pennsylvania fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Dr. Manuel Vargas Bernal
Puerto Rico Department of Health
P.O. Box 70184
San Juan, PR 00936-8184

RE: Personal Responsibility Education Program grants for Fiscal Years 2023 (2301PRPREP), 2024 (2401PRPREP), and 2025 (2501PRPREP).

Dear Dr. Vargas Bernal:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Puerto Rico provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Puerto Rico's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Puerto Rico's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Puerto Rico's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Puerto Rico will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

El Camino Curriculum, 2nd ed.

- Lesson 5, page 7: "After a few responses, show the following review video which explains the difference between gender identity and sex (3-4 min.) . . . .

  Tell students:

  Like the video shared, sex assigned at birth is based on how someone else sees our bodies and doesn't take into account how someone might see themselves as a whole person, or their gender identity. Culture can influence the ways people express their gender identity and shape people's gender expression in the ways someone dresses, talks, acts, and more. We learn many cultural values from those around us, such as parents, grandparents, and friends. This may include values about gender and sexuality."

- Lesson 5, page 10: Facilitator Note: "Remind students that gender is different from sex. Tell the students that in this lesson we will use the phrases 'person with a penis' and 'person with a vagina' when discussing reproductive systems."

- Lesson 5, page 29: "Transmasculine people can get pregnant if they have a uterus. Although testosterone hormone therapy decreases fertility, transmasculine people can still get pregnant during and after hormone therapy. It may also take longer for transmasculine people to know they're pregnant because testosterone hormone therapy causes irregularities to the menstrual cycle or stops it altogether."

- Appendix H: Supplemental Resources for Working with LGBTQ+ Youth; "Sex, Gender, and Identity," page 1: "People may feel discomfort around commonly gendered body parts like their chest or genitalia. Practices like tucking and binding are non-permanent options to change the way those body parts look in clothes and ease their ease distress. Tucking involves flattening the space between someone's legs by moving the penis and testicles. Binding is something people do to compress their chest to create the appearance of a flat chest. Some people see tucking and binding as daily components of their gender expression, and other people only use them sometimes."

- Appendix H: Supplemental Resources for Working with LGBTQ+ Youth; "LGBT Definitions," pages 2-4:

  "**Pansexual (Pan)** -- people who are attracted to people of all genders. Like bisexual people, pansexual people can be attracted to people of each gender in different ways and be attracted to people of some genders more than others. Gender is not as relevant for pansexual people as it is for bisexual people.
  Queer -- both a general descriptor of people who are not heterosexual as well as a specific identity. It can also be associated with a rejection of labels and gendered concepts like the gender binary. It has been used as a slur against LGBTQ+ people, so even though it has been reclaimed by the community, it is important to be mindful that some LGBTQ+ people, especially those who are older, may not

be comfortable with being called queer. It is important to use the terms people prefer to describe their identities and experiences.

Gender -- is a socially constructed identification that refers to a constellation of behaviors, norms, and characteristics that vary by culture and over time.

AFAB -- acronym for assigned female at birth. People use "assigned" to reflect that gender and sex assignments at birth are generally based on physical characteristics and may not be accurate to a person's experience or even biological context such as hormonal and genetic contributions.

Agender -- used to describe people who don't experience a gender. Agender people see gender as something that is abstract and doesn't relate to or resonate with them.

AMAB -- acronym for assigned male at birth. People use "assigned" to reflect that gender and sex assignments at birth are generally based on physical characteristics and may not be accurate to a person's experience or even biological context such as hormonal and genetic contributions.

Cisgender (Cis) -- people who identify with the gender they were assigned at birth.

Cishet -- people who are both cisgender and heterosexual; this term is short for cisgender, heterosexual.

Cisnormative -- refers to the idea that being cisgender is the norm and anyone who is not cisgender is abnormal. This idea has deep cultural roots and pressures people to identify as cisgender.

Gender binary -- refers to a system that classifies people as either men or women based on assigned sex and gender at birth. The gender binary relies on there being only two genders and those two genders being different from one another.

Gender dysphoria -- refers to the distress people experience when their gender identity and assigned gender are different.

Gender expression -- refers to how people show their gender, often through appearance and behavior.

Gender identity -- refers to someone's internal sense or understanding of their gender.

Gender non-conforming (GNC) -- used to describe people whose gender expression doesn't conform to the societal expectations of their assigned gender.

Genderfluid -- used to describe people who fluctuate between different gender identities. For example, some days a genderfluid person may feel more like a boy, somedays they may feel more like a girl, and other days they may feel like another gender outside of the binary.

Genderqueer -- used to describe people whose gender identity is queer or outside of the norms set by cisnormativity. This term originated in political circles within the queer liberation movement, and many people who use the term also identify their sexual orientation as queer, or not straight. Although genderqueer and non-binary are both terms used to indicate that a person does not have a binary identification, the use of the term "queer" in genderqueer indicates a perspective aimed at dismantling current ways of thinking about gender.

Non-binary -- can be used as an umbrella term to include people whose gender identity is outside of the gender binary and as a specific identifier. Non-binary

people can have different conceptions of their gender with some relating to binary experiences and others not relating to those experiences.

Physical transition -- refers to the process of making physical changes to one's body through hormone therapy and/or surgeries to better align their physical body to their gender identity.

Social transition -- refers to the process of changing non-physical aspects of one's gender identity, such as their name and pronouns, and incorporating new aspects of gender expression into day-to-day life.

Transgender (Trans) -- an umbrella term used to describe people who do not identify with the gender they were assigned at birth. Trans women are women who were assigned male at birth (AMAB) and trans men are men who were assigned female at birth (AFAB). Sometimes the term trans is used to specifically talk about trans men and women, and sometimes it is used to talk about all people who do not identify with the gender they were assigned at birth. Non-binary and genderqueer people are included in this definition, but not all non-binary and genderqueer people choose to also identify as trans. There are no requirements to "being" trans other than not identifying with your gender assigned at birth.

Transfeminine -- used to describe AMAB people who identify with femininity in terms of gender identity or gender expression. This can include trans women and non-binary people.

Transmasculine --used to describe AFAB people who identify with masculinity in terms of gender identity or gender expression. This can include trans men and non-binary people.

Two-Spirit --used as an umbrella term to describe Indigenous people who conceptualize themselves outside of the dominant cisgender and heterosexual ways of identifying. This specific term was created as a pan-Native American identifier and has only been in use for a few decades. However, the concept has deep and varied roots in Indigenous communities and should never be used by people outside of those communities. Additionally, just because someone is LGBTQ+ and Native American doesn't mean that they're Two-Spirit, and just because someone is Two-Spirit doesn't mean they identify as LGBTQ+."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the six adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Puerto Rico's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Puerto Rico to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute. We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, MeGan Hill at MeGan.Hill@acf.hhs.gov.

Puerto Rico is directed to remove these and all similar language throughout their curricula and program materials. Should Puerto Rico fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025**, at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Lori Zelano
Rhode Island Department of Health
3 Capitol Hill, Room 302
Providence, RI 02908

RE: State Personal Responsibility Education Program for Fiscal Years 2023 (#2301RIPREP), 2024 (#2401RIPREP); and 2025 (#2501RIPREP).

Dear Rhode Island Department of Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Rhode Island provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Rhode Island's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Rhode Island's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Rhode Island's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Rhode Island will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Teen Outreach Program (TOP), 2nd Edition

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

  Circle 'Sex' in 'Sexuality.'

  Ask
  - How much of our Word Web is about 'having sex' or 'sex' as physical behavior?

  Share
  - Sexuality is more than physical behavior

  Ask
  - Besides physical behavior, what else do you think could be part of a person's sexuality?

  If participants do not identify in the following, add
  - Sexual and reproductive anatomy
  - Body Image
  - Biological sex
  - Gender Including gender identity, gender expression and gender roles
  - Sexual orientation
  - Desires, pleasure, intimacy and reproduction
  - Beliefs, attitudes and values about sexuality"

- LAM-SI-F1, "This Is Me. Who Are You? page 94: "Ask
  - What comes to mind when you hear me say 'identity'?
  - What might be part of someone's identity?

  If participants do not identify the following, add
  - Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests.

  Share
  - We all have our own unique identity.
  - Today in TOP Club, we will explore our own identity and learn about others' identities.

- Identity is personal and can be sensitive. Anytime we share personal information with each other, we need to pay extra attention to our group guidelines.
- We are all part of keeping TOP a safe space.
- It's important to be patient, kind and supportive.
- Remember that it is not okay to put other people on the spot or identify other people by name and share their personal experiences."

- LAM-HW-F1, Facilitator Resource, "Frequently Asked Questions," page 148:

  "Why would someone with a penis not identify as a boy/man?
  Why would someone with a vulva not identify as a girl/woman? When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

- Pages 142, 156,179,187, 195, 202, 232, 254, 264, 271, 275, 280, 286, 319, and 344 (repeated admonition to use "inclusive" language in almost every lesson):

  "Use inclusive language. Even if you have known all your participants a long time, do not make assumptions about their sexuality and who they are interested in dating. LGBTQ youth can quickly feel isolated if all relationship examples and language are only heterosexual. Use the term 'partner' to refer to a romantic partner."

- LAM-HW-F6, "Abstinence and Expressing Affection," pages 195-98:

  "Circle the word 'sex' with 'sexuality' on the board/chart paper.
  Share
  - When people think if sexuality, often just think of sex.
  - However, sex is only one part of sexuality.
  - Sexuality also includes are bodies and how we feel about them, our desires and attractions to others, our relationships, our beliefs and values about sexuality, how we show love and affection and how we identify and express our gender.
  - While some people choose to express their sexuality through sex, others choose to practice abstinence."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted

infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Rhode Island's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Rhode Island to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Rhode Island is directed to remove these and all similar language throughout their curricula and program materials. Should Rhode Island fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt, arlisa.britt@acf.hhs.gov.

(allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Danielle Wingo
South Carolina Department of Public Health
400 Otarre Parkway
Cayce, SC 29033

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2401SCPREP), 2024 (#2501SCPREP), and 2025 (#2601SCPREP).

Dear Ms. Wingo:

On April 14, 2025, the Administration for Children and Families (ACF) requested that South Carolina provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing South Carolina's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from South Carolina's PREP curricula and program materials:[1]

Making Proud Choices, 5th edition

- Page 36 (Module 1, Activity B Procedure): "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for

[1] ACF initiated a medical accuracy review to determine if South Carolina's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, South Carolina will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "Define Terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another. **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Making Proud Choices! 5th Edition, Facilitator Curriculum California

- Pre-Module, Setting the Stage: Sexual Diversity and Healthy Relationships," Page 31: "Learning Objectives:
  - Explain how gender identity, gender expression, sex assigned at birth, sexual and emotional attraction, and sexual behavior are related to sexual identity.
  - Describe their own identity using affirming terms.
  - Explain how understanding sexual identity and diversity can positively impact all individuals and decrease the harms caused by stigma and shame."

- Page 32: "This pre-module sets a tone that welcomes diversity of sexual identity and creates a respectful space for all participants. They learn the distinctions between gender identity, gender expression, sex assigned at birth, sexual attraction/orientation and sexual behavior with the help of a visual aid. They apply this learning to understanding their own sexual identity, and discuss how stereotypes, stigma and shame can impact LGBTQ+ individuals."

One Circle Foundation (2015), Teacher Manual

- Page 14: "It is important to understand and clarify that sexual orientation and gender identity and expression are indeed three separate pieces of one's identity and not to be conflated or viewed as one in the same. For this reason, the acronym SOGIE (Sexual Orientation, Gender Identity and Expression) is used to acknowledge the differences between these three identity pieces and the expansive and continuum nature of these identities."

- Page 15: "**Gender Identity** refers to the gender an individual truly feels they identify as including who someone is – a male, female, both – genderfluid, genderqueer, gender non-conforming, neither, or other. Biological sex organs may or may not match one's gender identity. Transgender youth are young people who know themselves as a gender that is different from the assigned gender based on their biological sex organs at birth.
Gender Expression is physical manifestation of one's gender identity through clothing, hairstyle, voice, body shape, etc.
Sex Assigned at Birth is classifying people as male, female, intersex, or another sex based on a combination of anatomy, hormones, chromosomes. It is also important to know that about one in 1,500-2,000 people in North America are born with ambiguous sex organs known as intersex.

  A helpful infographic tool, The Gender Unicorn, created by youth, can be sourced through Trans Student Educational Resources (TSER) and is effective when learning and educating others regarding being SOGIE affirming."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. South Carolina's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs South Carolina to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] South Carolina is directed to remove these and all similar language throughout their curricula and program materials. Should South Carolina fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Latanya Bispham-Robinson, latanya.bispham-robinson@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Darcy McGuigan
Finance Director
South Dakota Dept. of Health
600 East Capitol Avenue
Pierre, SD 57501-2536

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301SDPREP), 2024 (#2401SDPREP), and 2025 (#2501SDPREP).

Dear Ms. McGuigan:

On April 14, 2025, the Administration for Children and Families (ACF) requested that South Dakota provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing South Dakota s PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from South Dakota's PREP curricula and program materials:[1]

Teen Outreach Program (TOP), 2nd edition, Curriculum

- LAM-SU-A2, "Defining Sexuality," page 80: "Facilitator Tip:

[1] ACF initiated a medical accuracy review to determine if South Dakota's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, South Dakota will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have different views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Ask
- How much of our Word Web is about 'having sex' or 'sex as a physical behavior?'

Share
- Sexuality is more than physical behavior.

Ask (add responses to Word Web)
- Besides physical behavior, what else do you think could be part of a person's sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body image
- Biological sex
- Gender including gender identity, gender expression and gender roles
- Sexual orientation
- Desires, pleasure, intimacy and reproduction
- Beliefs, attitudes and values about sexuality

Share
- Sexuality can include some or all of these things.
- Sexuality is a personal experience and will be different for everyone."

- LAM SI-F1, "This Is Me. Who Are You?" page 94: "Our identity, or how we see ourselves, includes many different things, such as our race/ethnicity, nationality, culture, religious affiliation, age, gender, sexuality, roles (Ex: athlete, big sister, etc.), personality traits and interests."

- LAM-HW-F1, Facilitator Resource, page 148: "Frequently asked Questions:

Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?
When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

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We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. South Dakota's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs South Dakota to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] South Dakota is directed to remove

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Tecia Sellers at tecia.sellers@acf.hhs.gov.

these and all similar language throughout their curricula and program materials. Should South Dakota fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Mohamed El-Kaissy
Tennessee Department of Children Services
315 Deaderick Street
9th Floor, OBS Building
Nashville, TN 37243

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301TNPREP), 2024 (#2401TNPREP), and 2025 (#2501TNPREP).

Dear Mr. El-Kaissy:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Tennessee provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Tennessee's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Tennessee's PREP curricula and program materials:[1]

Teen Outreach Program (TOP), 2nd Edition, Curriculum

- LAM-SU-A2, "Defining Sexuality," page 80; "Facilitator Tip: Sexuality is complex and can be difficult to define. It is normal for participants to struggle to

[1] ACF initiated a medical accuracy review to determine if Tennessee's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Tennessee will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

understand it broadly and to have different views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Circle 'sex' in "Sexuality."

Ask
- How much of our Word Web is about 'having sex' or 'sex' as a physical behavior?

Share
- Sexuality is more than physical behavior.

Ask
- Beside physical behavior, what else do you think could be part of a person's sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body Image
- Biological sex
- Gender Including gender identity, gender expression and gender roles
- Sexual orientation
- Desires, pleasure, intimacy and reproduction
- Beliefs, attitudes and values about sexuality

Share
- Sexuality can include some or all these things.
- Sexuality is a personal experience and will be different for everyone."

- LAM-HW-F1, "Frequently Asked Questions," Pages 147-48:

"Why would someone with a penis not identify as a boy/man?
Why would someone with a vulva not identify as a girl/woman? When we use body parts to describe people, we're talking about 'biological sex,' or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP."

Manhood 2.0, First Edition, Curriculum PowerPoint

- Preface: "The premise of Manhood 2.0 is that being aware and conscious of how we in our society are raised within the confines of restrictive ideas about gender is

not only a necessary, but also a liberating experience. The approach is rooted in popular education, in feminist collective action (intersectional feminism in particular), and in the work of Brazilian educator Paulo Freire. Freire espoused the idea of collective consciousness-raising among those oppressed by the many ways in which people are marginalized – through racism, sexism, homophobia, transphobia, classism, ableism, and so forth. We take this work further by not only supporting young men to recognize ways in which power and oppression manifest in their lives, but also providing them with opportunities to practice skills to create healthier relationships, positive social networks, and nonviolent communities."

- Page 39:

  "BIOLOGICAL SEX
  - Biological sex refers to the physical characteristics you are born with. It is assigned based upon a person's anatomy and physical attributes (such as external sex organs, sex chromosomes, and internal reproductive structures). When these classifications don't line up with what is typically considered a male or female body, the individual is usually referred to as 'intersex.'

  GENDER
  - Gender refers to the attitudes, roles, behaviors, activities, and attributes that a community or society determines is characteristic or uses to describes men, women, boys, and girls.
  - This is typically associated with or matches one's biological sex; individuals who feel that their gender and sex 'match,' or are associated, are referred to as 'cisgender.'
  - Some individuals' gender identity does not conform to those behaviors that are typically associated with their sex; these individuals can refer to themselves as transgender or non-binary, for example.
  - Definitions of 'masculine' and 'feminine' are not fixed. They change over time and are different from society to society. We learn to be our 'gender' by interacting with the world around us.
  - Sometimes these ideas of how to be a man are thought to be based on our biology rather than something that we learn (such as the common myth that violence is a part of men's biology).

- Page 40:

  "CLOSING STATEMENTS

  13 'Gender' refers to the way society defines the roles, behaviors, activities, and attributes of men, women, and people who are transgender or nonbinary.

  14 Gender is different from biological sex. It is not biologically derived or something we are born with.

> **15** Gender is different from one's sexual orientation – how someone identifies (as a man, woman, or other gender identity) is not related to who they are attracted to.
> **16** Characteristics that are 'manly' or 'womanly' are not fixed and can change depending on the person and over time. All men are not only 'one way,' and all women are not only 'one way.'"

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Tennessee's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Tennessee to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program

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delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

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ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Tracy Gruber
Utah Department of Health and Human Services
195 North 1950 West
Salt Lake City, UT 84116

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301UTPREP), 2024 (#2401UTPREP), and 2025 (#2501UTPREP).

Dear Ms. Gruber:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Utah provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Utah s PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Utah's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Utah's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Utah will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Get Real HS, 2nd edition, Curriculum

- Lesson 9.1 "Introduction to Sexuality," pages 2-3:

  "Define Sexuality and Sexual Health

  Ask students what they think the term *sexuality* means. Emphasize that sexuality is not just about sex assigned at birth or sexual behavior, but is a combination of many elements, including relationships and communication. Explain that sexuality can include feelings about oneself and others, as well as values and beliefs, body awareness, intimacy, gender and sexual identity, and sexual health.

  Teacher Note

  > **Sex Assigned at Birth and Gender Identity**
  > Be sure to take a moment to explain the difference between sex assigned at birth and gender identity to students, as this may be the first time they've heard these terms. See Teacher's Guide for definitions."

- Lesson 9.4 "Gender and Sexual Identity," page 25:

  "**Connecting the Lessons**
  Connects to Lesson 9.3: Sex, Gender and Shared Responsibility and Lesson 9.8: Healthy and Unhealthy Relationships

  Lesson Goals
  - Explain the importance of gender and sexual identity being self-identified.
  - Identify proper vocabulary for describing gender and sexual identity.
  - Explain the difference between sex assigned at birth, gender identity, gender expression and sexual orientation.
  - Discuss LGBTQ+ issues respectfully.
  - Demonstrate how to be an ally and to effectively communicate support for peers."

- Page 29: "Explain that a person's gender identity is how they define their own gender, which may or may not be the same as their sex assigned at birth; a person's gender expression is how they share their gender with the world. Tell students that they all thought about their own gender identity, and potentially gender expression, when they chose what word or words to use for 'gender' in the last activity. Every person has a sex assigned at birth, agender identity, a way of expressing their gender, and a sexual orientation. And each of these is unique to every individual person."

- Teacher's Guide, Lesson 9.1, page 109: "Another important part of sexuality is gender identity. Gender identity is a term that refers to a person's deeply personal

feeling of identifying as a man, woman or some other gender, which may or may not line up with the sex assigned to the person at birth."

In Clued (2019), Utah Adapted Curriculum

- Youth Curriculum Overview, Workshop Activities, page 5:

  "Introductions and Warm-Up (20 minutes)

  Facilitators introduce themselves, the IN·clued workshop agenda and Essential Questions, and facilitate participant introductions. Participants commit to group agreements to maximize physical, emotional, and psychological safety during the learning experience. The Peer Educators read a welcoming poem depicting diverse sexual and gender identities to create a supportive environment for workshop participants. Participants spend time exploring their IN·clued zines."

- Youth Workshop Curriculum, Page 11: "Preparation prior day of workshop:

  Call LGBTQ+ youth group facilitator to ask about:
  - Community-specific group language use (e.g. 'Queer youth,' 'LGBTQ+ youth,' 'Gender-expansive youth,' etc.)
  - Group structure (meeting times, locations, number of youth, etc.)
  - Already established group norms/agreements, if they have any
  - Prior activities/experiences the group has had around sexual health education or accessing sexual healthcare
  - Facilities—room set up, A/V equipment, room for breakout groups, etc.
  - Group dynamics that would be useful to know"

- Activity 1, page 14: "ADULT FACILITATOR: Gather everybody's attention and thank participants for being there. Introduce yourself with your name, pronouns (if you wish), your role, and why you care about LGBTQ+ sexual health. Introduce the purpose of the workshop.

  'We want to thank everybody for taking the time to be here today—we're really excited to be working with you for the next few hours, and are grateful to be with you in this space. IN·clued is a program just for LGBTQ+ youth to learn about how to get the sexual health information and services they need and have the right to. We know that sometimes lesbian, gay, bisexual, transgender, and queer or questioning young people don't have access to information and services that is for them. That's why we're here, to spend some time together talking about LGBTQ+ sexual healthcare in particular.'"

Making Proud Choices! 5th Edition, Curriculum

- Module 1, Activity B, Facilitator Note, page 36: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender

nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Module 1, Activity C, Procedure, pages 39-40: "**Respect Diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity.

  Define terms related to diversity as needed.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Teen Outreach Program (TOP), Curriculum

- LAM-SU-A2, "Defining Sexuality" chapter, page 80:

  "**Facilitator Tip**

  Sexuality is complex and can be difficult to define. It is normal for participants to struggle to understand it broadly and to have differing views. Support participants in sharing and listening to one another, and make sure dialogue remains respectful and inclusive.

Circle ‘Sex’ in ‘Sexuality’

Ask
- How much of our Word Web is about ‘having sex’ or ‘sex’ as a physical behavior?

Share
- Sexuality is more than physical behavior.

Add
- Besides physical behavior, what else do you think could be part of a person’s sexuality?

If participants do not identify in the following, add
- Sexual and reproductive anatomy
- Body Image
- Biological sex
- Gender Including gender identity, gender expression and gender roles
- Sexual orientation
- Desires, pleasure, intimacy and reproduction
- Beliefs, attitudes and values about sexuality

Share
- Sexuality can include some or all these things.
- Sexuality is a personal experience and will be different for everyone.

- LAM-HW-F1, Facilitator Resource, “Frequently Asked Questions,” page 148:

  “**Why would someone with a penis not identify as a boy/man? Why would someone with a vulva not identify as a girl/woman?**
  When we use body parts to describe people, we’re talking about ‘biological sex,’ or sex assigned at birth, which is different than gender. Gender is how people identify and express themselves. Transgender people are people whose gender identity is different from their biological sex or sex assigned at birth. Gender non-conforming and non-binary people are people whose gender identities are not exclusively either boy/man or girl/woman. However someone identifies, they should feel safe, respected and included in TOP.”

The “purpose” of a PREP grant award is for states to “carry out personal responsibility education programs consistent with this subsection.” 42 U.S.C. § 713(b)(1). The statute defines PREP as “a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).” 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Utah's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Utah to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Utah is directed to remove these and all similar language throughout their curricula and program materials. Should Utah fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

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ADMINISTRATION FOR CHILDREN & FAMILIES
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Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mr. Paul Daley
Vermont Department of Health
108 Cherry Street
Burlington, VT 05401

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2101VTPREP), 2024 (#2301VTPREP), and 2025 (#2301VTPREP).

Dear Mr. Daley:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Vermont provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Vermont's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Vermont's PREP curricula and program materials:[1]

Making Proud Choices! 5th edition, Facilitator Curriculum

- Module 1, Activity B Procedure, page 36: "Facilitator's Note: Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some

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youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Module 1, Activity C Procedure, pages 39-40: "Define terms related to diversity as needed.

  I want to be sure everyone understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another. **Gender identity** is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person. **Gender expression** is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Vermont Supplemental "Supporting LGBTQIA+ Youth" (2016), Teacher Manual

- Page 11: "Synopsis - In this class, students learn that they are about to participate in a program to reduce risks for unplanned pregnancy and STI/HIV. They learn that this particular class is designed to set a tone that makes the upcoming lessons relevant for everyone. Students complete a worksheet and participate in a discussion about self-identity. Then the teacher leads a discussion about sexual identity, which is one part of self-identity. Students learn about gender identity, sexual attraction and orientation, and sexual behaviors. Students then apply their learning by reading (or listening to) vignettes and answering questions about the protagonists' gender identities, attractions, and family and peer support."

- Page 17: "Transgender women and cisgender women are both women. Transgender men and cisgender men are both men. The use of cisgender helps clarify that gender identity exists in both cisgender and transgender people."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Richy Richard, richy.richard@acf.hhs.gov.

(allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Natalie L. Bailey
Administrator, DFA
Department of Human Services
41 B Mars Hill, Frederiksted
St. Croix, Virgin Islands

RE: Personal Responsibility Education Program for Fiscal Years 2023 (2301VIPREP), 2024 (2401VIPREP), and 2025 (2501VIPREP).

Dear Ms. Bailey:

On April 14, 2025, the Administration for Children and Families (ACF) requested that the Virgin Islands provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing the Virgin Islands' PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from the territory's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if the territory's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, the Virgin Islands will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Reducing the Risk, Teacher Manual, 5th ed.

- Page 14: "Be sure your reading of the roleplay allows for inclusivity and does not reinforce one view of gender identity or gender stereotypes. You can do this by introducing Lee and Lee as a couple without specifying their genders, by not differentiating the two Lees' lines using stereotypical male and female voices, and by leaving it open as to which Lee is pressuring and which does not want to have sex."

- Class 4, "Roleplay in Small Groups," page 71. "Note to the Teacher: Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively. Here are some tips:

    - Explain the situation in a matter-of-fact way. Let students know that every student in the class will, at some point, be doing a roleplay with a classmate of a different gender and with a classmate of the same gender. Most likely, they will do this several times.
    - Explain that they need to take their roles seriously because teens of all sexual orientations and gender identities need to learn how to resist sexual pressure and protect themselves. This will help ensure that they and their classmates get the most out of the role play activities."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. The Virgin Island's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs the Virgin Islands to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute; we are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Shakira Williams at shakira.williams@acf.hhs.gov.

The Virgin Islands is directed to remove these and all similar language throughout their curricula and program materials. Should the territory fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mary Clark
Washington State Department of Health
111 Isreal Road
Olympia, WA 98504

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301WAPREP), 2024 (#2301WAPREP), and 2025 (#2501WAPREP).

Dear Washington State Department of Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Washington State provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Washington's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Washington's PREP curricula and program materials:[1]

Rights, Respect, Responsibility (2024), Teacher's Guide (K – 12)

- Page 20: **"Teaching about Gender Identity in School Is Age-Appropriate**

[1] ACF initiated a medical accuracy review to determine if Washington's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Washington will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Everyone has a gender identity. Most people's sense of their gender (known as their gender identity) matches their sex assigned at birth. For some, however, their sense of their gender does not match their sex assigned at birth. Most typically, children between the ages of 18 months and 2 to 3 yeas begin to articulate some understanding of their gender identity, and children have a clear sense of their gender identity by age 4 or 5. At these ages, children also begin to develop speech and may begin to communicate how they understand gender. Often, transgender children will state with confidence at young ages, 'I am a boy' or 'Do not call me 'a girl.'

The lessons in *Rights, Respect, Responsibilities* are specifically written to challenge the gender binary and to be inclusive, respectful, and supportive of all gender expressions. There are many great resources offering additional ways for teachers to support transgender and non-binary students. They include:

- Advocates for Youth *Trans-Affirming Schools Project Resource Guide*
- Gay, Lesbian and Straight Education Network (GLSEN)
- *The Teaching Transgender Toolkit* available for purchase at www.teachingtransgender.com."

Puberty: The Wonder Years (Grades 4-6)

- Lessons and Student Learning Objectives (Slides)
  "Lesson 4-3 Respecting our Friends: Gender
  Students will be able to:
  - Define at least three of five terms used to describe gender identity and gender expression during a matching game
  - Demonstrate the respectful use of at least two gender-related terms while discussing student scenarios that illustrate gender diversity with peers and include respectful body language, words, and tone of voice."

UnHushed

- "Kindergarten—Session 02: Gender Jamboree [no page number]:

  PURPOSE
  This session leads participants through an exploration of gender as it relates to their own identity and the world around them.

  OBJECTIVES
  As a result of this session, participants will be able to:
  - Identify their own gender identity.
  - Name at least three gender identities.

  KEY MESSAGES

- Some people are boys, some people are girls, some people are both, and some
- people are neither.
- People can have a gender, but objects or activities cannot (e.g., colors, sports, toys).
- The 'right' way to show the world your gender is the way that feels best to you."

Positive Prevention Plus (2021), High School Curriculum and Teacher's Guide

- Page 39: "Understanding the Terms:

  Human sexuality is a combination of three distinct components.

  - **Biological Sex:** A term used to denote whether an individual is male or female, as determined by a physician or other medical professional at time of birth. This designation is often made solely based upon an examination of an infant's genitals, but may also involve chromosomes and gonads (ovaries or testicles.) Related term: *intersex*.

  - **Gender:** Attitudes, feelings, characteristics and behaviors that a given culture associates with being male or female and that are often labeled as "masculine" or "feminine." Related terms include gender role, gender non-conforming, gender identity, cisgender, transgender, gender expression, gender binary, gender expansive.

  - **Sexual Orientation:** A person's romantic or sexual attraction to people of another and/or same gender. Common terms used to describe sexual orientation include, but are not limited to: heterosexual, lesbian, gay, bisexual, pansexual, queer.

  Biological sex, gender, and sexual orientation vary with each individual. It is important to respect differences and appreciate diversity."

FLASH (2022), Elementary Curriculum

- Lesson 4, Page 2: "Gender & gender roles, recognizing the differences and similarities between males and females, boys and girls, men and women, is an integral part of understanding who we are as individuals and where we fit in our world. Gender consists of an individual's gender identity (whether they think of themselves as male or female, a man or a woman, a guy or a girl) and their gender expression (whether the ways they dress, walk, talk, and otherwise demonstrate more comfort with traditionally or stereotypically masculine or feminine ways of

moving through the world . . . or neither or some of each). Students will consider the advantages of being male or female, exploring some of the cultural role expectations that accompany gender issues in our society."

FLASH (2024), High School Curriculum

- Toolkit, page 13:
  - "Everyone has a sexual orientation and a gender identity.
  - A person knows their sexual orientation because of who they feel attracted to.
  - A person knows their gender identity because they feel like a boy, a girl, both, neither or somewhere in between.
  - People of all sexual orientations and gender identities need to know how to prevent pregnancy and STOs, either for themselves or to help a friend."

- Toolkit, pages 14-15: "LGBT Inclusivity
  - "Teaching about sexual orientation and gender identity creates better understanding and respect among all students and creates a climate where discrimination is unwelcome. It also provides a necessary protection for lesbian, gay, bisexual, trans, and queer (LGBTQ) students. The FLASH curriculum has been shown through rigorous evaluation to significantly reduce homophobia and transphobia among high school students (Kesler et al., 2023). It is important for educators to routinely teach inclusively, as every classroom will likely have students who identify (or will later identify) as LGBTQ, as well as students with family and friends who identify as LGBTQ."

- Lesson 4, pages 5-6, "Sexual orientation and gender identity

  - When a baby is born, the doctor usually says the baby is male or female, depending on the appearance of the baby's genitals. This is the baby's assigned sex.
  - The assigned sex of babies with a vagina, clitoris, and XX chromosomes is usually female.
  - The assigned sex of babies with a penis, scrotum, and XY chromosomes is usually male.
  - Some babies are born with variations in their genitals, reproductive organs, or chromosomes. This is called intersex. The doctor will usually assign a sex of male or female, although people may identify differently as they get older.
  - Gender identity is a deep feeling people have about whether they are a guy, a girl, both, neither, or somewhere in between.
  - People often know their gender identity when they are very little, before they start kindergarten, although everyone is different and some people will know when they are younger or older.

- Cisgender is when a person's gender identity is the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'Yes, I am a girl.'
- Transgender is when a person's gender identity is not the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'No, I'm not a girl.' People may also identify as nonbinary, genderqueer, or some other gender identity."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Washington's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Washington State to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Washington is directed to remove these and all similar language throughout their curricula and program materials. Should Washington fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Tara Buckner
West Virginia Department of Health and Human Resources
Bureau for Public Health
State Capitol Complex, Building 3, Room 206
Charleston, WV 25301

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301WVPREP), 2024 (#2401WVPREP), and 2025 (#2501WVPREP).

Dear Ms. Buckner:

On April 14, 2025, the Administration for Children and Families (ACF) requested that West Virginia provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing West Virginia s PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from West Virginia's PREP curricula and program materials:[1]

Making Proud Choices! 5th Edition, Facilitator Curriculum

- Module 1, Activity B, Facilitator's Note, page 36: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender

[1] ACF initiated a medical accuracy review to determine if West Virginia's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, West Virginia will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Module 1, Activity C, Procedure, pages 39-40: "**Respect Diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity.

  Define terms related to diversity as needed.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Reducing the Risk, 5th edition, Facilitator Curriculum

- Class 1A, Outline of Activities, page 14: "Be sure your reading of the roleplay allows for inclusivity and does not reinforce one view of gender identity or gender stereotypes. You can do this by introducing Lee and Lee as a couple without specifying their genders, by not differentiating the two Lees' lines using stereotypical male and female voices, and by leaving it open as to which Lee is pressuring and which does not want to have sex."

- Class 4, Note to the Teacher, page 71: "Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:
  - Explain the situation in a matter-of-fact way. Let students know that every student in the class will, at some point, be doing a roleplay with a classmate of a different gender and with a classmate of the same gender. Most likely, they will do this several times."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. West Virginia's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs West Virginia to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] West Virginia is directed to remove these and all similar language throughout their curricula and program materials. Should West Virginia fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Nakia Martin-Wright at Nakia.Martin-wright@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Kara Benjamin
Wisconsin Department of Health
1 West Wilson Street, Room 250
Madison, WI 53707

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301WIPREP), 2024 (#2401WIPREP), and 2025 (#2501WIPREP).

Dear Ms. Benjamin:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Wisconsin provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Wisconsin's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Wisconsin's PREP curricula and program materials:[1]

High School FLASH, Third Edition, Educator Manual

- Page 4: Lesson 4, "Sexual Orientation and Gender Identity
  1. Let's start with **assigned sex**.

[1] ACF initiated a medical accuracy review to determine if Wisconsin's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Wisconsin will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

- When a baby is born, the doctor usually says the baby is male or female, depending on the appearance of the baby's genitals. This is the baby's assigned sex.
- The assigned sex of babies with a vagina, clitoris, and XX chromosomes is usually female.
- The assigned sex of babies with a penis, scrotum, and XY chromosomes is usually male.
- Some babies are born with variations in their genitals, reproductive organs, or chromosomes. This is called intersex. The doctor will usually assign a sex of male or female, although people may identify differently as they get older.

If someone asked you to summarize assigned sex, what would you say? Who is it assigned by? Right, it's when the doctor says, 'It's a boy' or 'It's a girl,' depending on the baby's genitals. Good job. Any questions.

2. Let's move on to gender identity. While assigned sex is based on the body parts the doctor sees at birth, gender identity has nothing to do with body parts.

- Gender identity is a deep feeling people have about whether they are a guy, a girl, both, neither, or somewhere in between.
- People often know their gender identity when they are very little, before they start kindergarten, although everyone is different and some people will know when they are younger or older.
- Cisgender is when a person's gender identity is the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'Yes, I am a girl.'
- Transgender is when a person's gender identity is not the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'No, I'm not a girl.' People may also identify as nonbinary, genderqueer, or some other gender identity.

So how is gender identity different than assigned sex? Correct, gender identity is based on a deep feeling that a person has about themselves."

Making Proud Choices! 5th edition, Teacher's Manual

- Module 1, Activity B, Procedure, Facilitator Note, page 36: "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus "outing" themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends

the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Module 1, Activity C, Procedure, page 39-40: "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity."

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity.

  Define terms related to diversity as needed.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Positive Prevention Plus (2021), Teacher's Manual

- Lesson 2, Gender and Sexual Orientation, page 35:

  "CONTENT
  - Introduction
  - Gender and Sexual Orientation
  - LGBTQ+ Bias and Its Effects
  - Lesson Wrap-Up (Worksheet)

  OBJECTIVE
  - Define and discuss gender-related terms.

- Identify the importance of acknowledging and accepting diverse gender presentations and sexual orientations."

- Lesson 2, Gender and Sexual Orientation, Part B, page 39, "**Understanding the Terms**

  Human sexuality is a combination of three distinct components.

  - **Biological Sex:** A term used to denote whether an individual is male or female, as determined by a physician or other medical professional at the time of birth. This designation is often made solely based upon the examination of an infant's genitals, but may also involve chromosomes and gonads (ovaries or testicles). Related term: *intersex*.

  - **Gender:** Attitudes, feelings, characteristics and behaviors that a given culture associates with being male or female and that are often labeled as 'masculine' or 'feminine.' Related terms include: *gender role, gender non-conformity, gender identity, cisgender, transgender, gender expression, gender binary, gender expansive*.

  - **Sexual Orientation:** A person's romantic or sexual attraction to people of other and/or the same gender. Common terms used to describe sexual orientation include, but are not limited to: *heterosexual, lesbian, gay, bisexual, pansexual, and queer*.

  Biological sex, gender, and sexual orientation vary with each individual. It is important to respect differences and appreciate diversity."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Wisconsin's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Wisconsin to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Wisconsin is directed to remove these and all similar language throughout their curricula and program materials. Should Wisconsin fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

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[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt, arlisa.britt@acf.hhs.gov.

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Ms. Stefan Johansson
Wyoming Department of Health
Maternal and Child Health Unit
122 West 25th Street, 3rd Floor West
Cheyenne, WY 82002

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301WYPREP), 2024 (#2401WYPREP), and 2025 (#2501WYPREP).

Dear Ms. Johansson:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Wyoming provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Wyoming's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Wyoming's PREP curricula and program materials:[1]

[1] ACF initiated a medical accuracy review to determine if Wyoming's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Wyoming will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Making Proud Choices, 5th Edition, Facilitator Manual

- Page 36 (Module 1, Activity B Procedure, Facilitator's Note): "Asking participants to tell you their pronouns is a way of creating a safe space for transgender or gender nonconforming youth. Reinforce that sharing pronouns is optional; some youth may not feel comfortable sharing their pronouns and thus 'outing' themselves. Model what you want participants to say by giving your own pronouns. Some transgender youth might have typical pronouns (he/she/his/her/their) or they might request more creative pronouns such as hir or zir. Pronouns don't always line up with what observers might expect based on a person's perceived biological sex. The simple act of requesting pronouns sends the message that transgender and gender nonconforming youth are welcome and respected in the group."

- Pages 39-40 (Module 1, Activity C Procedure): "**Respect diversity:** Let's keep in mind that there's diversity in society and in the group. Individuals come from different family backgrounds, different racial and cultural groups and different living situations. Some young people have already had romantic relationships; others aren't even thinking about it. Some have had sexual intercourse. Some have had sex because they choose to; other's may have had sex against their will. Some may identify as gay, lesbian, bisexual or straight. Some may identify as male, female or transgender.

  Young people may express themselves in ways that don't conform with their biological sex. There are many ways that youth can express their gender identity. . . .

  Define terms related to diversity as needed.

  I want to be sure everyone under understands some of the terms we use when talking about diversity.

  Gender refers to the ideas in a culture or society about the appropriate ways for men and women to dress, behave, think and feel. Ideas about what gender behavior is appropriate change in different cultures and at different times in history. Sometimes one gender is given more power or status than another.

  Gender identity is peoples' inner understanding of what gender they identify with. It may be man, woman, something in between, or something that doesn't fit these labels. It may be the same as (cisgender) or different from (transgender) the sex they were assigned at birth. Gender identity is unique for each person.

  Gender expression is how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics."

Power Through Choices, 5th Edition, Facilitator Manual

- Preface, page iv: "Gender Inclusivity: *Power Through Choices* was designed to assist youth in developing the decision-making skills and self-efficacy to prevent pregnancy, HIV, and STIs, regardless of their gender, sexual identity, or sexual orientation. To be inclusive of the diversity found in the systems of care community, the curriculum includes gender-inclusive language, such as the pronouns 'they/them/theirs' rather than 'she/her/hers' or 'he/him/his,' characters with same-gender sexual experience, and language that does not reflect gender bodies and body parts."

Reducing the Risk, Revised 5th Ed., Facilitator Manual

- Page 14, Class 1A, Outline of Activities, Note to Teacher: "Be sure your reading of the roleplay allows for inclusivity and does not reinforce one view of gender identity or gender stereotypes. You can do this by introducing Lee and Lee as a couple without specifying their genders, by not differentiating the two Lees' lines using stereotypical male and female voices, and by leaving it open as to which Lee is pressuring and which does not want to have sex."

- Page 71, Class 4, Activities, "Roleplay in Small Groups, Note to Teacher: Over the course of the roleplay activities, students will be in a position where they must roleplay sexual pressure situations with classmates of both a different and the same gender. This may be awkward for teens who are sensitive to the suggestion of same-sex romance, for teens who identify as gay or lesbian, or for teens who are transgender or gender nonconforming. It's important to address this situation directly and proactively.

  Here are some tips:

  > Explain the situation in a matter-of-fact way. Let students know that every student in the class will, at some point, be doing a roleplay with a classmate of a different gender and with a classmate of the same gender. Most likely, they will do this several times."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

The statute includes no mention of gender ideology, which is both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects

described in section 713(b)(2)(C).[2] The statute neither requires, supports nor authorizes teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa; thus, gender ideology is outside the scope of the authorizing statute and any expenditures associated with gender ideology are not allowable, reasonable, or allocable to the PREP grant. See 45 C.F.R. §§ 75.403-405.

We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress.

Wyoming's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Wyoming to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Wyoming is directed to remove these and all similar language throughout their curricula and program materials. Should Wyoming' fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60)

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[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Arlisa Britt, arlisa.britt@acf.hhs.gov.

days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

Exhibit 21

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, DC 20201 | www.acf.hhs.gov

Tuesday, August 26, 2025

Mary Clark
Washington State Department of Health
111 Isreal Road
Olympia, WA 98504

RE: State Personal Responsibility Education Program grants for Fiscal Years 2023 (#2301WAPREP), 2024 (#2301WAPREP), and 2025 (#2501WAPREP).

Dear Washington State Department of Health:

On April 14, 2025, the Administration for Children and Families (ACF) requested that Washington State provide current curricula and programmatic materials in use or in any way relevant to your state Personal Responsibility Education Program (PREP) grant for a medical accuracy review in accordance with the Terms and Conditions of the grant. We appreciate your timely response to ACF's request.

While preparing Washington's PREP content for the medical accuracy review, ACF identified content in the curricula and other program materials that fall outside of the scope of PREP's authorizing statute at 42 U.S.C. § 713. Specifically, the following subjects and language are outside the scope of the authorizing statute and all references to it must be removed from Washington's PREP curricula and program materials:[1]

Rights, Respect, Responsibility (2024), Teacher's Guide (K – 12)

- Page 20: **"Teaching about Gender Identity in School Is Age-Appropriate**

[1] ACF initiated a medical accuracy review to determine if Washington's approach to biological sex in its PREP curricula is medically accurate and in compliance with the program statute and the terms and conditions of the award. In preparing the materials that we received, we saw that the curricula include gender ideology which is not authorized by the statute. As per this letter, Washington will need to remove this content from its PREP curricula and program materials. In light of this, we are changing our planned course of action and are no longer conducting a review for medical accuracy because the content that we were going to review for medical accuracy is outside of the subjects that are statutorily authorized in this program.

Everyone has a gender identity. Most people's sense of their gender (known as their gender identity) matches their sex assigned at birth. For some, however, their sense of their gender does not match their sex assigned at birth. Most typically, children between the ages of 18 months and 2 to 3 yeas begin to articulate some understanding of their gender identity, and children have a clear sense of their gender identity by age 4 or 5. At these ages, children also begin to develop speech and may begin to communicate how they understand gender. Often, transgender children will state with confidence at young ages, 'I am a boy' or 'Do not call me 'a girl.'

The lessons in *Rights, Respect, Responsibilities* are specifically written to challenge the gender binary and to be inclusive, respectful, and supportive of all gender expressions. There are many great resources offering additional ways for teachers to support transgender and non-binary students. They include:

- Advocates for Youth *Trans-Affirming Schools Project Resource Guide*
- Gay, Lesbian and Straight Education Network (GLSEN)
- *The Teaching Transgender Toolkit* available for purchase at www.teachingtransgender.com."

Puberty: The Wonder Years (Grades 4-6)

- Lessons and Student Learning Objectives (Slides)
  "Lesson 4-3 Respecting our Friends: Gender
  Students will be able to:
  - Define at least three of five terms used to describe gender identity and gender expression during a matching game
  - Demonstrate the respectful use of at least two gender-related terms while discussing student scenarios that illustrate gender diversity with peers and include respectful body language, words, and tone of voice."

UnHushed

- "Kindergarten—Session 02: Gender Jamboree [no page number]:

  PURPOSE
  This session leads participants through an exploration of gender as it relates to their own identity and the world around them.

  OBJECTIVES
  As a result of this session, participants will be able to:
  - Identify their own gender identity.
  - Name at least three gender identities.

  KEY MESSAGES

- Some people are boys, some people are girls, some people are both, and some
- people are neither.
- People can have a gender, but objects or activities cannot (e.g., colors, sports, toys).
- The 'right' way to show the world your gender is the way that feels best to you."

Positive Prevention Plus (2021), High School Curriculum and Teacher's Guide

- Page 39: "Understanding the Terms:

  Human sexuality is a combination of three distinct components.

  - **Biological Sex:** A term used to denote whether an individual is male or female, as determined by a physician or other medical professional at time of birth. This designation is often made solely based upon an examination of an infant's genitals, but may also involve chromosomes and gonads (ovaries or testicles.) Related term: *intersex*.

  - **Gender:** Attitudes, feelings, characteristics and behaviors that a given culture associates with being male or female and that are often labeled as "masculine" or "feminine." Related terms include gender role, gender non-conforming, gender identity, cisgender, transgender, gender expression, gender binary, gender expansive.

  - **Sexual Orientation:** A person's romantic or sexual attraction to people of another and/or same gender. Common terms used to describe sexual orientation include, but are not limited to: heterosexual, lesbian, gay, bisexual, pansexual, queer.

  Biological sex, gender, and sexual orientation vary with each individual. It is important to respect differences and appreciate diversity."

FLASH (2022), Elementary Curriculum

- Lesson 4, Page 2: "Gender & gender roles, recognizing the differences and similarities between males and females, boys and girls, men and women, is an integral part of understanding who we are as individuals and where we fit in our world. Gender consists of an individual's gender identity (whether they think of themselves as male or female, a man or a woman, a guy or a girl) and their gender expression (whether the ways they dress, walk, talk, and otherwise demonstrate more comfort with traditionally or stereotypically masculine or feminine ways of

moving through the world . . . or neither or some of each). Students will consider the advantages of being male or female, exploring some of the cultural role expectations that accompany gender issues in our society."

FLASH (2024), High School Curriculum

- Toolkit, page 13:
  - "Everyone has a sexual orientation and a gender identity.
  - A person knows their sexual orientation because of who they feel attracted to.
  - A person knows their gender identity because they feel like a boy, a girl, both, neither or somewhere in between.
  - People of all sexual orientations and gender identities need to know how to prevent pregnancy and STOs, either for themselves or to help a friend."

- Toolkit, pages 14-15: "LGBT Inclusivity
  - "Teaching about sexual orientation and gender identity creates better understanding and respect among all students and creates a climate where discrimination is unwelcome. It also provides a necessary protection for lesbian, gay, bisexual, trans, and queer (LGBTQ) students. The FLASH curriculum has been shown through rigorous evaluation to significantly reduce homophobia and transphobia among high school students (Kesler et al., 2023). It is important for educators to routinely teach inclusively, as every classroom will likely have students who identify (or will later identify) as LGBTQ, as well as students with family and friends who identify as LGBTQ."

- Lesson 4, pages 5-6, "Sexual orientation and gender identity

  - When a baby is born, the doctor usually says the baby is male or female, depending on the appearance of the baby's genitals. This is the baby's assigned sex.
  - The assigned sex of babies with a vagina, clitoris, and XX chromosomes is usually female.
  - The assigned sex of babies with a penis, scrotum, and XY chromosomes is usually male.
  - Some babies are born with variations in their genitals, reproductive organs, or chromosomes. This is called intersex. The doctor will usually assign a sex of male or female, although people may identify differently as they get older.
  - Gender identity is a deep feeling people have about whether they are a guy, a girl, both, neither, or somewhere in between.
  - People often know their gender identity when they are very little, before they start kindergarten, although everyone is different and some people will know when they are younger or older.

- Cisgender is when a person's gender identity is the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'Yes, I am a girl.'
- Transgender is when a person's gender identity is not the same as their assigned sex. For example, a doctor says, 'It's a girl!' at a baby's birth, and that child later feels 'No, I'm not a girl.' People may also identify as nonbinary, genderqueer, or some other gender identity."

The "purpose" of a PREP grant award is for states to "carry out personal responsibility education programs consistent with this subsection." 42 U.S.C. § 713(b)(1). The statute defines PREP as "a program that is designed to educate adolescents on -- (i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and (ii) at least 3 of the adulthood preparation subjects described in subparagraph (C)." 42 U.S.C. § 713(b)(2).

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We are aware that these curricula and other program materials were previously approved by ACF. However, the prior administration erred in allowing PREP grants to be used to teach students gender ideology because that approval exceeded the agency's authority to administer the program consistent with the authorizing legislation as enacted by Congress. Washington's current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified. See 45 C.F.R. § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award), §§ 75.403-405 (requiring grant expenditures to be reasonable and allocable in order to be allowable). ACF may impose additional conditions on grantees that fail to comply with any Federal statutes, regulations or terms and conditions that apply to their awards. See 45 C.F.R. § 75.371.

Therefore, ACF instructs Washington State to remove all content concerning gender ideology from its curricula, program materials and any other aspects of its

[2] 42 U.S.C. § 713(b)(2)(C) lists the following adult preparation subjects: "(i) Healthy relationships, including marriage and family interactions; (ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects; (iii) Financial literacy; (iv) Parent-child communication; (v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity; (vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management."

program delivery within 60 days of receipt of this letter and provide a copy of the modified materials to ACF for approval.

The content flagged on the pages of this letter provides examples of gender ideology content that does not adhere to the PREP statute;[3] Washington is directed to remove these and all similar language throughout their curricula and program materials. Should Washington fail to make the appropriate modifications to its PREP curricula and program materials, ACF may take additional enforcement action. See 45 C.F.R. § 75.371 (allowing HHS to withhold, disallow, suspend, or terminate Federal awards if imposing additional conditions on a grantee does not cure noncompliance).

Thank you for your attention to this matter. Please submit the modified curricula and materials by uploading to the Dropbox links previously provided to you within sixty (60) days, and no later than **Monday, October 27, 2025,** at 11:59 pm. You may email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew K. Gradison

Andrew Gradison
Acting Assistant Secretary
Administration for Children and Families

[3] We are not setting forth all of the problematic language in this letter but are providing a general description and examples so that you understand what needs to be removed from the curricula and program materials. If you have any questions about whether language needs to be removed, please contact the Federal Project Officer, Chéri Thompson at Cheri.Thompson@acf.hhs.gov.

Exhibit 22

An official website of the United States government

FOR IMMEDIATE RELEASE
August 26, 2025

Contact: HHS Press Office

202-690-6343
Submit a Request for Comment

Trump Administration Puts 46 States and Territories on Notice to Remove Gender Ideology Content from Sex Ed Materials

WASHINGTON – The U.S. Department of Health and Human Services (HHS) through its Administration for Children and Families (ACF) demanded that 46 states and territories remove all references to gender ideology in their federally-funded Personal

Responsibility Education Program (PREP) educational materials within 60 days. This action reflects the Trump Administration's ongoing commitment to protecting children from attempts to indoctrinate them with delusional ideology.

Last week, ACF terminated <https://acf.gov/media/press/2025/hhs-defunds-californias-attempt-indoctrinate-children-gender-ideology> California's PREP grant after the state failed to meet its demand to remove gender ideology from its educational materials. States and territories receiving these new letters are now on notice: failure to comply will result in similar enforcement actions including the withholding, suspension, or termination of federal PREP funding.

"Accountability is coming," said Acting Assistant Secretary Andrew Gradison. "Federal funds will not be used to poison the minds of the next generation or advance dangerous ideological agendas. The Trump Administration will ensure that PREP reflects the intent of Congress, not the priorities of the left."

The 46 recipients of these letters include the following states and territories:

States (40 total):
Alabama, Alaska, Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming.

Territories and D.C. (6 total):
Guam, Northern Mariana Islands, Palau, Puerto Rico, Virgin Islands, Washington D.C.

Letters to all 46 states and territories can be found here [PDF] <https://acf.gov/sites/default/files/documents/main/08.26.25-combined-prep-letters.pdf>.

Details on how much funding each state and territory could forfeit can be found here [PDF, 57 KB] .

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APRIL 29, 2025 | PRESS RELEASE

Content created by ASPA Press Office
Content last reviewed August 26, 2025

State/Territory	Remaining Funds
Alabama	**$2,078,740**
Alaska	**$540,470**
Arizona	**$3,019,500**
Colorado	**$1,107,964**
Connecticut	**$1,569,515**
Delaware	**$333,353**
District of Columbia	**$409,458**
Georgia	**$4,507,495**
Guam	**$546,902**
Hawaii	**$594,220**
Illinois	**$4,271,028**
Iowa	**$1,207,279**
Kentucky	**$1,454,075**
Louisiana	**$1,532,173**
Maine	**$584,111**
Maryland	**$2,418,689**
Massachusetts	**$2,363,785**
Michigan	**$3,398,430**
Minnesota	**$2,126,294**
Mississippi	**$1,290,734**
Missouri	**$2,274,827**
Montana	**$539,601**
Nebraska	**$764,118**
Nevada	**$1,051,476**
New Jersey	**$3,060,196**
New Mexico	**$675,585**
New York	**$6,028,068**
North Carolina	**$3,968,710**
Northern Mariana Islands	**$333,200**
Ohio	**$4,281,249**
Oklahoma	**$1,313,182**
Oregon	**$1,610,927**
Palau	**$603,364**
Pennsylvania	**$4,633,568**
Puerto Rico	**$1,069,741**
Rhode Island	**$594,224**
South Carolina	**$1,581,239**
South Dakota	**$606,410**
Tennessee	**$2,276,451**
U.S. Virgin Islands	**$662,591**
Utah	**$1,600,051**
Vermont	**$670,036**
Washington	**$2,633,804**
West Virginia	**$514,527**
Wisconsin	**$1,961,091**
Wyoming	**$674,114**
TOTAL	**$81,336,561**

Last Updated: 8/22/25

Exhibit 23

PREP SNAPSHOT

Personal Responsibility Education Program (PREP) Evaluation

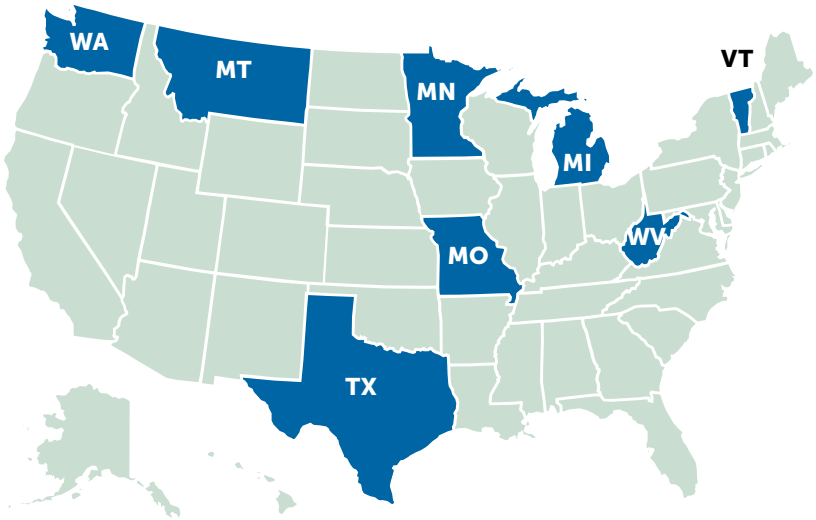
OPRE Report #2018-44
April 2018

Inputs and Outcomes: PREP Programs Serving Runaway and Homeless Youth

PREP grantees and their program providers are encouraged to serve highly vulnerable populations, including youth in foster care, youth in adjudication systems, homeless or runaway youth, pregnant or parenting youth, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, youth in residential treatment for mental health issues, and youth who have trouble speaking or understanding English.

Thirteen programs across eight states primarily served runaway or homeless youth. These programs reached over **1,000 youth** annually.[a]

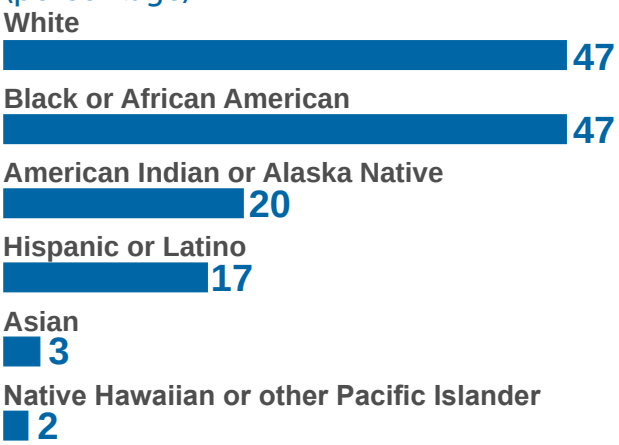
[a] Programs that "primarily served" a highly vulnerable population are those that reported that at least half of the youth they served were from a specific highly vulnerable population. Program data do not identify whether each individual participant is or is not from a highly vulnerable population.



51 percent of participants in these programs were served through community based organizations. Programs serving primarily runaway and homeless youth also operated in other settings, such as juvenile detention centers and schools.

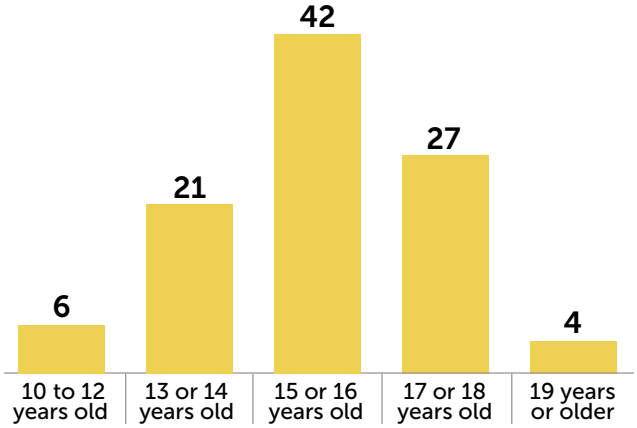
Demographic characteristics of participants in programs primarily serving runaway or homeless youth

Racial and ethnic composition of youth (percentage)



Note: Percentages sum to more than 100 percent because youth could select more than one race or ethnicity.

Age distribution of youth (percentage)



Programs serving primarily runaway and homeless youth include many youth who have engaged in risky sexual behavior

68 percent[1] of youth have been sexually active

Of these youth, **26 percent[2]** had ever been **pregnant** or gotten someone pregnant

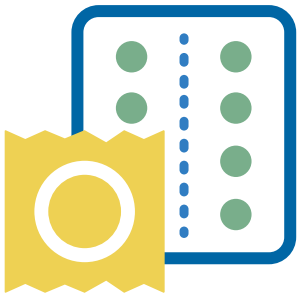
[1] compared to 41 percent of high school-age youth nationally and 42 percent of high school-age participants in all PREP programs

[2] compared to 18 percent of high school-age participants in all PREP programs

Of youth who had sex in the past 3 months, **45 percent[3]** did not reliably use any **birth control** and **49 percent[4]** did not reliably use **condoms** before participating in PREP

[3] compared to 39 percent of high school-age participants in all PREP programs

[4] compared to 28 percent of high school-age participants in all PREP programs



Participants in programs primarily serving runaway and homeless youth reported positive outcomes as a result of their participation in PREP programs

Sexual behavior intentions for the next six months (percentage)

- Less likely to have sexual intercourse: 37
- More likely to use birth control *(among those indicating they might have sex)*: 69
- More likely to use a condom *(among those indicating they might have sex)*: 72

Perceptions of program quality (percentage)

- Felt respected as people during the program: 86
- Material presented was clear: 83
- Discussions or activities helped them learn program lessons: 82
- Had a chance to ask questions: 81
- Programming was interesting: 72

Source: 2014–2015 PREP participant entry and exit survey and attendance, reach, and dosage data reported by SPREP, TPREP, and CPREP grantees.

Contract Number: HHSP23320110011YC

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Exhibit 24

PREP

PERFORMANCE INDICATORS

Personal Responsibility Education Program (PREP) Evaluation

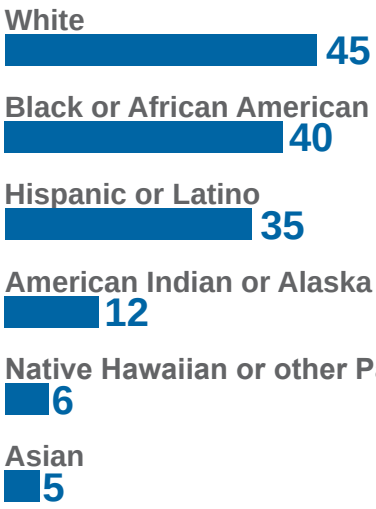
OPRE Report #2018-22
April 2018

Youth Participants' Characteristics and Outcomes

Findings based on Performance Measures reported by State, Tribal, and Competitive PREP grantees

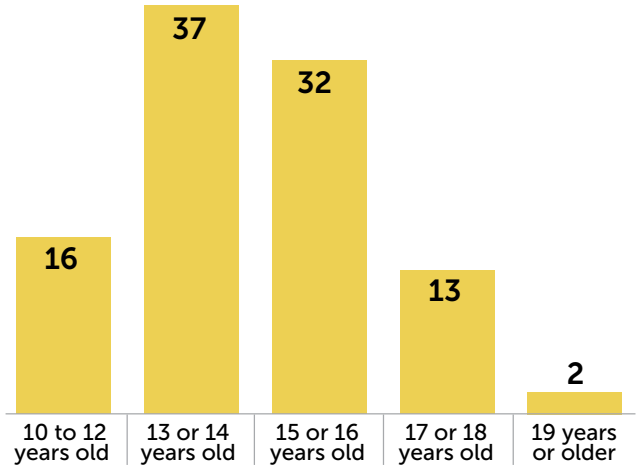
PREP programs serve a diverse population

Racial and ethnic composition of youth (percentage)



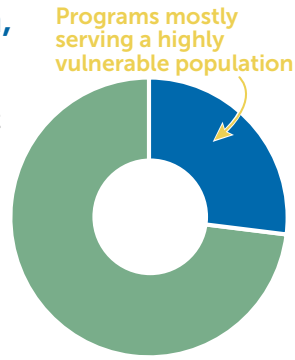
Note: Percentages sum to more than 100 percent because youth could select more than one race or ethnicity.

Age distribution of youth (percentage)

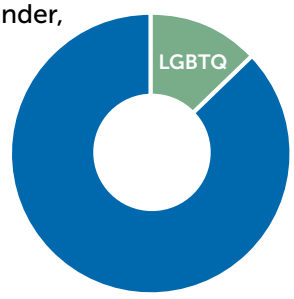


Grade reflects a similar distribution, with most participants between 7th and 10th grades.

27 percent of PREP programs served mostly highly vulnerable youth, including those in foster care; homeless or runaways; living with HIV/AIDS; pregnant or parenting; identified as LGBTQ; involved in adjudication systems; in residential treatment for mental health issues; or had trouble speaking or understanding English.

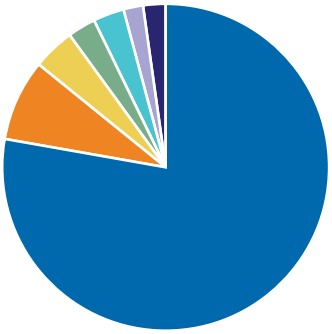


At program entry, 13 percent of youth identified as lesbian, gay, bisexual, transgender, or something other than straight.



Source: Entry surveys completed by PREP participants.

PREP programs operate primarily through schools.



Community-based organizations: **8%**
Juvenile detention centers: **4%**
Schools, after school: **3%**
Foster care settings: **3%**
Clinics: **2%**
Other settings: **2%**

Schools, during school hours: **78%**

For out-of-school-time programs *(in which participation is generally not mandatory),* **74 percent of youth completed at least 75 percent of the intended program dosage**

Youth report positive outcomes as a result of their participation in PREP programs.

72 percent **of youth reported that participation in PREP made them more prepared for adulthood.[a]**

This percentage is computed as the average across 10 items that align with the three most frequently implemented adulthood preparation subjects. For each item, we first calculated the percentage of respondents who answered that the program had made them "much more likely" or "somewhat more likely" to exhibit the positive behavior. The percentage of youth who perceived that the PREP program made them feel more prepared for adulthood is the average across the 10 individual percentages.

[a]This percentage has been revised since the February 2017 Fact Sheet.

Sexual behavior intentions for the next six months (percentage of youth)

More likely to use a condom *(among those indicating they might have sex)*	77
More likely to use birth control *(among those indicating they might have sex)*	69
Less likely to have sexual intercourse	62

Perceptions of program quality (percentage of youth)

Felt respected as people during the program	87
Material presented was clear	85
Discussions or activities helped them learn program lessons	84
Had a chance to ask questions	75
Programming was interesting	71

This is the second brief in a series. The first PREP FACT SHEET contains background information on PREP. For more information on PREP performance measures and emerging findings about the PREP programs, see http://www.prepeval.com/.

Source: 2014–2015 PREP participant entry and exit survey and attendance, reach, and dosage data reported by SPREP, TPREP, and CPREP grantees.

Contract Number: HHSP23320110011YC

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