IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

EXPERT DECLARATION OF DR. KATE MILLINGTON

EXPERT DECLARATION OF DR. KATE MILLINGTON

I, Kate Millington, M.D., pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a resident of Rhode Island. I am over the age of 18, of sound mind and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. The opinions expressed herein are my own and do not express the views or opinions of my employer.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. I am a Pediatric Endocrinologist at Hasbro Children's Brown University Health and an Assistant Professor of Pediatrics, Clinician Educator at Brown University.

5. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the states of Rhode Island and Massachusetts.

6. I received my medical degree from the University of Pennsylvania's Perelman School of Medicine in 2014. After completing a Residency in Pediatrics at Harvard University's Boston Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. I completed my Fellowship in 2020.

7. I have extensive experience in working with and treating children and adolescents with endocrine conditions including differences in sex development (DSD), gender dysphoria, type

1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating patients with gender dysphoria since 2018.

8. A major focus of my clinical, teaching, and research work pertains to the assessment and treatment of transgender adolescents.

9. I have published extensively on the topic of pediatric transgender health focusing specifically on the physiologic and metabolic outcomes of gender affirming care for transgender youth. I also regularly review the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a focus on the medical care of transgender adolescents.

10. I am involved in the education and training of medical students, residents and fellows. I am the co-director of the Endocrine Sciences course at the Warren Alpert Medical School of Brown University. In this course I also give lectures titled "Puberty" and "Transgender Health". I serve as a mentor to medical students who are specifically interested in LGBTQ health through the LGBTQ+ Healthcare and Advocacy Scholarly Concentration at the Warren Alpert Medical School of Brown University.

11. As a Fellow at Harvard, I was mentored by the clinicians in the Gender Management Services Clinic (GeMS) at Boston Children's Hospital. While working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on the medical care of transgender children and adolescents.

12. I began working as a Pediatric Endocrinologist in the Gender and Sexuality Clinic in the Division of Adolescent Medicine at Hasbro Children's at Brown University Health in 2022. The Gender Clinic provides comprehensive assessment, and when appropriate, treatment with

pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 300 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. I also actively conduct research related to the outcomes of medical gender affirming care for transgender youth.

13. I also provide care for patients with Differences of Sex Development (DSD). I have been involved in the care of patients with DSD both as an initial consulting endocrinologist when infants with atypical genitalia first present either in the well baby nursery or neonatal intensive care unit as well as throughout childhood in the outpatient clinic. I have assessed and treated over 150 patients with DSD. I have given lectures to medical students, residents, and fellows about the care of children with DSD.

14. I have authored numerous peer-reviewed articles related to treatment of transgender youth. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth as well as on my research.

15. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A.**

B. Prior Testimony

16. In the past year, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Soe v. Louisiana State Board of Medical Examiners,* Case No. 2024-172, Civil District Court for the Parish of Orleans (Jan. 8, 2024).

C. Compensation

17. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of $400 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

18. This report sets forth my opinions in this case and the bases for my opinions.

19. In preparing this report, I reviewed the Executive Order 14168, titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government," issued on January 20, 2025. I also reviewed the August 6, 2025 Notice of Award (PREP NOA) from the United States Department of Health and Human Services (HHS) Administration for Children and Families (ACF) regarding state Personal Responsibility Education Program (PREP) grants, the August 7, 2025 PREP Supplemental Terms and Conditions (PREP Supplemental T&Cs), and the August 26, 2025 directive letter from ACF to grantees (the PREP Directive) (collectively, the PREP Gender Conditions). I also reviewed the August 6, 2025 NOA (SRAE NOA) from HHS's ACF regarding state Sexual Risk Avoidance Education (SRAE) grants and the August 7, 2025 SRAE Supplemental Terms and Conditions (SRAE Supplemental T&Cs) (collectively, the SRAE Gender Conditions). I also reviewed 42 U.S.C. § 713, PREP's enabling statute, and 42 U.S.C. § 710, SRAE's enabling statute.

20. I also reviewed the materials listed in the bibliography attached as Exhibit B to this report, as well as the materials listed within my curriculum vitae, which is attached as Exhibit A. The sources cited therein include authoritative, scientific peer-reviewed publications. They include

the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

21. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the pertinent fields.

22. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects.

23. My opinions are based on my extensive background and experience treating transgender patients.

24. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

II. EXPERT OPINIONS

A. Introduction to Sex, Gender Identity, and Gender Dysphoria

25. *Sex* refers to a composite of several biological attributes including genetics, internal reproductive organs, external genitalia, and gonadal identity. It is not binary. Although most people have a binary male or female sex, there are individuals who have conditions (e.g., Differences in Sex Development (DSD) /Intersex/Variations of Sex Characteristics) that result in an atypical combination of the factors that make up one's sex. (Hiort et al., 2014) For example, someone with complete androgen insensitivity syndrome, a type of DSD, may have female external genitalia but 46,XY chromosomes, which is typically associated with the male sex. In most cases, infants have typically appearing genitalia and a medical provider assigns a sex at birth based on the impression of the infant's external genitalia.

26. In contrast, *gender identity* refers to one's internal sense of self. (Safer & Tangpricha, 2019) Everyone has a gender identity. Most people have a gender identity that conforms with the sex they were assigned at birth. However, some individuals have a gender identity that does not conform with their sex designated at birth. The umbrella term *transgender* is used to describe those individuals with a gender identity that is different than the sex designated at birth. (Safer & Tangpricha, 2019) Gender identity can include binary male or female identities, but also includes non-binary, gender queer, agender, and many other identities. Individuals with a gender identity that is the same as their sex assigned at birth are referred to as *cisgender*. The only way to know someone's gender identity is to ask them, as *gender expression*—the way a person communicates their gender through clothing, hair style, speech—does not always conform to gender identity.

27. *Gender dysphoria* is a mental health diagnosis that refers to a sustained and significant difference between one's experienced gender and the sex assigned to them at birth. The criteria for this diagnosis are laid out in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). (American Psychiatric Association, 2022) To meet these criteria, patients must have experienced an incongruence between their gender identity and designated sex leading to impairment in their functioning at school, work, home, with friends, or other important areas for at least 6 months. In my experience, all of my patients have experienced gender dysphoria for much more than 6 months before they seek medical gender affirming care.

B. The PREP and SRAE Gender Conditions Are Medically Inaccurate and Inconsistent With Scientific Knowledge

28. The language regarding "gender ideology" contained within the PREP and SRAE Gender Conditions in addition to Executive Order 14,168 signed by President Trump on January 20, 2025, are not consistent with what is known about the biological diversity amongst humans, the development of the reproductive tract, and the widely accepted scientific and medical definitions of sex and gender.

29. First, the PREP and SRAE Gender Conditions suggest that "gender ideology" which is defined in part as "teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa" is not "medically accurate[,]" "age appropriate[,]" or part of "the cultural context that is most appropriate for individuals in the particular population group to which [the teaching is] directed" or provided in the cultural context that is most appropriate for individuals in the particular population group to which [the teaching is] directed.". As defined above, the fact that gender identity is distinct from biological sex is widely accepted by the medical and scientific community and supported by numerous professional medical organizations including the American Academy of Pediatrics, Endocrine Society, Pediatric Endocrine Society, and American College of Obstetricians and Gynecologists. (Cronin & Stockdale, 2021; Hembree et al., 2017; *PES Statement Supporting Access to Gender Care - Pediatric Endocrine Society*, n.d.; Rafferty et al., 2018) Gender identity is distinct from sex. Sex is defined through a combination of several factors. These factors include chromosomes, gonadal identity (e.g. testes, ovaries, or some combination of these), and external genitalia. Gender identity is an individual's inner sense of their identity. Neither sex nor gender is binary. For transgender youth, their gender identity is distinct from the sex they were designated at birth. For example, a transgender girl who was designated male at birth and identifies as female is a girl. She is not a boy who is identifying as a girl. Here 'boy' refers to her designated sex, but 'female' refers to her

gender identity. Sex and gender are distinct and conflating the two is not consistent with the medical understanding of sex and gender.

30. Teaching adolescents about gender identity is "age appropriate" and "based on adolescent learning and developmental theories for the age group receiving the education." The vast majority of transgender individuals recognized their gender incongruence in childhood or adolescence. (James et al., 2016; Olson et al., 2015) Transgender and gender diverse identities are more common in modern day adolescents than in prior generations. Recent data from the CDC's Behavior Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) found that in the United States 1.4% of youth age 13 to 17 years identify as transgender compared to 0.3% of people 65 and older. (Herman et al., 2022) Puberty, which is a key milestone of adolescent development, is also often a crystalizing experience for transgender adolescents. (Coleman et al., 2022) Puberty often heightens the experience of gender dysphoria and brings questions of gender identity to the surface of adolescent experience. Thus, education aimed at adolescents that includes discussions of gender identity is relevant and is age appropriate.

31. Teaching about sex and gender identity is "culturally appropriate" and part of "the cultural context that is most appropriate for individuals in the particular population group to which [the teaching is] directed." Everyone has a gender identity, and most cultures recognize the existence of different genders. Many cultures, both modern day and historical, recognize the existence of individuals with non-binary and/or diverse genders. (Carswell et al., 2022) Thus, teaching about gender identity is appropriate for most individuals in most population groups.

32. The PREP NOA, SRAE NOA, PREP Supplemental T&Cs, and SRAE Supplemental T&Cs also define "gender ideology" as "teaching students…that there is a vast spectrum of genders that are disconnected from one's sex.". Gender is not binary and multiple

other gender identities exist including non-binary, gender queer, and other identities. (Coleman et al., 2022; Hembree et al., 2017; J. Y. Lee et al., 2024; Safer & Tangpricha, 2019). Stating that gender is binary and that other non-binary gender identities do not exist is not consistent with the medical and scientific understanding of gender identity.

33. Second, gender identity is an intrinsic part of identity and cannot be altered. Several studies have suggested a biological basis for gender identity. Patients with DSDs such as congenital adrenal hyperplasia who have increased exposure to androgens (male type hormones) before birth have a higher rate of male gender identification despite XX chromosomes and female sex assignment. (Dessens et al., 2005). Studies of brain structures have found that transgender people have brain structure more similar to their gender identity than to their designated sex. (Mueller et al., 2021; Saraswat et al., 2015). Identical twins, who share the same genetic material, are more likely to both identify as transgender compared to fraternal twins, who are genetically similar to typical siblings. This pattern points to a possible genetic component in the development of gender identity. (Saraswat et al., 2015). Gender, like sex, is not binary. It exists along a spectrum from male to female. This is borne out by multiple studies and large population surveys. (Coleman et al., 2022; Hembree et al., 2017; James et al., 2016; J. Y. Lee et al., 2024; Safer & Tangpricha, 2019).

34. Third, the PREP and SRAE Gender Conditions suggest that sex is binary and that only binary male and female people exist. This is neither true nor medically accurate. Following conception, a complex interplay of genetic, hormonal, and cellular processes leads to sex differentiation. At any point along this process variations can occur. These variations can lead to Differences in Sex Development (DSDs). DSDs are a collection of congenital conditions where the genetic, gonadal, hormonal, or anatomic sex is discordant. The prevalence of DSD varies by

condition and ranges from 1 in 500 to 2 in 100,000 live births.(Berglund et al., 2025) Some people with DSD come to medical attention shortly after birth if they have genitalia that look atypical, not completely female or male appearing. In this situation sex is not assigned right away. This is a time of uncertainty and can be very distressing for families. A multi-disciplinary team including pediatric endocrinologists performs laboratory and imaging tests to help to provide a diagnosis and guidance around the sex of the infant. The sex assignment is then made based on the best available evidence, degree of androgen (male hormone) exposure prenatally, fertility potential, and psychosocial factors. (P. A. Lee et al., 2006) It is not easy and requires expertise and care. Patients with DSD do not fit cleanly into a male or female binary definition. Activism from the patient community has led to a shared decision making approach to sex assignment that allows space for uncertainty, prioritizes patient input prior to irreversible interventions, and honors intersex identity that is not binary male or female. (Houk & Lee, 2012; Witchel et al., 2022).

35. People with DSD do not fit into the definitions of male and female implied in the PREP and SRAE Gender Conditions, or laid out in the Executive Order. They may have no reproductive glands (e.g., testes or ovaries), may have these glands but they may not function well or at all, or they may have a gland that has parts of both testes and ovaries. They may be unable to produce reproductive cells (sperm or eggs) at all. They may have external genital appearance that looks like one sex, but have the chromosomal and hormonal make up of the other sex. For example, individuals with Complete Androgen Insensitivity Syndrome (CAIS), a DSD, are unable to sense testosterone. People with CAIS have XY chromosomes, elevated testosterone levels, and testicles – all consistent with a male sex – but female appearing genital appearance and usually a female gender identity. These individuals would not fit into the binary male/female definitions.

36. Androgen insensitivity can also occur in a partial form, partial androgen insensitivity syndrome (PAIS), where testosterone can be partially sensed. Individuals with PAIS have XY chromosomes, elevated testosterone levels, and testicles—all consistent with a male sex—but atypical appearing genital appearance. Patients with PAIS can have either a male or female gender identity.(Cohen-Kettenis, 2010) These individuals would not fit into the binary male/female definitions.

37. There are many other examples of DSD conditions where sex assignment does not fit cleanly into these binary definitions. Gender identity in patients with DSD is variable and it is difficult to predict based on the chromosomal, hormonal, gonadal, or genital identity. (Cohen-Kettenis, 2010; Fisher et al., 2016; Houk & Lee, 2012).

38. Fourth, the PREP Directive states that "gender ideology" (defined in part as "teaching students that gender identity is distinct from biological sex or that boys can identify as girls and vice versa") is "both irrelevant to teaching abstinence and contraception and unrelated to any of the adult preparation subjects described in section 713(b)(2)(C)." Those adult preparation subjects include "[h]ealthy relationships[,]" "[a]dolescent 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" and "[p]arent-child communication."

39. Education about gender identity is integral to teaching about sexual health including abstinence and contraception. Including gender identity in comprehensive sexuality education is supported and recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.(Breuner & Mattson, 2016; Committee on Adolescent Health, 2016) Without understanding gender identity, adolescents cannot be expected to make educated choices regarding their sexual choices especially as it pertains to their risk of pregnancy. For

example, if a cisgender male who is sexually and romantically interested in other men were to become sexually active with a transgender man (e.g., an individual designated female at birth with a male gender identity) pregnancy could result. If sexual education does not include a discussion of gender identity, adolescents cannot adequately understand their risk for pregnancy.

40. Furthermore, as the above example illustrates, it is impossible to have comprehensive sexuality education that includes the broad scope of sexual identities and romantic desires without a conversation about gender identity. You cannot discuss human sexuality accurately without discussing the diversity of sexual identities including homosexual and heterosexual experiences, which requires the inclusion of a discussion about gender identities.

41. Learning about sex and gender identity, including, for example, the existence of transgender and gender diverse individuals and individuals with DSD, is medically accurate, age appropriate, and healthy for adolescents. Topics of sex and gender identity are relevant to learning about adolescent development. Adolescence is a time of great physiologic and neurodevelopmental change and development of gender identity can be a part of that. Many adolescents begin to understand their gender identity during this time. (Herman et al., 2022; James et al., 2016; Olson et al., 2015) Sex and gender identity is relevant to education regarding adolescent development.

42. An understanding of gender identity is relevant to learning about healthy relationships and parent-child communication. All people have a gender identity and these identities can color relationships, including parent-child relationships. To best understand relationship dynamics, it is important to consider how different identities, including gender identities, interact within them.

43. Fifth, transgender and gender diverse individuals, as well as individuals with DSD, statistically are part of the audience reached by the PREP and SRAE grants. Systematically removing any mention of the diversity of sex and gender identities from the education provided by these grants does not appropriately educate these individuals about their own experience. If the educational programs funded by the PREP or SRAE grants incorrectly insist that sex and gender are binary, they cannot adequately educate transgender and gender diverse adolescents or adolescents with DSD in accordance with the PREP and SRAE enabling statutes.

44. Gender minority youth are at increased risk for high risk sexual behaviors and negative sexual health outcomes compared to their cisgender peers including decreased condom use, earlier initiation into sex, more sexual partners, using drugs or alcohol prior to sex, higher burdens of sexually transmitted infections, and increased risk of pregnancy in adolescence. Transgender adolescents also report higher rates of substance use, victimization including being forced to have sexual intercourse and dating violence. (Andrzejewski et al., 2020; Johns et al., 2019; Ybarra et al., 2025)

45. A program that did not mention gender identity or did not teach that there is a diversity of human experience with regard to gender identity, or insisted that sex and gender are not binary, would not be medically accurate or complete.

46. Finally, to the extent the PREP and SRAE Gender Conditions rely on the definitions put forward in Executive Order 14168, that definition of sex is not consistent with human biology. The Executive Order states "'Female' means a person belonging, at conception, to the sex that produces the large reproductive cell. 'Male' means a person belonging, at conception, to the sex that produces the small reproductive cell." This statement is unmoored from biological reality.

47. At conception, an egg (presumably what the EO refers to as the large reproductive cell) and sperm (presumably what the EO refers to as the small reproductive cell) combine to form a zygote. The zygote contains genetic material, DNA, from the egg and from the sperm. The genetic material is grouped into chromosomes of which there are 23 pairs, 46 chromosomes total. Two of these chromosomes are termed the sex chromosomes. Typically the egg will contribute an X sex chromosome, the sperm will contribute either an X or a Y, and the zygote will have either XX sex chromosomes (typical female chromosomal sex) or XY sex chromosomes (typical male chromosomal sex). However, this is not always the case. There are variations in sex chromosomal makeup where the zygote may have only one X chromosome (Turner Syndrome) or two XX chromosomes and one Y chromosome (Klinefelter Syndrome). Many other combinations of sex chromosomes exist including XYY and XXX. Although uncommon, these conditions are not rare. Turner Syndrome occurs in approximately 1 in 2500 people and Klinefelter Syndrome in approximately 1 in 500.(Nielsen & Wohlert, 1991)

48. At this stage, a zygote can have chromosomal sex, but that chromosomal sex is not necessarily binary male (XY) or female (XX). It does not have gonadal sex, anatomic sex, or gender identity. It does not have the ability to produce its own reproductive cells, large or small. To label a zygote male or female is premature. A zygote at conception has not yet gone through sex differentiation and therefore cannot be easily labeled male and female. Thus, the definitions of 'male' and 'female' laid out in the Executive Order are not consistent with biological reality.

49. In summary, PREP and SRAE Gender Conditions and Executive Order 14168 are not consistent with biological reality or the diversity of human experience. They inaccurately represent human physiology and well-established scientific facts regarding the complex concepts

of sex and gender. They are not consistent with medical consensus regarding the definitions of sex, gender identity, and what constitutes a complete sexuality education program.

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

Executed on September 25th, 2025, at Providence, RI.

s/ Kate Millington
KATE MILLINGTON
Pediatric Endocrinologist
Hasbro Children's Brown University Health;
Assistant Professor of Pediatrics, Clinician Educator
Brown University

Exhibit A

September 2025

CURRICULUM VITAE
Kate Millington

Division of Pediatric Endocrinology and Diabetes
Hasbro Children's Brown University Health
111 Plain St Providence RI 02903
Phone: 401-444-5504

EDUCATION

2007	BA (Liberal Arts)	Bard College at Simon's Rock
2008	BS (Biomedical Engineering)	Fu Foundation School of Engineering Columbia University
2014	MD	Perelman School of Medicine University of Pennsylvania

POSTGRADUATE TRAINING

2014 - 2017	Residency, Pediatrics	Boston Combined Residency Program Boston Children's Hospital Boston Medical Center
2017 – 2020	Fellowship, Pediatric Endocrinology	Boston Children's Hospital

POSTGRADUATE HONORS AND AWARDS

2011	Medical Student Research Program	NIDDK
2014	Medical Student Award	Endocrine Society
2017	Medical Student Teaching Award	Harvard Medical School
2017	Farley Fellows Award	Boston Children's Hospital
2017	Travel Award	Pediatric Endocrine Society
2018	BCH Alumni Travel Award	Boston Children's Hospital
2018	Fellow Teaching Award	Boston Combined Residency Program
2018 - 2022	Faculty Teaching Honor Roll	Boston Combined Residency Program
2020	Best Novel Insight Paper	Pediatric Endocrine Society
2025	Dean's Excellence in Teaching	Warren Alpert Medical School
2025	Positive Champions of the Learning Environment	Warren Alpert Medical School

PROFESSIONAL LICENSES AND BOARD CERTIFICATION

2017	Massachusetts Medical License
2017	Certification in General Pediatrics, American Board of Pediatrics
2020	Certification in Pediatric Endocrinology, American Board of Pediatrics
2022	Rhode Island Medical License (MD18450)

ACADEMIC APPOINTMENTS

2022 - Present	Assistant Professor of Pediatrics, Warren Alpert Medical School
2020 - 2022	Instructor in Pediatrics, Harvard Medical School
2020 - 2022	Instructor in Pediatrics, Boston University School of Medicine

HOSPITAL APPOINTMENTS

2022 - Present	Attending Physician, Pediatric Endocrinology and Diabetes, Hasbro Children's Brown University Health
2020 - 2022	Attending Physician, Pediatric Endocrinology, Boston Children's Hospital
2020 - 2022	Attending Physician, Pediatric Endocrinology, Boston Medical Center

OTHER APPOINTMENTS

2020 – 2023	Scientific Symposium Abstract Review Committee United States Professional Association for Transgender Health
2023 – Present	Member, Newborn Screening Advisory Committee
2023 – Present	Rhode Island T1D Screening Committee
2024	Judge, 18th Warren Alpert Medical School Academic Symposium
2024 – Present	Abstract Reviewer, Pediatric Endocrine Society
2023 – Present	Faculty Mentor, LGBTQ+ Healthcare and Advocacy Scholarly Concentration, Warren Alpert Medical School
2024 – Present	Reviewer, Alpert Medical School Summer Research Assistantships
2025 – Present	Reviewer, UpToDate
2025	Mentor, PedsENDO Discovery Program, Pediatric Endocrine Society
2025	U.S. Coalition for Early T1D Action, Ariadne, T.H. Chan School of Public Health, Harvard University and Brigham and Women's Hospital

Journal Reviewer

Journal of Adolescent Health	2020
European Journal of Pediatrics	2023
Transgender Health	2023, 2024, 2025
BMC Medical Education	2024
BMC Endocrine Disorders	2025
BMJ Open	2025
Nature Medicine	2025

HOSPITAL COMMITTEES

2018 – 2022	Hypoglycemia Committee, Boston Children's Hospital
2019 – 2020	IPASS Implementation Committee, Boston Children's Hospital

2020 – 2022 GENESIS Scientific Review Committee, Boston Children's Hospital

MEMBERSHIP IN SOCIETIES

2014 – 2022 Massachusetts Medical Society
2014 – Present American Academy of Pediatrics
2015 – Present Endocrine Society
2017 – Present Pediatric Endocrine Society
2019 – 2022 United States Professional Association for Transgender Health
2019 – 2022 World Professional Association for Transgender Health
2020 – 2022 Society for Pediatric Research

PUBLICATIONS LIST

ORIGINAL PUBLICATIONS IN PEER-REVIEWED JOURNALS

1. **Millington K**, Miller V, Rubenstein RC, Kelly A. Patient and parent perceptions of the diagnosis and management of cystic fibrosis-related diabetes. Journal of clinical & translational endocrinology. 2014 Jul 11; 1(3): 100-107.

2. **Millington K**, Charrow A, Smith J. Case Series: Minocycline-Associated Thyroiditis. Hormone research in paediatrics. 2019 Jan 1; 92(4): 276-283.

3. Ahmed F, Zeve D, **Millington K**, Rea C. 11-year old boy with facial hair, acne and deepened voice. BMJ case reports. 2019 Mar 20; 12(3).

4. **Millington K**, Liu E, Chan Y. The Utility of Potassium Monitoring in Gender-Diverse Adolescents Taking Spironolactone. Journal of the Endocrine Society. 2019 Apr 4; 3(5): 1031-1038.

5. Tremblay E, **Millington K**, Monuteaux M, Bachur R, Wolfsdorf J. Plasma β-Hydroxybutyrate for the Diagnosis of Diabetic Ketoacidosis in the Emergency Department. Pediatric emergency care. 2020 Feb 1.

6. **Millington K**, Schulmeister C, Finlayson C, Grabert R, Olson-Kennedy J, Garofalo R, Rosenthal SM, Chan Y. Physiological and Metabolic Characteristics of a Cohort of Transgender and Gender-Diverse Youth in the United States. The Journal of adolescent health: official publication of the Society for Adolescent Medicine. 2020 May 13.

7. **Millington K**, Hayes K, Pilcher S, Roberts S, Vargas SO, French A, Veneris J, O'Neill AF. A serous borderline ovarian tumour in a transgender male adolescent. British journal of cancer. 2021 Feb 1; 124(3): 567-569.

8. Maru J, **Millington K**, Carswell J. Greater Than Expected Prevalence of Type 1 Diabetes Mellitus Found in an Urban Gender Program. Transgender health. 2021 Feb 15; 6(1): 57-60.

9. **Millington K**, Finlayson C, Olson-Kennedy J, Garofalo R, Rosenthal SM, Chan Y. Association of High-Density Lipoprotein Cholesterol With Sex Steroid Treatment in Transgender and Gender-Diverse Youth. JAMA pediatrics. 2021 May 1; 175(5): 520-521.

10. Schulmeister C, **Millington K**, Kaufman M, Finlayson C, Kennedy JO, Garofalo R, Chan Y, Rosenthal SM. Growth in Transgender/Gender-Diverse Youth in the First Year of Treatment With Gonadotropin-Releasing Hormone Agonists. The Journal of adolescent health: official publication of the Society for Adolescent Medicine. 2021 Jul 24.

11. **Millington K**, Chan Y. Lipoprotein subtypes after testosterone therapy in transmasculine adolescents. Journal of clinical lipidology. 2021 Nov 1; 15(6): 840-844.

12. Aamodt K, Fitzgerald S, Hanono A, Majzoub J, **Millington K**, Richmond T, Peeler K. Severe Hypernatremia in an Adolescent With Anorexia Nervosa. Clinical pediatrics. 2021 Dec 1; 60(14): 586-590.

13. Pollock NI, Flamand Y, Zhu J, **Millington K**, Stevenson K, Silverman L, Vrooman L, Cohen L. Hyperglycemia during induction therapy for acute lymphoblastic leukemia is temporally linked to pegaspargase administration. Pediatric blood & cancer. 2021 Dec 21: e29505.

14. Andzelm MM, Balasubramaniam S, Yang E, Compton AG, **Millington K**, Zhu J, Anselm I, Rodan LH, Thorburn DR, Christodoulou J, Srivastava S. Expansion of the clinical and neuroimaging spectrum associated with NDUFS8-related disorder. JIMD Rep. 2022 Aug 23;63(5):391-399.

15. **Millington K**, Barrera E, Daga A, Mann N, Olson-Kennedy J, Garofalo R, Rosenthal SM, Chan YM. The effect of gender-affirming hormone treatment on serum creatinine in transgender and gender-diverse youth: implications for estimating GFR. Pediatr Nephrol. 2022 Sep;37(9):2141-2150.

16. Tremblay ES, **Millington K**, Wu Y, Wypij D, Yang Y, Agus MSD, Wolfsdorf J. Utility of plasma beta-hydroxybutyrate to define resolution of diabetic ketoacidosis. Pediatr Diabetes. 2022 Dec;23(8):1621-1627.

17. Kempf AM, Burns ZT, Guss CE, **Millington K**, Pilcher S, Boyle PJ, Charlton BM, Haas-Kogan DA, Liu KX. Clinical outcomes and considerations of gender-affirming care for transgender and gender-diverse pediatric and young adult patients with cancer. Pediatr Blood Cancer. 2023 Jan;70(1):e29851.

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20. Hodson N, **Millington K**, Hyland P, Williams CR, Garofalo R, Rosenthal SM, Olson-Kennedy J, Chan Y-M. Physical activity among youth receiving gender-affirming treatment in the United States. Transgender Health 2024. doi: 10.1089/Trgh.2022.0155.

21. **Millington K**, Lee JY, Olson-Kennedy J, Garofalo R, Rosenthal SM, Chan YM. Laboratory Changes During Gender-Affirming Hormone Therapy in Transgender Adolescents. Pediatrics. 2024 May 1;153(5):e2023064380. doi: 10.1542/peds.2023-064380.

22. Logel SN, Maru J, Whitehead J, Brady C, Walch A, Lasarev M, Rehm JL, **Millington K**. Higher Rates of Certain Autoimmune Diseases in Transgender and Gender Diverse Youth. Transgend Health. 2024 Jun 17;9(3):197-204. doi: 10.1089/trgh.2022.0079. PMID: 39109261; PMCID: PMC11299103.

23. Seetharaman S, Sasidharan Pillai S, Ganta A, **Millington K**, Quintos JB, Topor LS, Serrano-Gonazalez M. Iodine Deficiency Hypothyroidism Among Children in the United States – 21st Century Resurgance? AACE Clin Case Rep. 2024 Aug 14:10(6):236-239

24. Schneider, D., Scully, K., Quintos, J. B., & **Millington, K.** (2025). Severe Hyperandrogenism Secondary to Polycystic Ovarian Syndrome in a Gender-diverse Adolescent. JCEM Case Reports, 3(10).

OTHER PEER-REVIEWED PUBLICATIONS

1. Kremen J, Williams C, Barrera EP, Harris R, McGregor K, **Millington K**, Guss C, Pilcher S, Tishelman AC, Baskaran C, Carswell J, Roberts S. Addressing Legislation That Restricts Access to Care for Transgender Youth. Pediatrics. 2021 May 1; 147(5).

2. Barrera E, **Millington K**, Kremen J. The Medical Implications of Banning Transgender Youth From Sport Participation. JAMA Pediatrics. 2022 Mar 1; 176(3): 223-224.

3. Krebs D, Harris RM, Steinbaum A, Pilcher S, Guss C, Kremen J, Roberts SA, Baskaran C, Carswell J, **Millington K**. Care for Transgender Young People. Horm Res Paediatr. 2022;95(5):405-414.

BOOKS AND BOOK CHAPTERS

Millington K, Williams C. Transgender Health. Endocrine Conditions in Pediatrics: Springer.

PUBLICATIONS SUBMITTED OR IN PREPARATION

1. Li M, Feldman N, Tanzer Joshua R, Tremblay E, **Millington K.** Impact of Demographic Features on Glycemic Control Management with Tubeless Automated Insulin Delivery Systems in Youth with Type 1 Diabetes Mellitus. Diabetes Spectrum. *In press*

2. Schneider D, Scully K, Quintos JB, **Millington K** Severe Hyperandrogenism Secondary to Polycystic Ovarian Syndrome in a Gender Diverse Adolescent. JCEM Case Reports. *In press*

ABSTRACTS

1. Seetharaman S, Sasidharan Pillai S, Ganta A, **Millington K**, Quintos, JB, Topor LS, Serrano-Gonzalez, M, Iodine Deficiency Hypothyroidism Among Children in the United States - 21st Century Resurgence? Pediatric Endocrine Society Meeting, San Diego, CA May 2023.

2. Li M, Feldman, N, Tanzer JR, **Millington K**. Impact of Demographic Features on Glycemic Control with Tubeless Automated Insulin Delivery System in Youth with Type 1 Diabetes Mellitus. 17th Warren Alpert Medical School Academic Symposium, Providence, RI, November 2023.

3. Li M, Feldman, N, Tanzer JR, **Millington K**. Impact of Demographic Features on Glycemic Control with Tubeless Automated Insulin Delivery System in Youth with Type 1 Diabetes Mellitus. Pediatric Endocrine Society Meeting, Chicago, IL, May 2024.

4. Schneider, D, Feldman, N, **Millington K**. Impact of GnRH Analogs on QTc Interval in Gender Diverse Youth. 18th Warren Alpert Medical School Academic Symposium, Providence, RI, November 2024.

5. Michles M, Sun F, Clark M, O'Toole D, Swartz S, **Millington K**, Svokos K, Doberstein C, Klinge P, Woo A, Kwan D, Gokaslan Z, Zadnik Sullivan P. Gender Affirming Care: Considerations for and Recommendations from Neurosurgery. Oral Presentation at the Student Neurology and Neurosurgery Research Conference, The Warren Alpert Medical School of Brown University, Providence, RI. January 2025

6. Michles M, Sun F, Clark M, O'Toole D, Swartz S, **Millington K**, Svokos K, Doberstein C, Klinge P, Woo A, Kwan D, Gokaslan Z, Zadnik Sullivan P. Gender Affirming Care: Considerations for and Recommendations from Neurosurgery. Oral Presentation at the Virtual Women in Neurosurgery Collaborative DEI Symposium. April 2025

7. The Effects of Sex Steroids on Electrocardiogram Measurements in Transgender and Gender Diverse Youth. Shetty N, Shah K, Rafael S, Rotondo K, Rafferty J, Chapman H, **Millington K**. Poster presentation Hasbro Children's Hospital Annual Celebration of Scholarship, Providence, RI, April 8, 2025.

8. Schneider D, Scully K, Quintos JB, **Millington K** Severe Hyperandrogenism Secondary to Polycystic Ovarian Syndrome in a Gender Diverse Adolescent. Pediatric Endocrine Society Meeting, Washington DC, May 2025.

SCHOLARLY WORK PUBLISHED IN OTHER MEDIA

Millington,K. Interview by Barbara Morse. Interview on Screening for Type 1 Diabetes Mellitus. WJAR10. TV. Aired 2/27/2025

INVITED PRESENTATIONS

LOCAL

2017	An 18-year-old female with fever and pulmonary lesions Department of Pediatrics Grand Rounds, Boston Children's Hospital
2018	Transgender Health: Past, Present, and Future Division of Endocrinology Grand Rounds, Brigham and Women's Hospital
2019	Gender Affirming Care of Children and Adolescents Center for Infertility and Reproductive Surgery, Brigham and Women's Hospital
2019	The Hyperinsulinemia and Hyperammonemia Syndrome Longwood Area Nutrition Seminar
2019	Endocrine Board Review Department of Pediatrics, Boston Children's Hospital
2020	Diabetes 101 Division of Emergency Medicine, Boston Children's Hospital
2020	Gender Affirming Care of Children and Adolescents Leadership in Adolescent Health Fellowship, Boston Children's Hospital
2022, 2023	Normal and Abnormal Puberty General Pediatrics Residency, Hasbro Children's Brown University Health
2023-25	Normal and Abnormal Puberty REI Fellowship Didactics, Women and Infant's Hospital
2023	Gender Affirming Care of Children REI Fellowship Didactics, Women and Infant's Hospital
2023	Interesting Endocrinology in Transgender Health, Endocrine Grand Rounds Division of Endocrinology, Rhode Island Hospital
2024	Beyond the Binary, Interesting Cases in the Care of Transgender Youth Department of Pediatrics, Hasbro Children's Brown University Health
2024	Pediatric Gender Affirming Care Spectrum, LGBTQ Medical Student Group Warren Alpert Medical School of Brown University
2024	The Care of LGBTQ Patients Doctoring I, Warren Alpert Medical School of Brown University
2025	Differences of Sex Development Neonatology Fellowship Didactics, Women and Infant's Hospital
2025	Morbidity and Mortality Conference, Endocrinology Department of Pediatrics, Hasbro Children's Brown University Health

REGIONAL

2020, 2021	Introduction to Pediatric Transgender Health, Exeter Health System, Exeter NH
2021, 2022	Making Clinical Research Gender Inclusive, Association of Research Nurses
2022	Transgender Health and Diabetes, Joslin Diabetes Center, Boston MA
2023	Update on Diabetes for Primary Care Physicians, East Greenwich Pediatrics

East Greenwich, Rhode Island

2024 Procedures in the Care of Transgender and Gender Diverse Youth
Rhode Island Trans Health Conference, Providence, RI

2025 Physical Health for LGBTQ+ Youth, Rhode Island Care Transformation Collaborative

NATIONAL

2024 Pediatric Transgender Health, Pediatric Grand Rounds
Georgetown Department of Pediatrics, Washington D.C.

2025 Laboratory Changes During Gender Affirming Care
Pediatric Endocrine Society Meeting, Washington D.C.

2025 Pediatric Transgender Health
Division of Pediatric Diabetes and Endocrinology
Children's Hospital at Montefiore Einstein, Bronx NY

GRANTS

2011 NIDDK Medical Student Research Program in Diabetes

2013 – 2014 Medical Student Research Grant, Cystic Fibrosis Foundation

2019 – 2022 "Effects of Sex Steroids on Cardiovascular Risk Factors in Transgender Adolescents"
Doris Duke Charitable Foundation (2019-119)
Principal Investigator, $200,000

2019 – 2021 "Effects of Sex Steroids on Cardiovascular Risk Factors in Transgender Adolescents"
National Institutes of Health Loan Repayment Program
Principal Investigator, $60,000

2020 – 2021 "Medical Gender Transition as a Novel Approach to Study the Effects of Sex Steroids on Cardiovascular Health"
Institutional Centers of Clinical and Translational Research
Principal Investigator, $10,000

2021 – 2022 "Defining the Role of Sex Steroids in Cardiovascular Disease Risk"
Boston Children's Hospital Office of Faculty Development (90158)
Principal Investigator, $75,000

2024 – 2025 "The Effect of Gender-Affirming Treatment on Electrocardiogram Measurements in Transgender and Gender Diverse Youth."
Children's Miracle Network
Department of Pediatrics, Hasbro Children's Hospital

Co-Investigator, $25,000

2024 – Present Type 1 Diabetes Trial Net Pathway to Prevention
National Institutes of Health, Subaward from Yale University
Co-Investigator

UNIVERSITY TEACHING, ADVISING and MENTORING ROLES

UNIVERSITY LEADERSHIP

2023 – Present Course Co-Leader, Integrated Medical Sciences III, BIOL 3654 IMS-III: Endocrine Sciences
Warren Alpert Medical School of Brown University
This course is a required part of the curriculum for second year medical students. Over 3 weeks the course covers all aspects of endocrinology including physiology, pharmacology, pathology, and pathophysiology. In addition to being a co-leader of the course I also contribute through participating as a small group leader over 6 small group sessions and give 4 of the lectures in the course. I review the exam questions and update questions based on student response metrics. I have developed new curriculum for this course including a small group session on diabetes technology.

UNIVERSITY TEACHING, ADVISING and MENTORING ROLES

UNIVERSITY TEACHING

2020, 2022 Medical Student Pediatric Clerkship, Boston University
1 – 2 lectures for 3rd year medical students in their pediatric clerkship. (~15 students)

2020, 2021 Homeostasis II (PWY 131), Harvard Medical School
Co-facilitated one small group session on endocrine topics for 2nd year medical students (~80 – 100 students)

2020, 2021 Disease and Therapy Course, Boston University
1 lecture for entire 2nd year class

11/2022, 11/2023 Integrated Medical Sciences III, BIO: Human Reproduction
Warren Alpert School of Medicine at Brown University, Providence, RI
1 lecture for entire 2nd year class

11/2022 - Present Integrated Medical Sciences III, BIOL3654: Endocrine Sciences
Warren Alpert School of Medicine at Brown University, Providence, RI
4 - 5 lectures for entire 2nd year class; twice weekly small group sessions for three weeks (~15 students)

5/2023 – Present Longitudinal Integrated Clerkship Mentor.

	1 student per 8-month longitudinal clerkship during 3rd year of medical school
8/2023 – Present	Small Group Faculty, BIOL3640 - Doctoring I/ II Warren Alpert School of Medicine at Brown University, Providence, RI Co-lead weekly small group session for 1st year medical students (8 students). Teach physical exam, clinical skills, trauma informed care principles, and approach to difficult topics in medicine. Lead patient panel for entire 1st year class on transgender health.

Exhibit B

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Witchel, S. F., Mazur, T., Houk, C. P., & Lee, P. A. (2022). Historical Review The Long Path to Our Current Understanding Regarding Care of Children with Differences/ Disorders of Sexual Development. *Hormone Research in Paediatrics*, *95*(6), 608–618. https://doi.org/10.1159/000527042

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF MICHELE ROBERTS

DECLARATION OF MICHELE ROBERTS

I, MICHELE ROBERTS, pursuant to 28 U.S.C. § 1746 declare as follows:

1. I am a resident of Washington State. I am over the age of 18, competent to testify as to the matters herein, and base this declaration on my personal knowledge and the records of the Washington State Department of Health to which I have access.

2. I am the Assistant Secretary for the Division of Prevention and Community Health (PCH) within the Washington Department of Health (DOH). I have a Master's Degree in Public Health, and am a Master Certified Health Education Specialist. I have worked at DOH in my role as Assistant Secretary of the PCH for 5 years.

3. PCH collaborates with state agencies, community partners and tribal nations to prevent disease and promote a healthy start, healthy choices and access to services. Through our work, we hope to enhance the health of individuals, families and communities and eliminate health inequities in disproportionately impacted populations. The PCH division has four programmatic offices and an administrative office. About 400 PCH employees work to deliver public health services across Washington.

4. I am familiar with DOH's administration of Federal Personal Responsibility Education Program (PREP) grants and contracts for sexual health education training and technical assistance that are funded through those grants. The DOH Office of Family and Community Health Improvement (OFCHI), which administers the PREP Grant, is a PCH programmatic office under my leadership. I have personal knowledge of the matters set forth below, or with respect to the matters for which I do not have personal knowledge, I have reviewed information gathered from DOH's records by others within the organization.

5. I submit this declaration in connection with Plaintiff States' Motion for Preliminary Injunction and Complaint for Injunctive and Declaratory Relief pertaining to the August 6, 2025

Notice of Award (NOA) from the United States Department of Health and Human Services (HHS) Administration for Children and Families (ACF) regarding state PREP grants, the August 7, 2025 PREP Supplemental Terms and Conditions (Supplemental T&Cs), and the August 26, 2025 directive letter from ACF to grantees (the PREP Directive).

6. In Washington, DOH supports training and technical assistance for comprehensive, science and evidence-based educational programming that local school districts and community-based organizations can leverage to reduce pregnancy, HIV and other sexually transmitted infections (STIs), and birth rates for youth. The PREP program has supported training and technical assistance for 35 school districts since funding was first awarded. Currently, 10 school districts participate. Across the State, thousands of youth are served each year by the programs we implement with PREP funding. This work supports Congress' goals for the PREP program, as well as the requirement in Washington law (Wash. State Rev. § 28A.300.475) that public schools provide comprehensive sexual health education that is consistent with state learning standards. The latter requirement was passed by the Washington Legislature and state voters in 2020, and has been in effect since December 3, 2020.

7. In applying for its PREP grants, DOH has complied with PREP's application requirements, which includes assurances that programming is evidence-based, medically accurate, age appropriate, provided in the cultural context most appropriate for individuals in the particular population group to which the programming is directed, and targeted towards high-risk youth. The programming addresses both abstinence and use of contraception, as well as at least three of six "adulthood preparation subjects" as described in 42 U.S.C. § 713(b)(2)(C), which include healthy relationships, parent-child communication, and healthy life skills. In its grant applications, DOH also addresses how Washington uses positive youth development principles when offering trauma-

informed prevention programming. (Positive youth development is an intentional, pro-social 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 youths' strengths; and promotes positive outcomes for young people by providing multiple opportunities, fostering positive relationships, and furnishing the support needed to build their skills, sense of mastery, and leadership strengths.) DOH last submitted a full grant application to ACF, including assurances of Washington's compliance with these requirements, in 2016. That application is attached hereto as Exhibit 1.

8. DOH certifies its ongoing compliance with PREP program requirements, including general and supplemental T&Cs, by using grant awards. The NOA for the award that DOH will draw down on or after October 1, 2025 (for federal fiscal year 2024 (FFY24)), specifically requires DOH to provide PREP programming to LGBTQ+ youth. Under other T&Cs, the NOA for FFY24 states that by accepting the grant award, the grantee agrees to "Provide PREP programming to youth populations that…have…special circumstances including culturally underrepresented youth populations such as...youth who identify as lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ+)[.]" That NOA is attached hereto as Exhibit 2.

Federal Funding Relied on by Washington Department of Health

9. In 2010 and 2016, Washington submitted PREP grant applications in response to ACF's Funding Opportunity Announcements (FOA). Since that time, Washington submitted a letter of intent packet to re-authorize its PREP grants each year. ACF extends funding to grantees for three-year grant terms. Washington applies for a new grant each year, resulting in overlapping awards. Washington has received these funds since 2012.

10. ACF issued to DOH three currently active awards covering the period from October 1, 2022 through September 30, 2027. For the period from October 1, 2022 through September 30, 2025, ACF provided $1,067,046 in PREP funding to Washington. For the period from October 1, 2023 through September 30, 2026, ACF provided $1,138,194 in PREP funding to Washington. For the period from October 1, 2024 through September 30, 2027, ACF provided $1,133,232 in PREP funding to Washington. DOH is currently operating using fiscal year 2023 funds and has not yet drawn down 2024 or 2025 funds.

11. ACF disburses PREP funding as reimbursements requested by DOH. DOH expects to request its next grant disbursement on or around October 1, 2025. Reimbursable expenses are accrued throughout the year. DOH's main training partner, Cardea Services, provides services and then bills DOH for reimbursement via an invoice and a report that is a monthly deliverable.

12. Washington has well-established partnerships with the Office of the Superintendent of Public Instruction (OSPI), school districts, state foster care system and community based organizations to support holistic teen pregnancy and HIV/STI prevention, and comprehensive sexual health education. Since 2012, Washington has contracted with Cardea Services to design and implement training programs to provide educators at partner organizations with the tools and information necessary to teach sexual health and personal responsibility education to high-risk students.

Effect of Comprehensive Sexual Health and Personal Responsibility Education

13. Research shows that comprehensive sexual health education programs are among the most effective strategies in preventing teen pregnancies. In fact, scientific review shows greater support for comprehensive sexual education programs than abstinence-only programs. In addition to reducing teen pregnancy, HHS has recognized curriculum-based sexual health education

programs as effective in reducing the risk behaviors that lead to sexually transmitted infections (STIs).

14. Data made public by HHS in 2023 shows that PREP curricula resonate with young people. About 69% of participants expressed interest in the content. Roughly 88% felt respected by the program. More than 77% said that they were more likely to better understand what makes a relationship healthy.

15. The HHS data also shows changes in behaviors related to pregnancy risk—a primary goal of the PREP program. After taking part in PREP-funded curriculum in 2020–2021, more than half (56%) of participants said they were more likely to abstain from sex for the next six months. Among those who said they might have sex, 59% reported they were more likely to use birth control and 65% were more likely to use a condom than before participating.

16. As noted above, DOH, Cardea, and local partners have worked together to support sexual health and personal responsibility education in Washington communities since 2012. Data shows a strong correlation between the state's efforts and positive outcomes for youth, and for the state as a whole.

17. For example, data collected by DOH since 2015 shows positive outcomes in the declining rate of teen pregnancy and birth rates. In 2015, there were approximately 25 teen pregnancies in Washington State per 1,000 youths. As of 2022, that number has fallen to 17 per 1,000. In 2015, there were approximately 17 births to teen mothers per 1,000 youths in Washington. That number was cut nearly in half by 2024.

18. DOH data shows the rate of STIs (Chlamydia, Gonorrhea, and genital Herpes) in Washington youth declining by a half or more in the same time period. DOH also collects data on

rates of HIV cases. This data studies populations ages 13-24, among other groups, and reports for that age bracket, new HIV diagnoses in Washington State fell from 58 in 2019 to 34 in 2023.

Communications from Federal Government

19. On or about April 14, 2025, DOH received via email a letter from ACF's Family and Youth Services Bureau (FYSB)'s Division of Positive Youth Development indicating that ACF was performing a "medical accuracy review" and requesting submission of "any current curricula and programmatic materials" related to state PREP grants. FYSB stated that the "purpose for the medical accuracy review of program materials is to ensure the information being shared with program participants is medically accurate and complete." That letter is attached hereto as Exhibit 3.

20. DOH enlisted its contractor Cardea to respond to the FYSB request, as Cardea possessed or had access to materials responsive to the request. As requested, Cardea submitted PREP curricula and other materials through the ACF DropBox on or before April 22, 2025. This included curricula from four publishers, as well as supplemental materials and slides from a fifth publisher.

21. On August 6, 2025, ACF received a Notice of Award (NOA) describing the financial information associated with Washington's FFY25 PREP grant award, identified as 2501WAPREP. The NOA states, "[t]he use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions." In the Remarks section, the NOA states, "Recipients are prohibited from including gender ideology in any program or service that is funded with this award." The NOA's Terms and Conditions section states, in part, "[t]he 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." The NOA is attached as Exhibit 4.

22. On August 7, 2025, ACF published Supplemental T&Cs applicable to PREP awards and award modifications that add funding which are issued on or after August 7, 2025. The Supplemental T&Cs prohibit grant recipients from including so-called "gender ideology" in PREP-funded programs and services. Per ACF's notice, these Supplemental T&Cs are effective immediately.

23. Per the August 6, 2025 NOA and the Supplemental T&Cs, the "gender ideology" terms and conditions of the NOA and Supplemental T&Cs are not accepted until the grantee uses federal funds to which the terms and conditions apply. DOH has not used any funds awarded under the August 6, 2025, NOA and thus has not accepted the "gender ideology" term in the NOA or the Supplemental T&Cs.

24. On August 26, 2025, DOH received via email another letter from ACF (the PREP Directive) stating that Washington's "current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified" because Washington's curriculum and materials include "gender ideology." The identified content, ACF claims, is "outside of the scope of PREP's authorizing statute…and all references to it must be removed from [the] PREP curricula and program materials." ACF further instructs Washington "**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." ACF asserts that it may take "additional enforcement action," and lists as possibilities "allowing HHS to withhold, disallow, suspend, or terminate Federal awards." That letter is attached as Exhibit 5.

Harms to the State of Washington

25. Washington is currently and will continue to experience harm as a result of the NOA, the Supplemental T&Cs, and the PREP Directive. The NOA, Supplemental T&Cs, and PREP Directive have created immense confusion for our agency and partners. Our agency's ability to plan for the future is severely negatively impacted. For example, our PREP grant partially funds two employee positions and fully funds one position at DOH. With the uncertainty of the PREP grant's continuation past October 27, 2025, our agency is being forced to contemplate reducing or terminating these valuable employees' positions.

26. Though the August 6, 2025 NOA applied additional terms and conditions only to one PREP grant award, identified as 2501WAPREP, the PREP Directive explicitly alleged noncompliance for curricula and program materials associated with prior PREP awards. These include the 2023 award funding, which DOH will exhaust in September, and the 2024 award, which will be drawn down beginning October 1, 2025.

27. As noted, DOH has not accepted supplemental terms and conditions issued for the 2025 PREP grant award, and has neither received nor accepted supplemental or additional terms and conditions for the 2024 or 2023 PREP grant awards. However, DOH is currently submitting invoices to be paid against 2023 grant funds. On or after October 1, 2025, DOH will begin incurring expenses to be paid against 2024 grant funds. The PREP Directive throws into disarray DOH's ability to incur and pay for contracted services that are not currently subject to any modified or supplemental terms and conditions.

28. Because of this uncertainty, DOH's contract with its main training partner, Cardea, has lapsed. This sole-source contract will require significant additional DOH staff labor to restart. In addition, it is DOH's understanding that a significant lapse in contract can seriously affect a school's ability to implement education because of scheduling disruptions and the nature of the school year.

29. In addition to these financial uncertainties, DOH is concerned about significant legal uncertainty because the PREP Directive conflicts with Washington learning standards, state law, and science. For example, the letter directs DOH to remove from one curriculum option the statement that "People of all sexual orientations and gender identities need to know how to prevent pregnancy and STOs [sexually transmitted organisms], either for themselves or to help a friend." This directive is troubling and confusing to DOH and forced DOH to seek legal counsel as to whether the PREP Directive conflicts with the PREP enabling statute itself (42 U.S.C. § 713), Washington's comprehensive sexual health education law (Wash. Rev. Code § 28A.300.475), or Washington's State Learning Standards.

30. Further, although ACF demands that DOH remove content from curricula, program materials, and program delivery, DOH has no control over the specific sexual health education curricula chosen by or taught by its local partners. First, where school curriculum choices are concerned, Washington is a local control state. In consultation with the state's Office of the Superintendent of Public Instruction, DOH identified five curricula to local partners that comply with state law, state learning standards, and also comply with the requirements of the PREP grant. Each local partner chooses the curriculum that it will teach.

31. Second, schools and local partners pay for the sexual health education curriculum that each partner chooses. Beyond partially or completely covering the salaries of three DOH

employees, the PREP grant to DOH pays for the agency's contract with Cardea, which provides training and continuous technical assistance to our local partners and on occasion subsidizes the cost of curriculum for some school districts.

32. Third, the sexual health education curricula are copyrighted by their respective publishers. Neither DOH nor any local partner has the right to modify any publisher's curriculum. Yet the PREP Directive proposes to penalize DOH for actions that were previously compliant with federal requirements, and that DOH is now challenged to address.

33. The training and technical assistance that DOH contractor Cardea provides to local partners is a crucially important part of fulfilling PREP program goals. DOH contracts with Cardea because of its expertise in teaching sexual health education by centering youth and humanity, while enhancing comfort for both participants and instructors. Cardea's approach to its work is grounded in the science of engaging youth on health education topics, with scientific, accurate, and complete information. If DOH is unable to restart its lapsed contract with Cardea, or if Cardea is unable to perform its role for any other reason, the initial impact will be felt by the workforce of health educators who will be deprived of support. The effectiveness of sexual health and personal responsibility education in Washington will suffer as a result, impacting the most vulnerable youth populations that Congress intended to reach through the PREP funding.

34. Further, the threat to our state's federal financial assistance for failure to remove content concerning "gender ideology" puts at risk at least $2,271,426, the total of PREP awards for FY24 that DOH would otherwise begin drawing down on October 1, 2025, and the FY25 award that will be available to draw down in October 2026. Washington would be unable to replace this funding, which has been appropriated by Congress and obligated to Washington, with sufficient state funding. PREP funding is the only funding DOH has dedicated to sexual health education.

35. Absent the funding Washington receives from the PREP Program, DOH could not move funds from elsewhere to pay for Cardea's services, and would be unable to continue contracting with Cardea. The impact of a disruption in funds would be devastating to the program. Given my experience, without the continued and uninterrupted funding of the PREP grant, DOH and its partners will not be as effective in administering and providing age-appropriate and medically accurate education to youth who are at particular risk of becoming pregnant or contracting HIV and other STIs. As a result, youth in Washington, especially high-risk youth, will suffer.

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

Executed on September 22, 2025, at Tumwater, Washington.

Michele R Roberts

MICHELE ROBERTS
Assistant Secretary
Division of Prevention and Community Health

Exhibit 1

Table of Contents

Table of Attachments:

State Plan Abstract

Project Title:	Washington State PREP (WA PREP) Formerly Washington State Sexual Health Program
State:	Washington State
Fiscal Year:	Federal Fiscal Year 2016
Grant Allocation Amount:	$1,186,419
Address:	DOH, Prevention and Community Health PO Box 47880 Olympia, WA 98504
Contact Name:	Lauri Turkovsky
Contact Phone Numbers:	Phone: 360-236-3538, Fax: 360-586-7868
Email and Web Site Address:	Lauri.Turkovsky@doh.wa.gov http://www.doh.wa.gov/ http://waprepforhealthyyouth.org/

The Washington State Department of Health (DOH), Division of Prevention and Community Health, Office of Healthy Communities, Access, Systems, and Coordination, Adolescent Health Unit will lead a collaborative effort to reduce teen pregnancy statewide. Other state partners (Sub-awardees) include the state Department of Social and Health Services, Juvenile Justice Administration (DSHS/JRA) and the Office of the Superintendent of Public Instruction (OSPI).

Teen pregnancy and birth rates in Washington State are high among several adolescent populations: youth of color (specifically Hispanic/Latino, American Indian/Alaska Native, and African American); those living in rural communities; adolescents engaged in the foster care system; incarcerated juvenile offenders; and/or lesbian, gay, bisexual, transgendered, or questioning (LGBTQ) teens. DOH will work with DSHS/JRA, OSPI and a contracted training and technical assistance consulting firm to recruit and select local community partners (LCPs) working with teens who have multiple risk factors. Recruitment efforts will be limited to LCPs in the 15 counties with the highest rates of teen pregnancy. Counties include urban, suburban, and rural communities. Each LCP will be assisted in selecting, implementing and sustaining an evidence-based program (EBP) in their school, juvenile detention facility, community-based youth serving organization, or behavioral health services facility. WA PREP will also provide education in three Adult Preparation Topics including: health life skills, healthy relationships, and parent-child communication.

The short-term goal of WA PREP is to implement an EBP with 880 youth across 33 implementation sites. Locally-selected EBPs will have a strong emphasis on abstinence education and resistance skill-building as well as information about the prevention of teen pregnancy, HIV, and sexually transmitted infections. The medium-term goal of the project will be to delay the initiation of sexual activity and to increase the use of condoms and other forms of contraception among sexually active youth. Research tells us that this approach will assist Washington State in further lowering the rate of teen pregnancy and births. Given our emphasis on implementing EBIs with the highest risk youth in the highest risk communities we anticipate the prevention impact of WA PREP to be seen at the statewide level.

WA PREP implementation and sub-awardee performance will primarily be monitored by the PREP Project Manager who is overseen by the Project Director and upper management structures within DOH. LCP performance and curriculum fidelity are closely monitored by the training, technical assistance, and evaluation consulting team.

V. Program Narrative

Goal Statement, Objectives and Logic Model:

(1) Goal:

The goal of Washington PREP (WA PREP) is to decrease disproportionately high rates of teen pregnancy and birth among adolescents who are: youth of color (Hispanic/Latino, American Indian/Alaska Native, and African American); living in rural communities; engaged in the foster care system; incarcerated; and/or lesbian, gay, bisexual, transgendered, or questioning (LGBTQ). DOH will achieve this goal by increasing the capacity of communities across the state to implement and sustain Evidence-Based Programs (EBPs), as well as facilitating Adult Preparation Subjects (APS).

(2) Outcome Objectives

WA PREP plans to achieve its goal by meeting the following participant and process objectives. The first six objectives are related to: 1) participants' aspirational outcomes that mirror those found in the EBPs selected by Local Community Partners (LCPs); and 2) APS outcomes.

1. By September 30, 2016, at least **50%** of participants will report they are more likely to abstain from sex in the next 6 months.
2. By September 30, 2016, at least **60%** of participants will report they are more likely to use birth control if they have sex in the next 6 months.
3. By September 30, 2016, at least **60%** of participants will report they are more likely to use condoms if they have sex in the next 6 months.

4. By September 30, 2016, at least **65%** of participants will report they are more likely to resist peer pressure.

5. By September 30, 2016, at least **75%** of participants will report they are more likely to be respectful toward others.

6. By September 30, 2016, at least **75%** of participants will report they are more likely to make plans to reach their goals.

Process Objectives

- By April 30, 2016, at least half of the continuation LCPs will have updated their sustainability plan.

- By June 30, 2016, all new LCPs will have a completed a readiness assessment, implementation plan, and preliminary sustainability plan.

- By July 10, 2016, at least eight new LCPs will have been selected.

- By Sept 30, 2016, all new LCPs will be trained in their selected EBPs.

- By Sept 30, 2016, at least five of eight new LCPs will have completed a fidelity-monitoring visit.

- By September 30, 2016, three-quarters of continuation site participants will have received 75% of their selected EBP.

- By Sept 30, 2016, all sites will have completed evaluation materials for participants who finished curriculum implementation cycles and submit them to WA PREP evaluation team by Oct 31, 2016.

- By September 30, 2016, all continuation/sustainability sites will have completed a long-term sustainability plan and received ongoing technical assistance (TA) to meet their sustainability milestones.

- By September 30, 2016, WA PREP will have provided at least two Adolescent Sexual Health trainings and EBI Training of Facilitators (ASH/TOFs) events will have been provided to sustainability sites to address staff turn-over.

- By September 30, 2016, the State PREP Team will have developed strategies to address major barriers to PREP sustainability.

(3) Logic Model

Goal: The goal of PREP is to decrease disproportionately high rates of teen pregnancy and births among youth who are: Youth of Color (Hispanic/Latino, Native American/Alaska Native, and African American), living in rural communities, engaged in the foster care system, incarcerated, and/or lesbian, gay, bisexual, transgender, or questioning (LGBTQ), primarily at the middle school and high school developmental level.

Inputs/Resources	Activities	Outputs	Outcomes

State PREP Team
• DOH, Cardea, DSHS, & OSPI
 	
Local Community Partners (LCPs)
• Local facilitators working in:
  ○ Public schools
  ○ Community-based organizations
  ○ Juvenile detention centers
  ○ Independent living skills centers
  ○ Residential drug treatment and mental health centers
 	
Evidence-based program (EBP) models
• Be Proud! Be Responsible! (BPBR)
• Draw the Line/Respect the Line (DTLRTL)
• Making Proud Choices! (MPC)
• Making Proud Choices! An Adaptation for Youth in Out of Home Care (MPC+)
• Reducing the Risk (RTR)
• Sexual Health and Adolescent Risk Prevention (SHARP)
 	
Evidence-informed program (EIP) model
• Family Life and Sexual Health (FLASH), High School
	Recruit 8 new LCPs
	• Conduct readiness assessments
	• Complete BDI Logic Model with LCPs
	• Set target number of youth to serve
	
	Train 8 new LCPs
	• Provide Adolescent Sexual Health and Training of Facilitator (ASH/TOF) training, covering all EBPs, EIP, adult preparation subjects (APS), positive youth development & trauma-informed approaches, adaptations, and ensuring inclusivity of LGBTQ youth
	
	Provide technical Assistance (TA) to new LCPs
	• Develop implementation plans
	• Develop sustainability plan
	• Provide ongoing technical assistance (TA) to LCPs
	
	Continue training & TA for 25 sustainability LCPs
	• Continue to advise LCPs on appropriate adaptations
	• Provide ASH/TOF to LCPs with major staff turnover
	• Identify barriers to sustainability
		8 new LCPs recruited
		• 8 readiness assessments completed
		• 8 BDI Logic Models completed
		
		8 new LCPs trained
		• 2-5 staff from each new LCP complete ASH/TOF, trained as facilitators in BPBR, DTLRTL, FLASH, MPC, MPC+, RTR, or SHARP, and the 3 APS
		
		8 new LCPs received TA
		• 8 implementation plans completed
		• 8 sustainability plans completed
		
		TA & training for 25 sustainability LCPs
		• 1 sustainability LCP ASH/TOF held
		• Corrective action plans to address barriers to sustainability finalized
		
		Implementations
		• At least one cycle of curriculum implementation completed at each new LCP site
		• At least one cycle of curriculum implementation completed at each sustainability LCP site
			Short Term Outcomes
			Increase in:
			• Intentions to abstain from sex
			• Intentions to use birth control and condoms when having sex
			• Ability to resist peer pressure
			• Ability to make plans to reach goals
			• Ability to be respectful of others
			
			Intermediate Term Outcomes
			Increase in:
			• Condom use
			• Delay of sexual intercourse
			• Referrals to youth-friendly health services
			• Access to youth-friendly health services

(3) Logic Model - *continued*

Goal: The goal of PREP is to decrease disproportionately high rates of teen pregnancy and births among youth who are: Youth of Color (Hispanic/Latino, Native American/Alaska Native, and African American), living in rural communities, engaged in the foster care system, incarcerated, and/or lesbian, gay, bisexual, transgender, or questioning (LGBTQ), primarily at the middle school and high school developmental level.

Inputs/Resources:	Activities:	Outputs:	Outcomes:
Participants/Audience • Adolescents at the middle and high school developmental levels (primarily ages 11-19) **Funding** • Federal TPP grant & local funds **Policy** • WA State: Healthy Youth Act, AIDS Omnibus Act, Harassment, Intimidation, and Bullying Prevention Act	**All LCPs implement curriculum** • Each LCP implements EBP/EIP at least once • Curricula adaptations made as needed to increase fit Cardea trainers observe delivery of at least one lesson at each new LCP **Evaluation** • Train all facilitators in evaluation protocols (e.g. youth entry/exit surveys, attendance, facilitator surveys, & fidelity monitoring) • LCPs submit evaluation data to Cardea • LCPs receive evaluation-related TA, as needed **Promote youth-friendly health services access** • Reinforce partnerships between LCPs and youth-friendly providers • Establish referral system **Other Activities** • Quarterly State PREP Team meetings • Meetings with LCPs	**Evaluation** • At least 8 cohorts of data from new LCPs (one per site) received • At least 25 cohorts of data from sustainability LCPs (one per site) received • Data from all cohorts analyzed • Data from all cohorts reported to federal funders **Participants/Audience** • At least 75% of the youth served at each LCP attend 75% or more of the intended program hours	*Long Term Outcomes* **Decrease in:** • Teen birth rates in LCP communities • Teen pregnancy rates in LCP communities • Incidence of HIV/STI sexual risk- taking behavior among teens in LCP communities

Needs Assessment:

State Plan for Goals and Health Objectives

WA PREP will achieve its goal of reducing teen pregnancy and sexually transmitted infection (STI) rates by meeting its health objectives of increasing participants' intentions to abstain from sex or to use contraception and condoms, if they become sexually active. DOH will achieve these goals and objectives by targeting locally selected EBPs to youth with special circumstances i.e. multiple risk factors/groups.

WA PREP has always focused program resources on youth at highest risk for teen pregnancy. DOH and the State PREP Team will continue to target our programs to youth who have a history of involvement with the foster care system; are incarcerated; are from poor or low-come families; live in rural areas; and are Latino, African American, or American Indian/Alaska Native.

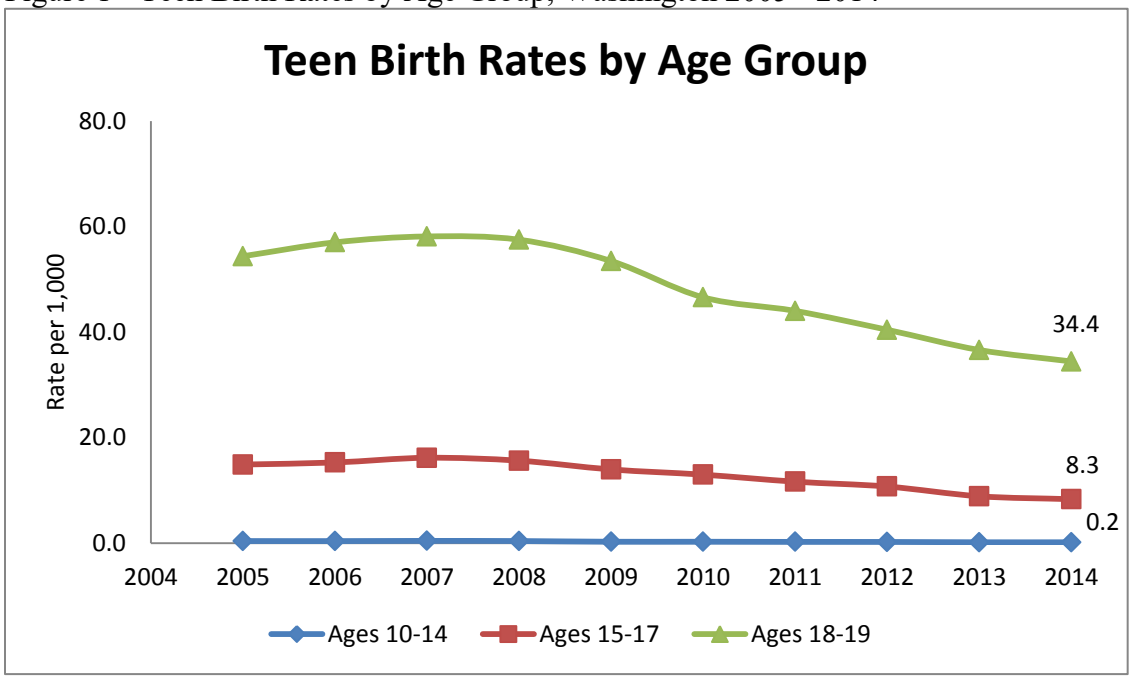
Beginning in FY 2016, DOH and the State PREP Team limited new LCP selection to communities from the 15 counties with the highest rates of teen pregnancy (See Table 1). Within those counties, recruitment was targeted exclusively to schools with the highest percentages of youth who also have one or more risk factors.

State Teen Birth and Pregnancy Rates

In 2014, the pregnancy rate for youth ages 10-14 and 15-19 was 0.2 per 1000 and 27.7 per 1000, respectively. In 2014, the teen pregnancy rate for ages 15-17 in Washington State was 13.3 per 1,000, representing 1,728 pregnancies statewide. There has been a steady decrease from 2007 to 2014. There were 1,078 live births for youth ages 15-17 in 2014. Rates for 18-19 showed a

steady decrease over the past 7 years. In 2014, roughly 20% of females ages 18-19 and 12% of females 15-17 with a live birth reported at least one prior pregnancy. [1] From 2009 to 20011, approximately 71% of surveyed Washington teen mothers (< age 20) reported that their births were unintended.[2] Teen birth and pregnancy rates for youth ages 10-14, 15-17, and 18-19 are shown below.

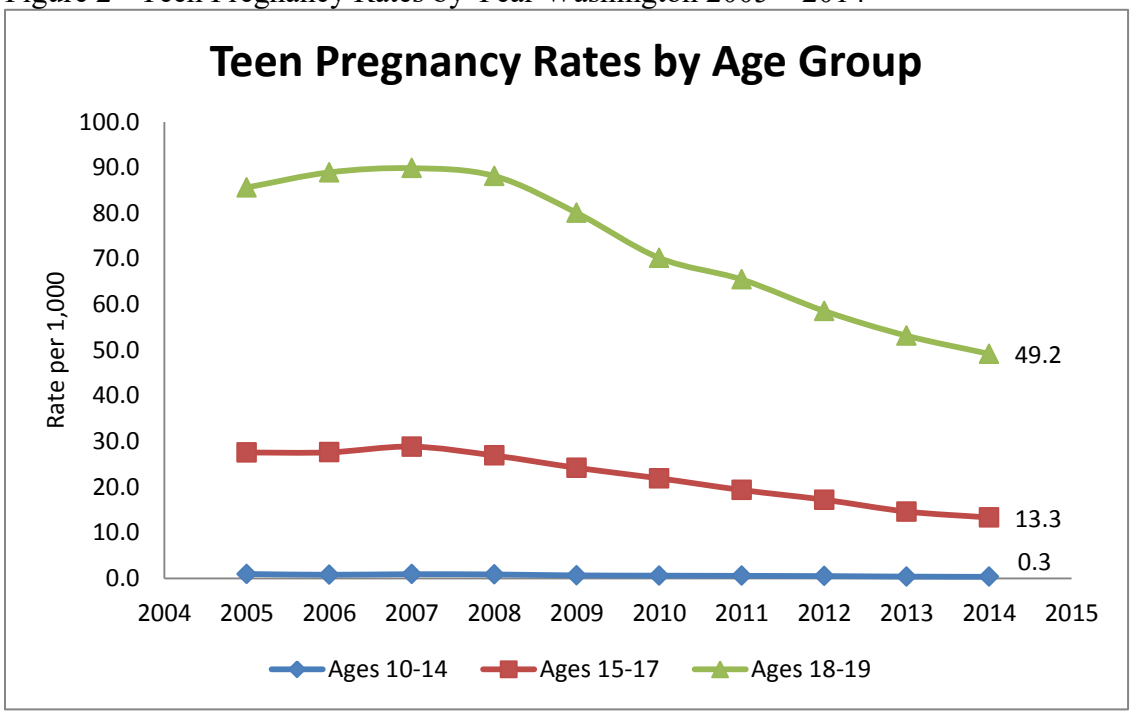
Figure 1 - Teen Birth Rates by Age Group, Washington 2005 - 2014



[1] Washington State Department of Health, Center for Health Statistics. Birth Certificate Data Files.

[2] Washington State Department of Health. Pregnancy Risk Assessment Monitoring System 2009-11

Figure 2 - Teen Pregnancy Rates by Year Washington 2005—2014



Geographic Distribution and Race/Ethnicity for Top 15 Counties with the Highest Teen Birth and Pregnancy Rates

For Washington youth ages 10-19 in 2014, teen birth and pregnancy rates are significantly higher in rural counties compared to the statewide rate. These counties generally have high proportions of Hispanic, American Indian/Alaska Native, and low-income youth. The counties with the highest number of teen births and pregnancies; include Adams, Asotin, Grant and Yakima (Table 1).

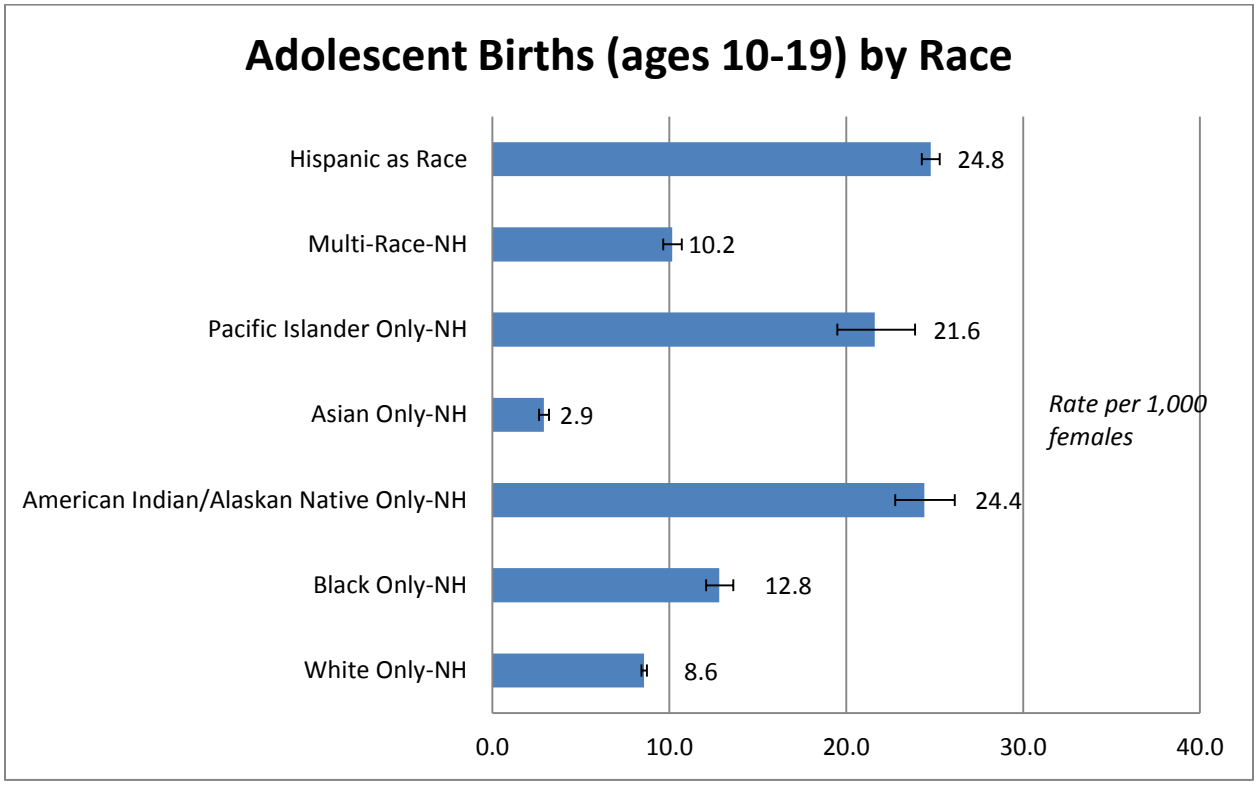
Table 1 - Adolescent Pregnancies and Birth Rates/Top 15 Counties, Ages 10-14, and 15-19, Washington 2014

County	Number of Births	Number of Pregnancies	Birth Rate per 1,000		Pregnancy Rate per 1,000		Rural/ Urban
Age groups	**10-19**	**10-19**	**10-14**	**15-19**	**10-14**	**15-19**	**N/A**
State Total	4128	6108	0.2	18.9	0.3	27.8	N/A
Adams	54	61	1.1	66.0	1.1	74.7	Rural
Asotin	24	28	0	44.4	0	51.8	Rural
Clallam	50	72	0.6	29.7	0.6	43.0	Rural

Cowlitz	90	111	0	29.3	0	36.2	Rural
Ferry	7	7	0	34.0	0	34.0	Rural
Franklin	130	151	0	40.9	0	47.5	Rural
Grant	148	164	0.5	45.3	0.5	50.3	Rural
Grays Harbor	51	71	0	26.1	0	36.3	Rural
Lewis	69	89	0.9	30.0	2.1	37.6	Rural
Mason	50	75	0.6	31.2	0.6	47.1	Rural
Okanogan	50	57	0	45.9	0	52.4	Rural
Pierce	563	876	0.2	23.0	0.4	35.6	Urban
Skagit	80	116	0	23.4	0.3	33.7	Rural
Walla Walla	48	59	0	20.6	0	25.4	Rural
Yakima	409	499	0.4	51.0	0.8	61.8	Rural

Between 2010- 2014, birth rates were significantly higher among Hispanic, non-Hispanic American Indian/Alaska Native, and non-Hispanic Pacific Islander adolescents and lower among non-Hispanic Asian and non-Hispanic white adolescents. Birth rates among adolescents have decreased significantly in the past five years for Washington State. The decrease among Hispanic and American Indian/Alaska Native adolescents has been slower, compared to other groups. Poverty; access to health care; and resources and low maternal education may account for some of these racial and ethnic differences. Pregnancy and birth rates may also be influenced by cultural values about sexuality, relationships, birth control, and abortion.

Figure 3 - Adolescent Births Ages 10-19 Race and Hispanic Origin Birth Certificates, Washington 2010-2014[3]



Socio-economic Conditions

An analysis of Washington State Birth certificate data shows a higher rate of adolescent pregnancy in counties with higher poverty rates. Yakima County has a poverty rate of 20.5% and a high school graduation rate of 71.2%, all of which are below the state levels. The teen pregnancy rate was 28.31% in 2014, which is above state teen pregnancy rate.

[3] Center for Health Statistics, Washington State Department of Health. Birth Data Files, 2010-2014

Table 2 – Poverty/Income Rates of Counties with Highest Teen Pregnancy Rates

Indicators	Poverty (2009-2013)[4]	Poverty < 18 years age (2013)[5]	Unemployment Rate (2014 average)[6]	Median Household Income (2010-2014)[7]	High School Graduation (2010-2014)[8]	County Health Ranking (out of 39) – (2015)[9]
State	13.2%	18.6%	6.2%	$60,294	90.2%	n/a
Yakima	20.5%	29.0%	9.0%	$43,956	71.5%	37
Franklin	17.3%	24.0%	8.5%	$56,719	71.9%	29
Adams	19.0%	23.7%	7.5%	$44,533	66.4%	23
Okanogan	23.2%	30.8%	7.5%	$39,665	82.4%	28
Grant	15.8%	24.5%	7.7%	$46,772	75.8%	30
Asotin	16.3%	25.8%	5.6%	$42,689	88.7%	22
Ferry	22.4%	33.1%	11.8%	$37,542	87.5%	39
Lewis	17.1%	26.3%	9.3%	$42,917	86.8%	32
Mason	15.6%	27.8%	8.6%	$49,538	87.3%	31
Pierce	13.1%	19.3%	7.3%	$59,711	90.5%	18
Skagit	15.7%	21.5%	7.4%	$54,917	88.2%	20
Cowlitz	20.6%	23.1%	8.3%	$46,571	87.2%	27
Grays Harbor	19.6%	28.2%	10.5%	$43,379	86.5%	38
Walla Walla	15.7%	22.6%	6.4%	$47,854	88.6%	16
Clallam	16.2%	24.8%	8.7%	$47,008	91.6%	26

[4] United States Census bureau http://www.censusgov/quick facts/table/PST045215/00accessedFebruary8th 2016

[5] Kids Count Data Center http://datacebter.kidscount.org/data/tabkes/3298-childrin-under18-in-poverty?loc=49&loct=5#detailed/5/6947-6985/false/36/any/7986.6800 accessed February 9th 2016

[6] Washington State Employment Security https://fortress.wa.gov/esd/employmentdata/reports-publications/economic-reports/monthly-employment-report/map-of-county-unemployment-rates accessed February 8th 2016

[7] County health ranking and Roadmap http://www.countyhealthrankings.org/app/washinton/2014/overview- accessed February 8th 2016

[8] United States Census bureau http://www.censusgov/quick facts/table/PST045215/00accessedFebruary8th 2016

[9] County health ranking and Roadmap http://www.countyhealthrankings.org/app/washinton/2014/overview- accessed February 8th 2016

Sexually Transmitted Infections

Of reportable STIs, Chlamydia is the most commonly reported STI in both Washington State and the U.S., with the highest incidence among young adults. Washington youth ages 15-19 had a Chlamydia rate of 1,342 cases per 100,000 in 2014. Among the 5,978 cases in 2014, 83% were among females in this age group.

Table 3 - Chlamydia Rates among Washington Youth 2005-2014

	Rates for Males per 100,000			Rates for Females per 100,000		
Year	**10-14**	**15-19**	**20-24**	**10-14**	**15-19**	**20-24**
2005	6.1	407.8	843.3	107.7	2246.6	2258.3
2006	6.6	363.0	736.9	92.0	2161.3	2170.1
2007	7.1	384.6	745.0	89.9	2123.9	2203.8
2008	8.1	435.3	872.5	97.9	2366.5	2428.8
2009	7.6	450.2	865.2	81.0	2439.7	2556.4
2010	3.6	434.8	829.4	93.7	2335.8	2714.6
2011	9.3	443.0	1032.6	79.6	2479.9	2952.0
2012	10.3	502.8	1059.5	71.9	2439.5	3098.6
2013	4.9	423.4	1074.5	74.2	2319.1	3101.2
2014	9.4	451.0	1153.0	63.5	2279.3	3029.8

After years of steady decrease, the rate of Gonorrhea sharply climbed from 2011-2014. In 2014, there were 694 cases of Gonorrhea diagnosed among Washington youth ages 15-19, a rate of 155.9 per 100,000, compared to 444 cases, a rate of 99.7 per 100,000 in 2013. Sixty-three percent (63%) of the cases among youth ages 15-19 in 2014 were females. There were 17 cases of syphilis diagnosed among Washington youth ages 15-19, a rate of 3.8 per 100,000.[10]

[10] Washington State Sexually Transmitted Disease Profile 2014. http://www.doh.wa.gov/Portals/1/Documents/Pubs/347-634-WAState2014.pdf Accessed on November 2015.

Table 4 - Gonorrhea Rates among Washington Youth 2005-2014

	Rates for Males per 100,000			Rates for Females per 100,000		
Year	**10-14**	**15-19**	**20-24**	**10-14**	**15-19**	**20-24**
2005	0.9	88.8	226.8	16.6	236.1	249.1
2006	1.8	103.3	231.6	15.8	275.1	281.5
2007	9.8	169.4	212.5	16.9	247.0	249.6
2008	1.3	71.5	180.8	15.5	206.9	214.8
2009	0.4	45.1	157.7	5.7	12.2	158.4
2010	1.3	53.9	169.7	4.7	135.4	154.4
2011	0.9	50.8	170.4	3.7	127.8	170.3
2012	0.4	59.4	213.9	3.3	137.1	196.7
2013	0.4	68.0	248.0	3.8	133.0	261.7
2014	0.0	114.0	344.0	13.1	199.9	337.6

HIV and AIDS is a relatively rare occurrence among Washington youth. There are about 120 youth ages 10-24 living with HIV, representing less than 1% of the state population living with HIV. The table below shows the count of Washington youth with HIV positive diagnosis by year, gender, and age.[11]

Table 5 - Number and Year of First HIV Diagnosis among Washington Youth by Age group2005-2014[12]

	Male			**Female**		
	Age at HIV Diagnosis (yrs)			Age at HIV Diagnosis (yrs)		
Year	10-14	15-19	20-24	10-14	15-19	20-24
2005	-	3	51	-	1	60
2006	-	6	48	-	2	61
2007	-	9	63	2	8	72
2008	-	9	52	-	5	65
2009	-	9	56	2	4	67
2010	-	6	54	3	4	63
2011	2	3	61	-	2	62
2012	1	13	59	3	1	64
2013	-	7	57	-	5	61
2014	1	11	50	1	0	57
Totals	4	76	551	11	32	632

Adolescent Sexual Behavior

[11] Washington State Department of Health. HIV/AIDS Surveillance Report

[12] Source: HIV surveillance data reported to the Washington State Department of Health as of 10/31/2015

The Healthy Youth Survey provides important results about the health of adolescents in Washington State. In 2014, 3,725 (less the 40% surveyed) Washington State students responded to the sexual activity questions in the survey. Among youth in the 10th and 12th grades, 26.6% and 51.6%, respectively, reported having had sexual intercourse and 16% in the 10th grade and 27.8% in the 12th grade reported that they used a condom the last time they had sex. Twelve percent (12.6%) of students in the 10th grade and 19.3% in the 12th grade reported having had only one sexual partner.[13]

State Plan for Serving High Risk Youth

American Indian/Alaska Native Youth

Washington State has 29 federally recognized tribes and nations statewide, in addition to two other member organizations of the American Indian Health Commission of Washington State.

Two of our LCPs are schools on tribal land. Our site selection criteria have always prioritized tribal schools and organizations. Presently, our liaison at the Office of the Superintendent of Public Instruction (OSPI) is working with their Office of Native Education to facilitate partnerships between WA PREP and tribal schools and other academic programs. Our intention is to increase the number of American Indian/Alaskan Native youth reached by WA PREP.

WA PREP will continue working with a Boys & Girls Club of Washington sites located near the Lummi reservation and with Wellpinit and Mt. Adams, two school districts that have a high percentage of American Indian/Alaska Native youth.

[13] Washington State Department of Health: 2013 Heathy Youth Survey, https://www.askhys.net/library/2014/StateMultiGr.pdf

WA PREP will continue to draw on experience and best practices shared with us by the Northwest Portland Area Indian Health Board (NWPAIHB) and OSPI's Office of Native Education. We will incorporate suggested curriculum adaptations and strategies for addressing specific needs of Native American/Alaska Native youth. The *Native STAND* is a video adaptation of the EBI *STAND* that has been shared with Wellpinit for use as green light adaptations to their *Draw the Line / Respect the Line* and *Reducing the Risk* curricula.

To address challenges in transition to adulthood among Native Youth, WA PREP is working with the Mt. Adams School District on the Yakima Nation reservation to integrate its existing Native curriculum with WA PREP APS.

In FY 2016, the WA PREP Project Manager will be working with the Adolescent Health Unit Special Projects Coordinator to explore opening a new school based health center in the Mt. Adams School District that can offer reproductive and mental health services. There are currently a limited number of primary health care services available to students in their small town. Moreover, there are frequently concerns about confidentiality in seeking services; the receptionists, billing, and records staff are frequently related to students. Most students are forced to travel more than 25 miles to seek confidential reproductive healthcare services.

Runaway/Homeless Youth

Homeless youth have other teen pregnancy risk factors and WA PREP reaches these youth through the juvenile justice system, which has a high rate of homelessness. PREP EBIs delivered in traditional and alternative public schools, as well as tribal school districts capture-varying numbers of homeless youth. In the Mt. Adams School district, a newly selected FFY 16 implementation site, fifty percent of students in this tribal school district are homeless.

Youth in Foster Care

To achieve WA PREP goals among youth in, or aging out of, foster care, WA PREP will continue to work with Independent Living Skills programs such as the YMCA and YouthNet. In addition, WA PREP will continue to work with other LCPs that serve large numbers of foster youth, as reported through WA PREP youth exit survey data (e.g., Boys & Girls Clubs of Washington, county juvenile detention facilities, Juvenile Rehabilitation institutions and community facilities, and school districts). When feasible for the LCPs, WA PREP will continue to promote implementation of *Making Proud Choices: An Adaptation for Youth in Out of Home Care (MPC+)*, a trauma-informed adaptation designed specifically for youth in foster care. In addition, WA PREP will provide technical assistance for LCPs that have recently, or will soon transition to, *MPC+* due to high numbers of youth in foster care. In Washington State, there are currently no sexual health education programs specific to youth in foster care. Given the school transitions experienced by some youth in protective care, there can be interrupted school experiences, including participation in teen pregnancy and STI prevention education. Additionally, the experience of mobility between families makes the APS offered through PREP particularly critical to these young people's success.

Youth in Rural Areas

Through targeted recruitment in rural school districts, DOH and the State PREP Team will work with continuing and new LCPs in areas with disproportionately high teen birth rates. To support EBP implementation in areas with disproportionately high teen birth rates, the WA PREP training team will continue to focus individualized TA efforts on supporting rural school districts, where administrators and teachers alike are often filling multiple roles and may require

more assistance. This will include helping to gather data to present in school board and community meetings and providing TA on other efforts related to building community support.

Other Youth at Disproportionate Risk

WA PREP will continue to enhance training materials and activities for gender inclusivity. The WA PREP training team will also implement a post-training module on making language adaptations to curricula to make them more inclusive of gender and sexual diversity.

To address the specific needs of youth at disproportionate risk, the WA PREP training team will continue to focus T&TA efforts on supporting facilitators in framing WA PREP interventions and conversations about sexuality with a trauma-informed lens.

Target Population

Washington State Youth Population Demographics for Counties Served

Washington State has an estimated population of 6.9 million people in 2014. Approximately 437923 (6.3%) were ages 10-14 and 445271 (6.4%) were ages 15-19. Among youth ages 10-14, 16% are white, 19% are Hispanic, 1% are AI/AN, <1% are black, and among youths ages 15-19, 14% are white, 17% are Hispanic, 1% are AI/AN, and <1% are black.

Slightly less than 18% of Washington State youth are Hispanic, although this varies greatly by county, ranging from 4% in Lincoln County to 74% in Adams County. WA PREP will serve youth in 15 of the highest risk counties in Washington (Table 6).

Table 6 – Population (ages 10-19) for Washington State 15 counties with highest teen pregnancy rates by Gender and Percentage by Race/Ethnicity, 2014

Geography	Male Total	Female Total	White NH	Black NH	AI/AN NH	Asian/PI NH	Hispanic	Multi-racial
State Total	452,015	431,179	62%	4%	2%	8%	18%	7.%
Adams	1,821	1,736	23%	1%	1%	<1%	74%	1%
Asotin	1,161	1,154	87%	1%	2%	1%	6%	4%
Clallam	3,624	3,482	71%	1%	7%	2%	11%	8%
Cowlitz	6,873	6,363	77%	1%	1%	2%	14%	5%
Ferry	405	488	65%	1%	15%	1%	7%	10%
Franklin	7,822	6,555	30%	1%	<1%	1%	65%	2%
Grant	7,583	6,713	42%	1%	1%	1%	53%	2%
Grays Harbor	4,293	4,075	70%	1%	6%	2%	16%	6%
Lewis	4,811	4,629	76%	1%	2%	1%	15%	5%
Mason	3,489	3,342	72%	1%	4%	1%	14%	7%
Okanogan	2,629	2,313	49%	1%	14%	1%	32%	4%
Pierce	54,092	50,175	59%	7%	1%	7%	14%	11%
Skagit	7,632	7,044	61%	1%	2%	2%	29%	4%
Walla Walla	3,721	4,543	61%	1%	1%	2%	32%	3%
Yakima	20,027	17,157	29%	1%	4%	1%	63%	2%

Estimated Participant Involvement

During the FFY16 grant period, WA PREP will work with 8 new implementation partners statewide and 25 continuation sites. Collectively, the PREP project will reach 880 participants from sites that serve youth with from two or more high-risk, vulnerable populations.

Implementation sites include:

- 2 State juvenile detention institutions - medium and maximum security (50 participants)
- 8 State juvenile detention facilities - minimum security (64 participants)
- 5 County juvenile detention – all security levels (125 participants)
- 8 Schools (375 participants)
- 8 Boys and Girls Clubs (200 participants)

- 2 Community-Based Organizations providing Independent Living Skills education to youth in or aging out of the child welfare system (16 participants)
- 1 Substance abuse treatment facility (25 participants)
- 1 Involuntary commitment, mental health facility (25 participants)

Based on previous annual demographics of PREP Project participants we expect 334 (38%) of the 880 participants to be 10-14 and 546 (62%) to be 15-19 years old. Previous data also indicate that the likely racial breakdown of our FFY16 participants will be:

- American Indian or Alaska Native: 167 (19%)
- Asian: 27 (3%)
- Black or African American 176 (20%)
- Native Hawaiian or Pacific Islander: 35 (4%)
- White: 431 (49%)
- Multiple races: 44 (5%)

Previous data also indicate that the likely ethnic breakdown of our FFY16 participants will be:

- Hispanic: 264 (30%)
- Non-Hispanic: 616 (70%)

Vulnerable Populations Served

American Indian/Alaska Native

Washington State has an estimated population of 883,000 youths (ages 10-19) in 2014. Approximately 20733(2%) of these youth statewide identify as American Indian/ Alaska Native. With the highest percentage of American Indian/Alaska Natives in Ferry and Okanogan County (see table 6).

Juvenile Justice System

Washington has 21 county-operated detention facilities that are maintained by the juvenile courts and one regional center that is maintained by a consortium of counties. Juveniles from all 39 counties are held in these 22 facilities. In 2014, there were 17,727 juvenile admissions to detention; some youth are admitted multiple times in a year, so this number is not a total number of youth incarcerated that year. In the last 10 years (i.e. 2004 to 2013), admissions decreased by nearly 40% (39.6%). Youth entering the juvenile justice system in 2014 were 51% white, 15% Black, 7% Native American, 2% Asian/Pacific Islander and 21% Hispanic. Admissions for Hispanic youth increased significantly (57%) over the past 10 years. About half (47.3%) of youth detention admissions were youth of color. Females represented 31% of the juvenile detention admissions in 2014.

Runaway/Homeless Youth

The number of homeless students in Washington State has increased over the past 5 years. During the 2013-2014 school year, there were 1,047853[14] students enrolled in Washington's

[14] October 2013 student enrollment count. Washington State Office of Superintendent for Public Instruction.

schools and 32,494 students identified themselves as homeless that accounted for 3.1% of students statewide. [15]

School Year	Number of Homeless students
2009-2010	21,826
2010-2011	26,049
2011-2012	27,390
2012-2013	30,609
2013-2014	32,494

Of the number of homeless students enrolled per race group, 7.6% were American Indians/ Alaska Native, 7.6% were Black/African American and 6.6% were Native Hawaiian/Pacific Islander students were homeless. About 2.7% of 8th graders, 2.6% of 10th graders and 4% of 12th graders were homeless students.

Most of the focus counties in this grant have higher homeless rates than state average. School districts in focus counties with highest number of homeless students are Ocosta and Aberdeen school district (Grays Harbor County) at 14% and 11% respectively and Warden school district (Grant County) at 10%. Homeless youth are less likely to graduate high school and in Washington State, the graduation rate among homeless youth is 46.1% as compared to 77.2% statewide.[15] Homeless youth also have an increased risk of engaging in risky sexual behaviors, which can adversely affect their development and health, but there is no state specific data available on pregnancy, birth and sexually transmitted infections among Washington state homeless youth.

[15] Washington State Office of Superintendent for Public Instruction – Homeless Student Data Report 2013-2014

Foster Care

While Washington State teen pregnancy rates for youth in foster care are not available, a national study found that the birth rate for girls in foster care (17.2%) was more than double the rate of their peers outside of the foster care system (8.2%).[16]

In September 2014, the number of children under the age of 18 living in foster care in Washington State was 10,630.[17] Teens in welfare system are at an increased risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant compared to those not in foster care system.[18]

A national survey of child and adolescent well-being (NSCAW II) also examined substance use, sexual activity, conduct behaviors, and suicidality among child welfare youths. Overall 66% of teens reported at least one health risk behavior. Suicidality was approximately 1.5 times higher among this population of teens compared to those that are not in the foster care system. [19]

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[16] Pecora, P. J., Williams, J., Kessler, R. J., Downs, A. C., O'Brien, K., Hiripi, E., & Morello, S. (2003a). *Assessing the effects of foster care: Early results from the Casey National Alumni Study*. Seattle, WA: Casey Family Programs.

[17] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. http://www.acf.hhs.gov/sites/default/files/cb/children_in_care_2014.pdf. Accessed February 22nd 2016.

[18] Boonstra HD. Teen pregnancy among women in foster care: a primer. **Guttmacher Policy Review.** 2011;14(2).

[19] Health-risk behaviors in teens investigated by U.S. Child Welfare Agencies. Heneghan A[1], Stein RE[2], Hurlburt MS[3], Zhang J[4], Rolls-Reutz J[4], Kerker BD[5], Landsverk J[4], Horwitz SM[6].

Lesbian, Gay, Bisexual, Transsexual, Questioning (LGBTQ) Youth

Youth who identify themselves as lesbian, gay bisexual, transgender or questioning (LGBTQ) are at an increased risk of negative outcomes. Available research suggests that between 20%-40% of all homeless youth identify as LGBTQ. [20]

It is difficult to estimate the number of youths in Washington State that identify as LGBTQ because of the low response rate to the question on sexual identity on a state version of the national YRBSS youth survey. In 2014, the Washington State Healthy Youth Survey (YS) had a 19% response among 10th and 12th graders on the question what best describes their sexuality. Of the 19% that responded to the question on sexual orientation, 12.4% of 10th graders and 11.8% of 12th graders identified as lesbian, gay, bisexual or questioning.

LGBTQ youths are at an increased risk of engaging in risky sexual behaviors including survival sex (sex in exchange for basic needs), and this puts them at risk for victimization and sexually transmitted diseases. [21]

Non-discrimination in Project Participation

Consistent with federal and state requirements, DOH is committed to ensuring that all youth will be able to participate in program services without regard to race, ethnicity, sexual orientation, or gender identity. Sometimes discrimination is not intentional. WA PREP's method for addressing social justice issues through training and technical assistance raises awareness of internal biases and gives EBI facilitators tools to identify their internalized biases and moderate their impact.

[20] Lesbian, Gay, Bisexual and Transgender youth – An epidemic of homelessness. Ray, Nicholas
[21] LGBT youth and the services to support them: a snapshot of the knowledge base and research needs. OPRE, Mathematica Policy Research and the Williams Institute 2015 Report.

A central focus of WA PREP is creating safe and supportive environments for youth who may have more difficulty with conversations around sex and sexuality. When developing training, we will continue to use exemplary resources and tools designed to support LCPs minimizing bias toward underrepresented teens. We will also continue to encourage facilitators to seek out these types of resources. For example, WA PREP highlights resources created by LGBTQ youth and local communities when we train on inclusion. Sensitivity to the experiences of teen parents is addressed in trainings using materials and stories written by adolescent parents themselves.

During the ASH/TOFs, WA PREP will continue to reinforce the importance of inclusive sexuality education by highlighting the disproportionate teen pregnancy, STD, and dating violence rates for LGBTQ students. In addition, we will continue to use modeling and practice as tools in training facilitators how to create safe and supportive environments. For example, we will model how to create ground rules and strategies for ensuring that participants follow these agreements. We will also create opportunities to practice answering sexual health questions involving values, slang, and other sensitive topics, including about gender, sexual orientation, sexual behavior, and LGBTQ relationships and model how to respond to these questions in an inclusive, affirming, and non-judgmental manner.

Through ongoing technical assistance, we will continue to help facilitators adapt curriculum/materials that are heteronormative, cis-normative, or shaming/ blaming to be either gender neutral or, for example, more explicitly including gay and lesbian couples in role-plays. We will also address systems-level issues such policies and procedures related to gender-neutral bathrooms, gender questions on documents and forms, and LGBTQ bullying and harassment.

Finally, as highlighted earlier, we will continue to share generalized observations with LCPs about how frequently youth self-report that they were bullied in the implementation, based on race or LGBTQ status and provide TA on strategies for promoting safe and supportive environments. The team will also share best practice policies and procedures for bullying and harassment prevention and intervention from other districts in the state and from the Washington State School Directors' Association.

Program Management

The Washington State Department of Health (DOH) is the lead applicant organization for WA PREP. We are located within the executive branch of state government, with the Secretary of Health reporting directly to the Governor. We include five divisions, one of which is the Division of Prevention and Community Healthy (PCH). The Division houses the Office of Health Communities.

Within the PCH, the Access, Systems, and Coordination Section, Adolescent Health Unit will lead the PREP project. The Unit Manager supervises the State PREP Project Manager, directly oversees the project, and works with PCH management to govern and oversee PREP.

The DOH has created the State PREP Team comprised of the: DOH Adolescent Health Unit Manager, DOH State PREP Project Manager, liaisons from the Washington State Department of Social and Health Services , Juvenile Rehabilitation Administration (DSHS/JRA), OSPI, and a team from Cardea Services that includes a Resource Center Director, Project Director, and the training and evaluation teams. Because of their extensive work with LCP's, Cardea also brings the perspectives of implementation partners.

The DOH State PREP Project Manager facilitates a bimonthly meeting of the State PREP Team to project progress. These meetings are documented through detailed meeting minutes that become part of the public record. Sub-contractors and LCPs sign contracts or Memoranda of Agreement (MOAs) that detail required tasks, expectations, and deliverables. Progress is tracked through quarterly reports. Additional levels of oversite provided by management bodies within DOH, the State PREP Team, and through federal PREP reporting mechanisms.

In addition to formal means of monitoring OSPI, DSHS/JRA and Cardea (sub-contractors), the State PREP Project Manager communicates at least biweekly with each by phone or through email. Bimonthly, face-to-face meetings are held with the DSHS/JRA and OSPI liaison positions to ensure progress toward tasks and deliverables.

LCPs are required to sign formal MOAs that outline process deliverables (e.g., assessment, implementation and sustainability plans and evaluation materials). The Cardea training team has designated primary contacts for each LCP to ensure close monitoring of progress on implementation and evaluation. As LCPs meet key deliverables, they are paid a stipend in increments. The WA PREP training team confirms that deliverables have been met, and the Cardea Resource Center Director and Project Director approve payment. These MOAs are re-negotiated annually.

Cardea training managers are in regular contact with the OSPI and DSHS/JRA liaisons regarding school and juvenile detention center implementation sites. In the course of training, TA and evaluation support with the LCPs, WA PREP provides close oversite. Information about implementation progress at each site is communicated regularly to the PREP Project Manager.

The DOH State PREP Project Manager meets weekly with the DOH Adolescent Health Unit (AHU) Manager to provide updates on grant activities and progress. The AHU Manager reports relevant updates to a DOH management team and executive leadership, as requested. WA PREP also welcomes meeting with the federal Grants Specialist and PREP Project Officer to evaluate performance in relation to the project plan to ensure that the work is on time, within budget and meeting requirements.

Collectively, WA PREP is training and evaluation teams and assessment and monitoring tools that ensure that EBPs are implemented with fidelity. The training team offers training in both groups and site-by-site to train new staff as turnover occurs. A major focus of sustainability planning with all groups is to identify policies, procedures, alternate funding sources, and administrative supports, which can reduce long-term staff turnover.

WA PREP evaluation efforts are monitored through a centralized data log that is updated regularly and reported to DOH monthly. The entry of participant pre and post intervention surveys; evaluation-related technical assistance and training; evaluation reports and briefs; and other data management processes are reported to DOH monthly, as well as being discussed during monthly evaluation conference calls with the DOH Epidemiologist and State PREP Project manager and the WA PREP evaluation team.

DOH and the State PREP Team will continue to create a detailed project plan and timeline with milestones that are monitored and documented. As outlined earlier, sub-contractors and LCPs sign contracts or MOAs detailing required tasks and expectations. Progress is tracked through submission of reports and other deliverables. The DOH State PREP Project Manager monitors these, oversight bodies within DOH, and State PREP Team and through federal PREP reporting

mechanisms. All sub-contractors attend Bimonthly State PREP Team meetings. Project progress is discussed at length and captured in detailed meeting minutes.

Overall plans and priorities are designed by the State Team but decisions are made by the DOH project manager and Adolescent Health Unit Manager. LCP implementation decision e.g. the selection of curricula, implementation plans, staff involvement), are made with support from the WA PREP training and evaluation team. The PREP Program Managers will occasionally need to become involved with problem program implementation sites. When this happens, corrective action plans are established and the liaisons and WA PREP teams assist the site in meeting their project expectations.

Financial accountability is monitored by the PREP Project Manager through review of sub-contract invoices. The fiscal unit of DOH monitors whether contractor expenditure are consistent with contract agreement and federal and state requirements. The LCPs use of grant funds is monitored by the DOH sub-contractor Cardea. These implementation sites are not paid until their training and evaluation monitor indicates that they have met their obligations.

Communication

WA PREP recognizes that regular, frequent, and clear communication is key to managing a complex project with numerous and diverse partners. The entire WA PREP State Team meets every other month to discuss current issues or concerns; ongoing data collection/evaluation process; and future plans for expansion and sustainability. The PREP Project Manager meets weekly with the Project Director to check-in regarding current activities, upcoming events and planning. Fiscal staff report the grant's financial status monthly and the PREP Project Manager facilitates regular conference calls with all contractors. As discussed previously, the training

team is in frequent contact with LCPs to provide mentoring, trouble-shooting and on-going training. WA PREP primary contractor, Cardea submits a month Evaluation Activities Memo.

Staff turnover

Well trained, engaged, appreciated employees are much more likely to remain in their current positions. Consequently, at DOH, new employees are engaged in a rigorous program that includes agency, division and office orientation. Each new staff is given a customized orientation plan to introduce them to their new position and trainings are mutually identified and agreed upon between the employee and their supervisor. Opportunities for development are sought out and staff are urged to participate to maintain engagement and enthusiasm. Staff are encouraged to attend local, regional and national conferences and trainings that are appropriate for their overall professional development. In the Adolescent Health Unit, all staff are required to be knowledgeable about other projects within the Unit, collaborate with each other and participate in agency-wide work groups. Supervisors and staff meet regularly to ensure that staff are receiving appropriate support and feedback to be effective, productive and engaged. The division has a formal process for publicly acknowledging achievements and these take place at regular all-staff meetings.

Turnover at implementation sites is discussed above.

Roles and Responsibilities—Key Staff

The DOH Adolescent Health Manager, (0.1 FTE) and DOH State PREP Project Manager, (1.0 FTE) will work with a project management team (State PREP Team) that includes staff from DSHS/JRA (0.5 FTE), OSPI (0.5 FTE), DOH Epidemiologist, (0.25 FTE), Cardea Resource Center Director (.25 FTE), Cardea Project Director, (.4) three full-time Cardea Resource Center

trainers (2.75 FTE), and Evaluation Team (.95). The State PREP Team will continue to work collaboratively to ensure the success of PREP.

Ms. Cynthia Morrison, MA ABS, DOH Adolescent Health Unit Manager

Ms. Morrison will serve as the Project Director. She will be a member of the State PREP Team and be responsible for supervising and supporting the State PREP Project Manager. Ms. Morrison reports to the Washington State Title V director and is responsible for oversight of all programs in the AHU. Activities include:

- Providing coordination within the DOH Division of Promotion and Community Health on adolescent health issues such as unintended pregnancy, STD/HIV prevention and mental health;
- Providing support for pregnant and parenting teens and their families;
- Providing training and education to teachers, nursing and medical students and providers in appropriate care for adolescents;
- Contracting with local health jurisdictions and other local community organizations to improve access to care and services for Latina/o populations in areas of high need;
- Working with schools, insurance providers and health care providers to promote school based health centers;
- Providing technical assistance to OSPI for the review and implementation of comprehensive sexual health education in public schools.

Ms. Morrison has a Master's degree in Applied Behavioral and Bachelor's degrees in Psychology and Biology and has been a program coordinator and manager at DOH for nearly nine years. She has extensive experience working collaboratively with state and local partners to

implement statewide programs and projects, and supervising professional staff to assure that programs and projects are accountable and implemented as intended. Ms. Morrison is a former Professor of Psychology and Human Sexuality.

Dr. Lauri Turkovsky, EdD, DOH, State PREP Project Manager

Dr. Turkovsky manages all project sub-recipients; serves as the Washington State's representative with the Grants Specialist and FSBY Project Officer; assures timely data collection and other reporting requirements; oversees progress toward program goals and objectives; ensures appropriate fiscal management; and determines the program's direction in consultation with the members of the State PREP Team.

Dr. Turkovsky has a doctorate in Social Justice Education and has been the State PREP Project Manager for one year. She has extensive experience in sexuality education and teen pregnancy prevention as well as program and project management at in Washington State government. For 15 years, Dr. Turkovsky worked extensively with prevention coalitions providing training and technical assistance in EBPs; monitored implementation fidelity; and provided qualitative and quantitative evaluation services.

Ms. Marla Russo, MPH, Office of Superintendent of Public Instruction, PREP Liaison

OSPI is the state's K-12 authority on education and has been involved in the Washington State PREP project from its beginning. Ms. Russo is the PREP liaison, both internally to OSPI and externally with school districts and other PREP partners. She provides OSPI data for planning and implementation; consultation to the Statewide PREP Team on the K-12 specific issues, and assists schools with information and resources as requested. Ms. Russo is responsible for recruiting schools to the PREP program; facilitating understanding of how PREP curricula meet

other educational and Washington State law requirements; and helps coordinate PREP with related OSPI efforts.

Mr. Scott Lohr, BA, Department of Social and Health Services, Juvenile Rehabilitation Administration, PREP Liaison

Mr. Lohr serves as a liaison between DSHS/JRA Community Facilities and Institution programs and other PREP partners. He ensures coordination and delivery of DSHS/JRA PREP training, technical assistance, and performance outcomes, as well as guaranteeing that performance-based contract outcomes are delivered and received. Mr. Lohr represents DSHS/JRA at relevant stakeholder meetings and assists in the facilitation of those meetings as needed. He is working to incorporate PREP in to the state's reentry program requirements for program future sustainability. Other duties include reviewing and analyzing data for capacity building and ensuring effective communication between Cardea technical assistance consultants, local detention facility site liaisons, and DSHS/JRA state offices.

Ms. April Pace, JD, Cardea Services, President/Chief Executive Officer, Resource Center Director

Ms. Pace will serve on the State PREP Team and will be responsible for fiscal and administrative oversight of Cardea's work. She has served as a President/CEO for Cardea for more than 20 years and has directed a wide range of initiatives on issues ranging from family planning and reproductive health, reproductive justice, and women's health to organizational development and cultural proficiency. Ms. Pace has excellent project management and facilitation skills and has assisted numerous federal, state and local partners to convene key stakeholders. She has managed a variety of federal, state, local and foundation grants, assuring the timely submission of high-quality deliverables. Ms. Pace received her JD from The George Washington University,

National Law Center. As a member of the State PREP Team, she will serve as the primary liaison between DOH and Cardea on contracting and personnel issues. Ms. Pace will be responsible for all fiscal and administrative oversight of subcontracts with LCPs. Finally, she will work closely with the DOH State PREP Project Manager, Cardea Project Director, and Cardea training and evaluation teams to monitor and assure successful implementation of the work plan and timetable.

Ms. Wendy Nakatsukasa-Ono, MPH, Vice President, PREP Project Director

Ms. Nakatsukasa-Ono will serve on the State PREP Team and will be responsible for supervising and supporting the Cardea training and evaluation teams. Ms. Nakatsukasa-Ono has more than 25 years of experience in public health. At Cardea, she served as Program Director for 14 years and has served as Vice President for nearly three years. Ms. Nakatsukasa-Ono manages the Grove Foundation-funded Working to Institutionalize Sexuality Education (WISE), CDC-funded Capacity Building Assistance for High Impact Prevention, and a number of other training, organizational development, and research and evaluation projects. She also serves on OSPI's Exemplary Sexual Health Education Steering Committee. Prior to joining Cardea, Ms. Nakatsukasa-Ono served as Community Health Planner for the Center for Multicultural Health and as Community Assessment Coordinator for Public Health—Seattle & King County's HIV/STD Program. She graduated from University of Washington with an MPH.

Cardea Training Team

Cardea has a team of trainers with extensive experience in sexuality education, including implementation of EBPs with fidelity. The team will train facilitators from each LCP in the EBP that the community has chosen. The team will also provide training in APS and ongoing

technical assistance to ensure that facilitators have the knowledge and skills needed to effectively implement their selected EBPs.

Program Plan/Approach

In order to reduce the adolescent pregnancy and birth rate in Washington State, WA PREP will deliver Evidence Based Programs to youth with multiple risk factors including: public and alternative schools, tribal schools; after-school and other community-based organizations serving high risk youth; juvenile incarceration facilities; adult living skills programs for youth in the foster care system; and youth in a substance-abuse treatment facility.

During FFY16, WA PREP will be offering EBPs in 8 new intervention sites as well as 33 sustainability sites across the state. New sites are chosen through direct recruitment among schools and community-based youth serving organizations with a high percentage of youth from multiple risk groups. Both Cardea staff and the OSPI liaison use community connections to make potential sites aware of the PREP project and invite them to submit a letter of interest.

A lesson learned from previous years of recruitment efforts was that use of a full Request for Qualifications process was too cumbersome for organizations to complete; this is particularly true for schools and CBOs that serve youth at highest risk for teen pregnancy, STIs, and HIV. A one-page letter of interest that asks for a short description of why an agency is interested in PREP; who within the organization is supportive of participation in the project; initial plans for implementation (age group of youth, what frequency of lessons, etc.); and how the organizations might sustain efforts beyond the first year. The most recent round of recruitment showed that this approach was successful in engaging schools with high percentages of youth who have co-

occurring conditions. Organizations that submit letters of interest engage in a more in-depth readiness assessment with WA PREP to ensure they will be successful with implementation and sustainability.

Assessment of the Substantial Emphasis of Abstinence and Contraception

WA PREP will continue to use several strategies to assess the emphasis on abstinence and contraception in EBPs for the prevention of pregnancy and STIs.

- Through the BDI logic model process, WA PREP will work with LCPs to assess local data on early sexual activity, unprotected sex and teen pregnancy. Based on this assessment, WA PREP will assist the LCP in selecting an EBP that addresses the needs of the youth being served by the LCP.
- Facilitators will assess LCPs levels of knowledge about human sexuality, STIs and contraception before and after the training. Through this assessment, the training team will evaluate lessons learned and increased knowledge levels as a result of attending the training.
- When youth participate in WA PREP classes, they will complete an entry and exit survey. Question 8 on the exit survey helps to assess the difference in youth knowledge of STIs, abstinence, and contraception before and after participation in the classes.
- The training team will suggest adaptations to EBPs to enhance content, if/as needed (e.g., adding a birth control lesson to *SHARP*).

Medical Accuracy

The WA PREP training team will continue to regularly monitor several sources for updates on medical accuracy, including federal agencies (e.g., FYSB, CDC, HRSA, OAH), state and local

health departments, and national nonprofits (e.g., Advocates for Youth, SIECUS). For example, TOF sessions on HIV/STI will include medical updates such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and new antiretroviral therapy (ART) recommendations for people who are HIV-negative and HIV-positive, respectively. Sessions on birth control will feature new IUD recommendations for teens.

During TOFs, the training team will reinforce incorporating medically accurate content as green light adaptations, while maintaining fidelity. Post-TOF, the team will provide facilitators with updates in the form of email, phone and newsletter communications.

Fidelity Monitoring

The training team has extensive experience providing T&TA to build organizational capacity for implementing EBPs with fidelity. Using a BDI Logic Model process, the team collaborates with youth-serving LCPs to assess needs and resources, clarify goals, and select an EBP. After completing a three- to four-day Adolescent Sexual Health and Training of Facilitators (ASH/TOF), LCP administrators and facilitators work with WA PREPs training and evaluation teams to develop a detailed implementation plan to ensure that the EBP is delivered with fidelity and includes appropriate adaptations to increase cultural proficiency. The training team and each LCP also commit to implementation with fidelity through an MOA.

WA PREP will continue to use existing mechanisms for monitoring fidelity:

- The training team will train new facilitators on their selected EBPs. During the ASH/TOF, the team will explain the importance of fidelity, including an introduction to fidelity monitoring and acceptable adaptations. Participants will engage in a green, yellow, red light adaptation exercise to learn how to distinguish between acceptable and

unacceptable changes to an EBP. In addition, the evaluation team will guide new facilitators through the evaluation protocols, including practice with completing a fidelity monitoring log.

- WA PREP will conduct Fidelity Monitoring Visits (FMVs) during the first or second implementation at each new site. During these visits, the team observes new facilitators and documents concerns about fidelity to the curriculum or other aspects of the implementation. They share observations with the facilitators and work with them to make any necessary adjustments. The FMV is a requirement in the MOA, so LCPs are motivated to engage in the process.
- For each lesson, facilitators will complete an adaptation and fidelity log (AFL) to document how each activity within a lesson was taught (i.e., "as suggested", "with changes", or "did not teach") and share additional comments. At the completion of an implementation cycle, the facilitators submit the AFLs along with other PREP evaluation materials. The evaluation team reviews the AFLs and shares any yellow or red light adaptations, so the designated primary contact from the training team can connect with the facilitator to develop a corrective action plan.

Adult Preparation Subjects

Based on national guidance, PREP funds are to be used to educate youth on three of six APS:

1. Healthy Life Skills
2. Healthy Relationships
3. Parent-Child Communication
4. Adolescent Development
5. Educational and Career Success

6. Financial Literacy

Nationally, Healthy Life Skills, Healthy Relationships, and Parent-Child Communication are the most frequently selected APS, and PREP promotes these three APS. WA PREP will continue to support LCPs in incorporating APS into their selected EBPs.

Healthy Life Skills

Healthy Life Skills include communication, self-management, goal-setting, decision-making to avoid unhealthy behaviors, and other skills that help youth deal effectively with the challenges of everyday life. All EBPs include lessons on Healthy Life Skills.

Examples—Healthy Life Skills lessons from EBPs

- *SHARP*, Module 2: Self Efficacy and Benefits. Risky Behaviors video.
- *Draw the Line/Respect the Line*, Lesson 6: Reduce Your Risk
- *Making Proud Choices*, Module 8: Enhancing Refusal and Negotiation Skills. Role Play

Healthy Relationships

Healthy Relationships are based on trust, honesty and respect. Youth learn about gender-based stereotypes, how to show caring and affection without having sex, differences between healthy and unhealthy relationships, skills to develop healthy relationships as well as to safely end unhealthy ones. If a Healthy Relationships lesson is not offered in a LCP's selected EBP, WA PREP will support facilitators in selecting an appropriate lesson from another EBP.

Examples of Healthy Relationships lessons from EBPs

- *Draw the Line/Respect the Line*, Grade 8, Lesson 3: Difficult Moments: Activity 3.3 Role Play
- *High School FLASH*, Lesson 6: Healthy Relationships
- *SiHLE*, Workshop 4-Relationships and Power

Parent-Child Communication

Positive communication between young people and parents helps young people establish values and make healthy decisions in all aspects of their lives. Supporting both parents and young people in fostering open communication may be an effective prevention tool as it can make young people more likely to turn to their parents to discuss sexual matters. If a Parent-Child Communication lesson is not offered in a LCP's selected EBP, WA PREP will support facilitators in selecting an appropriate lesson from another EBP.

Examples of Parent-Child Communication Lessons from EBPs

- *Draw the Line/Respect the Line*, Lesson 4.4: Parent Homework
- *Reducing the Risk*, Lesson 3.1: Talk to your Parents about sex and relationships homework
- *SHARP*, Lesson 3: Refusals – Parent/Student at home activity
- *High School FLASH*, Lesson 7: Family Homework-Talking about Sexual Violence Prevention

Assuring and Monitoring Implementation of Adult Preparation Subjects

WA PREP will continue to use several strategies to assure and monitor implementation of APS.

- WA PREP will provide an overview of the APS requirement during the ASHTOF and allow time for facilitators to brainstorm strategies for incorporating APS into their selected EBP.
- WA PREP includes APS lessons from EBPs in ASH/TOF training materials. The training team models how to teach at least one of these lessons during the ASH/TOF.
- Prior to implementation, the training team will assist facilitators in selecting APS lessons and addressing the logistics of how to incorporate these lessons into their selected EBP, including factors that increase cultural proficiency.
- As outlined earlier, each LCP will complete an AFL for each lesson during implementation. The AFL includes a section to document which APS were incorporated and how much time the facilitators spent preparing for and teaching the lessons. Since the log will be submitted with evaluation materials, it allows for ongoing monitoring of the incorporation of APS into the LCPs' selected EBP.
- The training team will continue working with facilitators to address any challenges with integrating APS into their selected EBP.

Referrals to Clinical Services

Youth involved in most WA PREP sites receive information about referrals to clinic-based reproductive health services. Many of the EBPs include the delivery information specifically about obtaining sexual health services in their community. Other curricula ask students to research available services in their area. Juvenile incarceration facilities offer on-site health services where sexually transmitted infection testing can be obtained and, in some cases, birth control is be dispensed.

Organizationally, the DOH School Based Health Center (SBHC) and WA PREP projects are both housed within the Adolescent Health Unit. In FFY16 and 17, greater emphasis will be placed on connecting the two programs' services. Specifically, there are assessment efforts underway about how a new SBHC might be established in the Mt. Adams school district on the Yakima Indian Nation reservation where services are limited and concerns about confidentiality are significant. The community has a population of 793 and is roughly 25 miles to any other source of health services.

Model(s) to be Replicated/Implementation Strategy

WA PREP conducts an intensive assessment with each LCP to clarify sexual health education goals for the youth they serve. Based on this assessment, LCPs and training managers select the EBP that is proven to be effective the site's specific population (e.g., age, grade-level, race/ethnicity) and setting (e.g., schools, clinics, communities). Currently, WA PREP offers seven curricula: 1) *Be Proud! Be Responsible!*; 2) *Draw the Line! Respect the Line!;* 3) *FLASH*; 4) *Making Proud Choices*; 5) *Making Proud Choices—An Adaptation for Youth in Out-of-Home Care*; 6) *Reducing the Risk*; and 7) *SHARP*.

With the exception of *FLASH*, all of the WA PREP curricula are on OAH's EBP list. This year, with permission from the PREP Project Officer, we added *FLASH*, a comprehensive science-based sexual health education curriculum designed to prevent pregnancy, STDs and sexual violence. The curriculum is designed for use in school classrooms as a part of a health unit and has a strong family involvement component. *FLASH* adheres to the *Characteristics of Effective Sex and STD/HIV Education Programs* and is aligned to both the CDC's *National Health Education Standards for Sexual Health* and the *National Sexuality Education Standards*, authored by the Future of Sex Education. The curriculum includes all APS and includes

examples and activities that are appropriate for youth from a diversity of geographic areas, racial/ethnic backgrounds, and sexual orientation.

WA PREP selected *Making Proud Choice*s and *Draw the Line! Respect the Line!* as options for middle school-aged youth and *Be Proud! Be Responsible!* and *Reducing the Risk* as options for high school-aged youth. We later added *Making Proud Choices—An Adaptation for Youth in Out-of-Home Care* to address the needs of youth in Juvenile Rehabilitation institutions and community facilities. This curriculum has also proved appropriate and successful in Boys & Girls Clubs sites that serve youth with a history of trauma and/or who live in foster care. Finally, we selected *SHARP* for our partners who are working with youth in Juvenile Rehabilitation institutions and community facilities.

We will continue to provide training to all LCP's in making positive and inclusive language adaptations to all curricula. For most of these curricula, supplementary activities are needed to meet the Adult Preparation Requirement. We will continue to provide LCPs with training on APS, which includes materials explaining which curricula cover which Adult Preparation subjects, and curriculum-specific suggestions for fulfilling the requirement. We will provide copies of some activities, and provide TA to sites working to integrate their own existing programming into the APS requirement.

PREP facilitators receive three to four days of training (depending on the EBP) in promote curriculum fidelity. Unique to Washington we believe, the first day of training focuses on increasing the comfort and confidence of new facilitators on foundational sexual health education topics. These include: human sexuality, anatomy and physiology, contraceptive methods (including condoms), HIV/STIs, values related to sexuality education, and linking and referring youth to clinical and other services. The next two to three days of training focus on the

rigorous scientific research that validates EBP effectiveness and both instruction on and practice implementing the selected EBP with fidelity. In addition, participants receive content on APS, effective facilitation skills, how to use the Values Question Protocol to answer sensitive questions.

After completing a three- to four-day ASH/TOF, LCP administrators and facilitators work with WA PREPs training and evaluation teams to develop a detailed implementation plan to ensure that the EBP is delivered with fidelity and includes appropriate adaptations to increase cultural proficiency. WA PREP and each LCP also commit to implementation with fidelity through an MOA.

WA PREP will continue to use existing mechanisms for monitoring fidelity:

- The training team will train new facilitators on their selected EBPs. During the ASH/TOF, the team will explain the importance of fidelity, including an introduction to fidelity monitoring and acceptable adaptations. Participants will engage in a green, yellow, red light adaptation exercise to learn how to distinguish between acceptable and unacceptable changes to an EBP. In addition, the evaluation team will guide new facilitators through the evaluation protocols, including practice with completing a fidelity monitoring log.
- The training team will conduct FMVs during the first or second implementation at each new site. During these visits, the team observes new facilitators and documents concerns about fidelity to the curriculum or other aspects of the implementation. They share observations with the facilitators and work with them to make any necessary adjustments. The FMV is a requirement in the MOA, so LCPs are motivated to engage in the process.

- For each lesson, facilitators will complete an AFL to document how each activity within a lesson was taught (i.e., "as suggested", "with changes", or "did not teach") and share additional comments. At the completion of an implementation cycle, the facilitators submit the AFLs along with other PREP evaluation materials. The evaluation team reviews the AFLs and shares any yellow or red light adaptations, so the designated primary contact from the training team can connect with the facilitator to develop a corrective action plan.

If a LCP requests an adaptation to the program, the training team will request an explanation in writing on why the adaptation needs to occur, using the following process:

- If the training team determines that the proposed adaptation is a green light adaptation, the team will approve the adaptation and request that the LCP document any changes on the AFL.
- If the training team determines that the proposed adaptation is a yellow light adaptation, the team will only approve the adaptation, with sufficient assurance and documentation that the LCP will adhere to the core components of the EBP and that the proposed adaptation will not compromise fidelity. The LCP will document any changes on the AFL.
- If the training team determines that the proposed adaptation is a red light adaptation, the training team will deny the adaptation.

Sub-Awardee Involvement:

WA PREP has two levels of sub-awardees: training and technical assistance providers and the Local Community Partners (LCP) that are implementing their Evidence-Based Program. The

DOH contracts directly with a liaison from the Washington State Department of Social and Health Services/Juvenile Rehabilitation Administration and one from the Washington State Office of the Superintendent of Public Instruction. These sub-awardees assist in making the PREP project's general requirements understandable to each organization's unique institutional culture. DOH also employs a consulting agency, Cardea Services, to provide: readiness assessments with Local Community Partners (LCP) prior to selection for WA PREP participation; training on an LCP's selected EBP; technical assistance to LCPs in program and evaluation implementation; and evaluation services including data entry, analysis, federal data submission, and communications to LCPs regarding project outcomes.

The other sub-awardees in the WA PREP project are the LCPs themselves. Potential sites e.g. schools, community-based agencies, and juvenile justice sites are made aware of funds through direct recruitment strategies. The DOH project manager, in collaboration with the Statewide PREP Team, narrows recruitment to areas and organizations with youth who have multiple risk factors. Within these limits, organizations are contacted directly by Cardea through the network of connections discussed in the Collaboration and Stakeholder Participation section. Schools and juvenile detention facilities are contacted directly by their liaison.

During FFY16, interested agencies are required to complete a short letter of interest briefly discussing their reason for interest in the project; project involvement support at their site; the number and demographics of the youth expected to complete an EBI; and the administrative support secured assist in sustainability efforts. Based on these letters of interest, a Cardea training team member conducts an in-depth readiness assessment by phone to further explore these areas. This application process is based on lessons learned from previous years of PREP participation. Formal application processes were too challenging for many schools and did not

allow Statewide PREP Team members enough opportunities to offer proposal development assistance. Based on the results of these detailed assessments, the Statewide PREP Team chooses successful applicants.

The PREP new applicant awards process for FFY16 began in August of FFY15. WA PREP is planning to conduct a second round of recruitment in April, 2016 select three new LCP summer vacation related. For new sites, we will conduct Adolescent Sexual Health and EBP trainings in late August, 2016 before youth begin the new school year, a transition that impacts most implementation site types.

Collaborations and Stakeholder Participation:

As described throughout, WA PREP is a collaboration of partners: the state Office of the Superintendent of Public Instruction, Department of Social and Health Services Juvenile Rehabilitation Administration and our numerous implementation sites. Additionally, WA PREP coordinates and collaborates with a number of other statewide sexual health education programs in Washington State promote the implementation of effective sexual health education. These include Working to Institutionalize Sexual Health Education (WISE), Exemplary Sexual Health Education (ESHE), and Stronger Together: The Northwest Coalition for Adolescent Health (NWCAH) Capacity Building Project. All of these groups

The WISE project aims to advance sustainable implementation of school-based sexuality education, with the ultimate goal of increasing the number of youth in Washington State public schools who have access to and receive comprehensive sexual health education.

OSPI receives funding through CDC, Division of Adolescent Sexual Health (CDC/DASH) to promote Exemplary Sexual Health Education (ESHE), access to sexual health services, and safe

and supportive environments in schools. The state WA PREP Coordinator and Adolescent Health Unit Manager are members of the state ESHE Steering Committee.

The U.S. Department of Health and Human Services (HHS) Office Of Adolescent Health's (OAH) awarded Planned Parenthood of the Great Northwest and the Hawaiian Islands funds to provide capacity building assistance to at least six community-based organizations through their Stronger Together: The Northwest Coalition for Adolescent Health (NWCAH) Capacity Building Project. The primary goal of the project is to increase the capacity of organizations to deliver and sustain implementation of evidence-based teen pregnancy prevention (TPP) programs to reduce teen pregnancy across the region.

The OAH also awarded other organizations in central Washington a Teen Pregnancy Prevention Program Tier 1B grant. Planned Parenthood of Greater Washington and Northern Idaho (PPGWNI), along with more than 40 formal partners in the Inland Northwest Healthy Youth Collaborative will implement evidence-based teen pregnancy prevention (TPP) programs to scale high need communities in Washington, many of which include PREP implementation sites.

All stakeholders and collaborative work under the state Adolescent Health Unit umbrella and complement our efforts to promote programs statewide including school based health centers, immunizations, smoking and other substance abuse prevention among adolescents.

Performance Measurement

Cardea Services, as described in the Sub-Awardee Involvement section, has a strong track record of building LCP capacity to follow the national evaluation protocols required to track federal performance measures (PMs) and remains committed to facilitating the collection of this data. Prior to the release of uniform, nationally required PMs in August 2013, Cardea used locally

developed, curriculum-specific instruments, but was able to seamlessly transition to the standardized PM instruments and quickly train LCP facilitators in the new evaluation protocols. If PMs change again, the Cardea training and evaluation teams have the capacity to adapt and adopt the changes and train our LCPs to quickly implement the changes.

Currently, the Cardea evaluation team provides extensive training and assistance related to evaluation protocols during the initial ASH/TOF, a follow-up implementation planning and evaluation interactive webinar, and on an ongoing basis, as needed. At the conclusion of an implementation cycle, LCPs send all evaluation materials (e.g., participant entry and exit surveys, attendance log, staff survey, and adaptation and fidelity log) to Cardea within 10 days. As a result of this practice, the team is able to efficiently manage data processing and routinely submit the annual PMs to ACYF/FYSB in advance of the August 31 deadline.

Cardea will continue to track the five broad categories of PMs, including (1) output measures; (2) fidelity/adaptation; (3) implementation and capacity building; (4) outcome measures; and (5) community data, through a combination of analyzing LCP-level data and reviewing county-level health statistics in collaboration with DOH.

(1) ***Output measures***—Cardea will continue to capture output measures (e.g., number of LCP facilitators trained and observed, number of youth served, hours of service delivery) through a combination of internal record keeping and data collection activities by each LCP. The training and evaluation teams will document the number of facilitators trained at each LCP through the ASH/TOF registration list. When the training team completes FMVs, they will note the number of facilitators observed. These counts will also be recorded in Cardea's internal LCP database. In addition, facilitators will continue to keep

track of participant attendance through an Excel spreadsheet. The spreadsheet auto-calculates the total number of sessions attended for each youth. When facilitators submit evaluation materials at the end of a cycle, the evaluation team will transfer attendance data to Mathematica's Participant Engagement tool that has additional features for calculating the number of youth served (i.e., number who met the threshold of attending 75% or more of intended program sessions), as well as the hours or service delivery. The team will also record the number of youth served during each implementation in an internal data submission log to track LCP progress toward their target number of youth served.

(2) ***Fidelity/adaptation***—Cardea will continue to work with LCPs to capture fidelity and any adaptations through program-specific AFLs. For each lesson, facilitators will complete an AFL to document how each activity within a lesson was taught (i.e., "as suggested", "with changes", or "did not teach") and share additional comments. In addition to capturing important information about fidelity, the AFLs allow the Cardea evaluation team to capture the percentage of activities completed across the cohorts.

(3) ***Implementation and capacity building***—Cardea will continue to track LCP implementation and capacity building efforts (e.g., community partnerships, competence in working with the identified population) through a combination of the Staff Perception Survey, FMV, and a data submission log. Facilitators will complete the Staff Perception Survey at the conclusion of each implementation cycle to reflect on strengths, challenges, and needs for technical assistance. In addition, facilitators will report on community partnerships developed as a result of WA PREP. During the FMV, the Cardea training team will assess LCP competence in working with their target population(s) and provide

feedback, as needed. Finally, the evaluation team will use the internal data submission log to track dates of implementation and materials received from each LCP for each cohort of youth served.

(4) ***Outcome measures***—Cardea will continue to capture outcome measures (e.g., changes in attitudes and intentions) through the standardized participant surveys. As data arrives, the evaluation team will manually enter the individual responses from the entry and exit surveys into the Excel templates developed by Mathematica. The team maintains LCP-specific entry and exit data templates throughout the Performance Measurement Year (PMY). At the end of the PMY, the team will use the summary tabs of the data templates to report on all measures in the RTI reporting system.

(5) ***Community data***—DOH manages county-level health statistics related to STI rates, teen pregnancy rates, and teen birth rates. Cardea will continue to collaborate with DOH to regularly review data in counties where LCPs are active and identify counties where the State PREP Team may wish to target efforts in future years.

Evaluation

National evaluation(s)

DOH understands and accepts the requirement that, if the grantee is selected for a national evaluation, then it and any sub-awardees will commit to participating. As the PREP grantee, DOH affirms this commitment to join any national evaluation as a project site.

Local evaluation plans

In response to the guidance about reporting on local evaluation plans, DOH notes that WA PREP is not proposing a local evaluation component as part of its application.

Itemized Budget and Justification

A. Personnel **Total: $ 117,573**

	ANNUAL SALARY	% OF TIME	MONTHS	REQUESTED
Cynthia Morrison, Health Services Consultant 4, Project Supervisor	$ 71,317	0.10	12	7,132
Lauri Turkovsky, Health Services Consultant 3, Project Coordinator	$ 64,624	1.00	12	64,624
Bintu Marong-Ceesay, Epidemiologist 2	$ 75,798	0.25	12	18,950
Fiscal Support, Health Services Consultant 3	$ 64,624	0.35	12	22,618
Secretary Senior, Administrative Support	$ 42,491	0.10	12	4,249
Total :		1.80		117,573

Position Descriptions

Project Supervisor: The Adolescent Health Unit Manager supervises the DOH PREP coordinator position and provides oversite to the project as a whole. She also supervises the management of adolescent health programs including several federal grants such as the teen pregnancy prevention grant as well as coordinating general adolescent health activities within DOH. Through collaborations with interested parties, she helps develop local and statewide systems and tools that will enhance overall adolescent health.

PREP Project Coordinator: Will serve as the liaison with the Grants Specialist and ACF Project Officer. She develops and manages contracts with DSHS, OSPI, and CHT to ensure that the program is implemented as outlined in the work plan and timetable. She monitors progress toward goals. Lauri will collaborate and implement a progress dissemination plan to ensure transparent and effective communication with internal and external stakeholders. Assure establishment of data collection and reporting systems, and ensure appropriate fiscal management and that all grant reporting and other requirements are met.

Epidemiologist: Will oversee performance measures and evaluation efforts. Will lead the planning and conduct of the overall evaluation to ensure data collection and analysis are in compliance with Institutional Review Board requirements. Monitor statewide epidemiologic data for changes in teen pregnancy and birth rate that may be related to PREP program outcomes.

Centralized Fiscal Support, HSC 3: Fiscal support to this project will be provided by the ASC contract and grant consultant and fiscal staff. They will make sure that department, state, and federal requirements are met in contracts and grant management; make sure project staff understand their budgets and expenditures, and help with fiscal planning and reporting.

Administrative Support: Support to this project will be provided to help with scheduling, meeting and travel logistics, and other administrative support activities as needed.

B. Fringe Benefits **Total: $ 38,799**

Fringe benefits charged at 33% include OASI, retirement/pension, industrial insurance, disability insurance, and Medicare.

C. Travel **Total: $ 4,071**

In-State Travel: *$ 973*

Project Coordinator and epidemiologist meet with contractors regularly and community groups as needed. DOH policy requires employees to use state owned vehicles, if available. If a state owned vehicle is not available, DOH reimburse employees for mileage at the standard mileage rate.

Out-of-State-Travel *$ 3,098*

For staff member travel to required national meetings and travel to relevant professional development trainings or conferences, including a two-day topical training.

D. Equipment **Total: $0**

E. Supplies **Total: $ 842**

General Office Supplies (pens, pencils, paper, notebooks, staples, computer disks, file folders, notepads, copy machine toner, copy machine paper, paper clips, scotch tape, pc upgrades) at $39/month x 1.80 FTE x 12 months. Staff to carry out daily activities of the program using general office supplies. Supplies relate to all objectives.

F. Contractual Total: **$ 860,000**

1. **CARDEA** $ 760,000

Cardea will provide: assistance in community readiness assessment and selection of community-specific Evidence-Based Program; purchase curricula; technical assistance and training on curriculum implementation and sustainability; evaluation services including meeting federal performance measures submission.

Itemized Budget and Justification:

Salaries: 290,260
Staffing will vary to fit project needs. Estimate 4.70 FTE including Project Director, Research Manager, Administrative Manager, Curricula Specialist, Training Coordinator, EBI trainers, and Operations staff

Fringe (35%)		101,591
Travel:		99,620

In-State
- Staff travel to sites for technical assistance visits; observation of sites for fidelity monitoring; and meetings with State PREP Advisory Team.
- Staff travel and per diem for in-state implementation visits (2 staff x 2 trips x 10 sites).
- Reimbursement for stakeholders, teachers, and community members to attend trainings, advisory meetings and community/stakeholder meetings.

Out-of-State
- Staff travel to national meetings and trainings with prior approval from DOH PREP Coordinator.

Supplies:		24,890
General office supplies	5,000	
Education materials, supplies, and curricula	19,890	
Sub- Contracts:		89,500

- Stipends for 3 new intervention partners. Funding to assist new implementation partners with start-up costs such as substitute teachers to costs for school staff attending training and time away for technical assistance on sustainability planning.

Other Costs:		154,139
Communications	6,000	
Printing and postage	6,565	
Rent	48,104	
Facility and meeting room rental	19,700	
Administrative overhead (directly allocated corporate fiscal, legal, human resources, and administrative staff; support for board of directors; insurance; audit; office machine rental; business and occupation tax)	73,770	
Grand Total		**760,000**

2. **OSPI** $45,000

OSPI will provide part-time staff to represent the interests of OSPI and their local program stakeholders on the State PREP Team in implementing PREP. They will provide direction on PREP implementation to assure that PREP builds on existing resources within their agency, communicate with internal and external stakeholders to endure project success, and coordinate with other teen pregnancy prevention efforts in the state.

Personnel:	45,000

3. **DSHS – Rehabilitation Administration/Juvenile Rehabilitation** $55,000
Agency will provide staff to coordinate PREP activities with existing JJRA efforts and collaborate with PREP to leverage sexual health education for JJRA clients.

Personnel: 55,000

G. Construction Total: **$0**

H. Other **Total: $ 14,263**

Lease Costs $ 9,612
Costs for monthly space rental and janitorial services are $445 per month for each workstation rental cost. ($445 per month x 1.80 FTEs x 12 months)

Communication Costs $ 950
Costs include monthly telephone line charges, voice messaging services, telephone equipment, faxing, and long distance charges and data lines. The amount is based on historical costs of approximately $44 per month.
($44 per month x 1.80 FTEs x 12 months)

Employee Training $ 630
These funds cover program charges for mandatory Department of Health staff training or staff development classes.
($350 per FTE x 1.80 FTEs)

Information Services Support $ 3,071
DOH centralized computer support services and maintenance of the LAN system, email and calendar maintenance, and hardware and software support at $122 per month for 1.80 FTEs. An additional fee of $242 per FTE is assessed for software once per year. ($122 per month x 12 months x 1.80 FTE) + ($242 x 1.80 FTE)

I. Total Direct Charges **$ 1,035,548**

A. Personnel	117,573
B. Fringe Benefits	38,799
C. Travel	4,071
D. Equipment	0
E. Supplies	842
F. Contractual	860,000
G. Construction	0
H. Other	14,263
Total	**$1,035,548**

J. Indirect Charges **$50,871**

DOH currently has a DHHS provisional indirect rate of 23.1% for PCH for state fiscal year 2016. The allocation base is total direct costs excluding capital expenditures, sub-awards, and flow through programs. The agency has an approved rate of 1.2% on flow-through programs. The base for this agreement is $175,548 and flow-through funds are $860,000**.**

K. Total Direct and Indirect Charges **$1,086,419**

A. Personnel	117,573
B. Fringe Benefits	38,799
C. Travel	4,071
D. Equipment	0
E. Supplies	842
F. Contractual	860,000
G. Construction	0
H. Other	14,263
J. Indirect Cost	50,871
Total	**$1,086,419**

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated 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 Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

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 insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION

Washington State Department of Health

* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Prefix: Mrs. * First Name: Janna Middle Name:

* Last Name: Bardi Suffix:

* Title: PCH Assistant Secretary

* SIGNATURE: [signature] * DATE: 2/22/2016

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
[signature]	PCH Assistant Secretary
APPLICANT ORGANIZATION	DATE SUBMITTED
Washington State Department of Health	2/22/2016

Standard Form 424B (Rev. 7-97) Back

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

17. Is The Applicant Delinquent On Any Federal Debt?

Yes ☐ No ☒ Explanation

18. By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

** I Agree ☒

** This list of certifications and assurances, or an Internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	First Name:
Mrs.	Janna

Middle Name:

Last Name: Bardi

Suffix:	Title:
	Assistant Secretary, Prevention and Community

Organizational Affiliation:

Telephone Number: 360-236-3723

Fax Number:

Email: Janna.Bardi@doh.wa.gov

Signature of Authorized Representative:

Date Signed: 2/22/2016

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0002
Expiration Date: 5/31/2014

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

1.a. Type of Submission:

- [x] Application
- [ ] Plan
- [ ] Funding Request
- [ ] Other

Other (specify):

1.b. Frequency:

- [x] Annual
- [ ] Quarterly
- [ ] Other

Other (specify):

1.c. Consolidated Application/Plan/Funding Request?

Yes [ ] No [x] Explanation

1.d. Version:

- [x] Initial
- [ ] Resubmission
- [ ] Revision
- [ ] Update

2. Date Received: 01/28/2016

STATE USE ONLY:

3. Applicant Identifier:

5. Date Received by State:

4a. Federal Entity Identifier:

6. State Application Identifier:

4b. Federal Award Identifier:

7. APPLICANT INFORMATION:

a. Legal Name: Washington State Department of Health

b. Employer/Taxpayer Identification Number (EIN/TIN): 91-1444603

c. Organizational DUNS: 8088831280000

d. Address:

Street1: PO Box 47855

Street2:

City: Olympia

County / Parish:

State: WA: Washington

Province:

Country: USA: UNITED STATES

Zip / Postal Code: 98504-7855

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this submission:

Prefix:

First Name: Lauri

Middle Name:

Last Name: Turkovsky

Suffix:

Title: PREP Grant Coordinator

Organizational Affiliation:

Telephone Number: 360-236-3538

Fax Number:

Email: Lauri.Turkovsky@doh.wa.gov

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

8a. TYPE OF APPLICANT:

A: State Government

Other (specify):

b. Additional Description:

9. Name of Federal Agency:

HHS, ACF, ACYF, Family and Youth Services Bureau

10. Catalog of Federal Domestic Assistance Number:

93.092

CFDA Title:

11. Descriptive Title of Applicant's Project:

Personal Responsibility Education Program (PREP)

12. Areas Affected by Funding:

13. CONGRESSIONAL DISTRICTS OF:

a. Applicant: WA:ALL

b. Program/Project:

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

14. FUNDING PERIOD:

a. Start Date: 10/01/2016

b. End Date: 09/30/2019

15. ESTIMATED FUNDING:

a. Federal ($): 1,086,419.00

b. Match ($):

16. IS SUBMISSION SUBJECT TO REVIEW BY STATE UNDER EXECUTIVE ORDER 12372 PROCESS?

☐ a. This submission was made available to the State under the Executive Order 12372 Process for review on:

☐ b. Program is subject to E.O. 12372 but has not been selected by State for review.

☒ c. Program is not covered by E.O. 12372.

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

17. Is The Applicant Delinquent On Any Federal Debt?

Yes ☐ No ☒ Explanation

18. By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

** I Agree ☒

** This list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	First Name:
Mrs.	Janna

Middle Name:

Last Name: Bardi

Suffix:	Title:
	Assistant Secretary, Prevention and Community

Organizational Affiliation:

Telephone Number: 360-236-3723

Fax Number:

Email: Janna.Bardi@doh.wa.gov

Signature of Authorized Representative:

Date Signed:

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

Consolidated Application/Plan/Funding Request Explanation:

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

APPLICATION FOR FEDERAL ASSISTANCE SF-424 - MANDATORY

Applicant Federal Debt Delinquency Explanation:

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 01/31/2019

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. FY16 Personal Responsibility Education Program (PREP)	93.092	$ 0.00	$ 0.00	$ 1,086,419.00	$ 0.00	$ 1,086,419.00
2. FY17 Personal Responsibility Education Program (PREP)	93.092	0.00	0.00	1,086,419.00	0.00	1,086,419.00
3.						
4.						
5. Totals		$	$	$ 2,172,838.00	$	$ 2,172,838.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) FY16 Personal Responsibility Education Program (PREP)	(2) FY17 Personal Responsibility Education Program (PREP)	(3)	(4)	Total (5)
a. Personnel	$ 117,573.00	$ 117,573.00	$	$	$ 235,146.00
b. Fringe Benefits	38,799.00	38,799.00			77,598.00
c. Travel	4,071.00	4,071.00			8,142.00
d. Equipment	0.00	0.00			
e. Supplies	842.00	842.00			1,684.00
f. Contractual	860,000.00	860,000.00			1,720,000.00
g. Construction	0.00	0.00			
h. Other	14,263.00	14,263.00			28,526.00
i. Total Direct Charges (sum of 6a-6h)	1,035,548.00	1,035,548.00			$ 2,071,096.00
j. Indirect Charges	50,871.00	50,871.00			$ 101,742.00
k. TOTALS (sum of 6i and 6j)	$ 1,086,419.00	$ 1,086,419.00	$	$	$ 2,172,838.00
7. Program Income	$	$	$	$	$

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. FY16 Personal Responsibility Education Program (PREP)	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9. FY17 Personal Responsibility Education Program (PREP)	0.00	0.00	0.00	0.00
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,086,419.00	$ 271,604.00	$ 271,605.00	$ 271,605.00	$ 271,605.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,086,419.00	$ 271,604.00	$ 271,605.00	$ 271,605.00	$ 271,605.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. FY16 Personal Responsibility Education Program (PREP)	$ 1,086,419.00	$	$	$
17. FY17 Personal Responsibility Education Program (PREP)		1,086,419.00		
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 1,086,419.00	$ 1,086,419.00	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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Exhibit 2

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 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
Rabeeha Ghaffar
Project Director
rabeeha.ghaffar@doh.wa.gov

8. Authorized Official
*See Remarks

Federal Agency Information

9. Awarding Agency Contact Information
Janice Caldwell
Director, Family Protection & Resilience Portfolio
janice.caldwell@acf.hhs.gov
214-767-2965

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
2401WAPREP

12. Unique Federal Award Identification Number (FAIN)
2401WAPREP

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
Supplement

18. Is the Award R&D?
*See Remarks

Summary Federal Award	Financial Information
19. Budget Period Start Date 10-01-2023	**End Date** 09-30-2026
20. Total Amount of Federal Funds Obligated by this Action	$897,102.00
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	$1,138,194.00
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 10-01-2023 -	**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

E-sign
Manolo Salgueiro
Supervisory Grants Management Specialist

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 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	2024,G99SU24	$1,138,194.00	$897,102.00	$1,138,194.00	2401WAPREP	Formula

Terms and Conditions

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 2024

State PREP Terms and Conditions
FY2024

By acceptance of awards for this program, the grantee 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)

PERSONAL RESPONSIBILITY EDUCATION PROGRAM
Catalog of Federal Domestic Assistance (CFDA) Program No. 93.092

APPLICABLE LEGISLATION, STATUTE, REGULATIONS

1. The administration of this program is authorized under Title V, Section 513, of the Social Security Act.

2. The program is codified at 42 U.S.C. §713.

3. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards is located under 45 CFR Part 75. In accordance with 45 CFR §75.101 Applicability, this program must comply with 45 CFR Part 75 in its entirety. No exceptions were identified.

4. Additional applicable regulations and requirements can be found in the General Terms and Conditions for Mandatory: Formula, Block and Entitlement Grants.

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

5. This program has a Maintenance of Effort (MOE) requirement per Public Law 111-148 and Title V, Section 513(a)(5), of the Social Security Act. No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under 513(a)(4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2024 (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 grant 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 grant 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 which they were awarded and within the time period allotted.

8. The OMB approved Financial Reporting form for this program is the Financial Federal Report SF-425. The SF-425 is due annually and no later than December 30, which is 90 days after the end of each project period.

9. Funding (project) period and obligation period. In accordance with Title V, Section 513 of the Act, this program has a 3-year project/obligation period starting the first day of the Federal Fiscal Year, October 1, for which funds were awarded and ending the last day of the second following Federal Fiscal Year, September 30. Any Federal funds not obligated by the end of the respective obligation period will be recouped by this Department.

10. Liquidation period. In accordance with 2 CFR200.344 provision, effective October 1, 2023, all obligated Federal funds awarded under this grant must be liquidated no later than 120 days after the end of the funding/obligation period. Any Federal funds not liquidated by January 30 will be recouped by this Department.

11. Submission Methodology: All periodic SF-425 financial reports for all grant programs must be submitted electronically through the Payment Management System (PMS). Recipiens must not submit duplicate copies either by mail, by fax or as an email attachment of any reports submitted.

12. 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.

a. An interim financial report (covering Year 1 of the project period) is due 90 days following the end of Federal Fiscal Year 1;
b. An interim financial report (covering Year 2 of the project period) is due 90 days following the end of Federal Fiscal Year 2;
b. A final financial report (cumulative, covering the entire 3-year project period) is due 120 days following the end of Federal Fiscal Year 3.

PROGRAM REPORTING

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 grant. 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). Electronic online program management report submission through GrantSolutions/On-line Data Outreach (OLDC) is required.

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-profitsRecipients must collect and report on these measures approximately twice a year.

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 required to submit an IRB letter of determination within 90 days of award. 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.

REAL PROPERTY AND TANGIBLE PERSONAL PROPERTY REPORTING

1. The OMB approved Real Property and Tangible Personal 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 renovation are not an allowable activity or expenditure under this grant.

b. Tangible Property Report (SF-428s). The SF-428 Tangible Personal Property forms must be submitted as described in the General Terms and Conditions.

OTHER TERMS AND CONDITIONS

1. Have the project fully functioning and serving youth within at least 90 days following the issuance of the Notice of Award.

2. 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.

3. 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, AfricanAmerican, 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.
4. Send at least two key staff persons to the 3-day Adolescent Pregnancy Prevention (APP) Program Grantee Conference held in the San Francisco, CA area in 2024, and tentatively in the Washington, DC, area in 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; Portland, Oregon; and Boston, Massachusetts.

5. Collect and report on all OMB cleared federal PREP performance measures (recipient, partners and sub-recipients). PREP Performance Measures are currently approved under OMB # 0970-0497, expiration date 07/31/2026.

6. For states and sub-recipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.

7. 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.

EFFECTIVE PERIOD

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

Points of contact for additional information or questions concerning either the operation of the program or related financial are:
a. Program Office:
Tecia Sellers
Program Specialist
330 C St., SW.
Washington, DC 20201
Tecia.Sellers@acf.hhs.gov
202-401-5733

b. Office Grants Management:
Manolo Salgueiro
Grants Management Officer,
330 C St., SW.
Washington, DC. 20201
Manolo.salgueiro@acf.hhs.gov
202-690-5811

Remarks

* This field is intended to be included in the standardized Notice of Award and will be displayed in subsequent quarters.

Exhibit 3

ADMINISTRATION FOR CHILDREN & FAMILIES
Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

April 14, 2025

Mary Clark
Washington State Dept. of Health
PO BOX 47880
Olympia, WA, 98504

RE: State Personal Responsibility Education Program 1701WAPREP

Dear Mary Clark:

The Administration for Children and Families (ACF), Family and Youth Services Bureau (FYSB), Division of Positive Youth Development's State Personal Responsibility Education Program (PREP) grant recipients and subrecipients are required to comply with all statutory requirements of PREP including ensuring the programs are "medically accurate and complete" and the program provides "age-appropriate" information and activities. 42 U.S.C. § 713(b)(2)(B); *see also* 45 CFR § 75.303(b) (requiring compliance with all Federal statutes, regulations, and the terms and conditions of the Federal award); and 45 CFR § 75.364(a) (requiring grantees to provide HHS with access to any records pertinent to the Federal award).

In accordance with the terms and conditions of your State Personal Responsibility Education Program grants, you may be requested to submit curricula and programmatic materials to FYSB, for a medical accuracy review, as specified in the *Terms and Conditions, Other Terms and Conditions Section under Program Reporting and Requirements*.

This letter is to request that you submit for a medical accuracy review any current curricula and programmatic materials in use or in any way relevant to your State PREP grant. This includes both the curricula and programmatic materials you are currently implementing as well as any curricula and programmatic materials you have approved for use by subrecipients or subcontractors in your state's PREP program. Please submit these curricula and materials within three (3) business days, and no later than April 17, 2025 by 11:59 PM ET.

Instructions for submitting these curricula and materials are as follows:

- Provide electronic copies of all curricula materials and supplemental information that will be provided to facilitators and program participants, including, but not limited to:
    - Teacher Manual
    - Student Manual
    - Handouts

- Video Links
- DVDs
- Brochures
- PowerPoints
- Text Messages
- Video Game Content
- Consent/Assent Forms

The purpose for the medical accuracy review of program materials is to ensure the information being shared with program participants is medically accurate and complete. A Guidance Document on the medical accuracy review process is attached to this email. Be sure to complete the attached Grantee Submission Form to identify all program materials that will be uploaded to Dropbox. It is very important this form be submitted along with your curricula. We ask that all supplemental materials be listed at the bottom of the form, separate from the curricula files.

Please email your FYSB Federal Project Officer if you need clarification regarding this request.

Sincerely,

Andrew Gradison

Acting Assistant Secretary
Administration for Children and Families

Enclosures:
Medical Accuracy Review Guidance Document
Grantee Submission Form

Exhibit 4

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 5

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.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF RYAN SHARNBROICH

DECLARATION OF RYAN SHARNBROICH

I, Ryan Sharnbroich, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a resident of New York State. I previously was a Washington State resident for more than 30 years. I am over the age of 18, competent to testify as to the matters herein, and base this declaration on my personal knowledge and the records of Cardea Services to which I have access, including records relevant to Cardea's contracted work on behalf of the Washington Department of Health (DOH).

2. I am a Senior Director leading sexual health and services programming for Cardea Services, a 501(c)(3) tax-exempt corporation incorporated in California, with offices in Seattle, Austin, and Oakland. My position is Director of Professional Learning and Sexuality Education. I am also an Adjunct Professor at Columbia University, focused on curriculum delivery in adult education. I have a dual Bachelor of Arts in medical anthropology and Bachelor of Science in public health from the University of Washington, a Master's in Education from the University of Washington, and a Master's of Public Health from Columbia University. I have held my position with Cardea since 2021. Before my current position, I worked for two years for organizations focused on curriculum development and professional development for educators. Prior to this, I was a national board certified teacher in a Puget Sound public school district for eight years, delivering sexual health education in grades K-8.

3. I am familiar with Cardea's work on contracts that are funded through Federal Personal Responsibility Education Program (PREP) grants to the Washington Department of Health (DOH). I submit this declaration in connection with Plaintiff States' Motion for Preliminary Injunction and Complaint for Injunctive and Declaratory Relief pertaining to the August 6, 2025 Notice of Award (NOA) from the United States Department of Health and Human Services (HHS)

Administration for Children and Families (ACF) regarding state Personal Responsibility Education Program (PREP) grants, the August 7, 2025 PREP Supplemental Terms and Conditions (Supplemental T&Cs), and the August 26, 2025 directive letter from ACF to grantees (the PREP Directive).

4. Cardea envisions a world in which optimal health and well-being, equity, and justice are realities for all communities. We view our mission as addressing complex program, policy, and systems issues by co-creating solutions that center community strengths and wisdom. To this end, Cardea partners with health and human services agencies across the U.S. to deliver services such as social impact evaluation, policy advancement, capacity development, and professional learning.

5. DOH is a PREP grantee. Cardea contracts with DOH and receives PREP funding through this contract, and has done so since 2012. Though Cardea has for many years contracted with DOH on other projects, in Washington our PREP grant-funded work focuses on providing teachers and educators with the tools and information necessary to deliver sexual health and personal responsibility education to high-risk students.

6. Cardea operates in 30 states and territories to administer similar comprehensive, evidence-based educational programming to reduce pregnancy, HIV, sexually transmitted infections (STIs), and birth rates for youth. In Washington State, unique among our service areas, this work is almost entirely funded by PREP. Our work in Washington is also unique in that Cardea uses a "train the trainer" model, training local entities to deliver sexual health and personal responsibility education curricula. One reason for this is Washington's focus on local control, which allows school districts or schools to select the curriculum that is best suited to their students. Neither Washington nor Cardea directs partner school districts in their choice of sexual health

education curricula. Instead, through our contract with DOH, Cardera helps local partners carry out their own plans to deliver the curriculum that each has chosen. In the October 2024 to September 2025 performance period, per the terms of its contract with DOH, Cardea received $816,340.00 from DOH in PREP funding to provide these services in Washington.

7. Since funding was first awarded in 2012, Cardea's PREP program work in Washington has involved approximately 35 school districts. We have also worked with more than 40 youth-serving organizations, for example, community health centers, YMCAs, and juvenile rehabilitation centers. However, following the 2020 passage of state requirements for comprehensive sexual health education in local schools (Wash. State Rev. Code § 28A.300.475) Cardea's sole focus has been on partnering with public school districts. Our current Washington State partners are ten local school districts. Across the state, thousands of youth in these school districts are served each year by the programs we implement with PREP funding.

8. Cardea works with local school district partners on a school year basis. We have three full time employees fully dedicated to the program, and at least two part time employees dedicated to the program. In late spring, we assist districts with planning for instruction in the fall. We walk our partners through PREP program requirements. In consultation with elected school boards, each district selects the sexual health education and personal responsibility curriculum it will teach, drawing from a menu of options that the Washington State Office of the Superintendent of Public Instruction (OSPI) has identified as compliant with state law, state learning standards, and PREP program requirements. Cardea walks district staff through that selection process, performs customized readiness assessments for each district, answers questions about issues the district faces, and identifies the need for advanced trainings of teaching staff. We provide support, often highly customized support, throughout the school year. We carry out fidelity monitoring

(including classroom observation and interviews) to make sure district staff are implementing our training and meeting state requirements. We hold office hours to answer questions and provide support for teaching staff. We then meet with district personnel in the spring and summer to assess the effectiveness of their efforts, and to determine each district's needs for the coming fall.

9. In Cardea's experience, it is very important that professional development be curriculum-based, if not necessarily curriculum-focused. As explained above, neither DOH nor Cardea selects the sexual health and personal responsibility curricula that each of our local partners teaches. However, we need to know the curricula well enough to explain how they can be effectively delivered. For example, we might provide training on how to answer sensitive questions, and how such questions could come up within the curriculum that a district has chosen. Our training is specific to each curriculum because training that is too general is difficult for our partner schools to apply.

10. Though Cardea does not deliver sexual health and personal responsibility curricula directly to Washington youth, we are aware that the curricula that our partners teach is evidence-based, medically accurate, and age appropriate. Without exception, this programming addresses both abstinence and the use of contraception, as well as at least three of six "adulthood preparation subjects" as described in 42 U.S.C. § 713(b)(2)(C). It is provided in the cultural context most appropriate for individuals in the particular population group to which the programming is directed and targeted towards high-risk youth. Additionally, the curricula use positive youth development principles when offering trauma-informed prevention programming.

Effectiveness of programs

11. As part of its work administering sexual health and personal responsibility training, Cardea measures outcomes by conducting entrance and exit surveys to training participants. Our

local partners report that they value Cardea's guidance on how, as a matter of policy, they should integrate their current practice, sexual education best practices, and state requirements and standards. They also report that they appreciate guidance on basic issues related to gender identity, for example the meaning of various gender identity terms, and how gender identity might relate to other lessons, for example lessons about dating.

12. Participants often rate training on answering sensitive questions as the most helpful aspect of our work. In this portion of our programming, we break questions down into different types and provide strategies for answering those questions. Questions that educators field from youth include, "What do I do if I'm afraid to tell my family that I'm gay/trans?" "Is there something wrong with me if I feel like my gender/sexual identity has changed over time?" "What should I do if my gender identity doesn't match what people expect of me?" and "How do I navigate a particular situation in a same-sex relationship?" We equip partners to answer these questions, which might mean providing community resources. The feedback on this portion of our training is always very positive.

13. What is clear from our partners' questions, and from their training feedback, is that gender diverse and other LGBTQ+ youth exist in Washington at rates that are underreported. It is important to Cardea that our trainings address LGBTQ+ issues because we strive to reflect the communities our partners serve.

14. Cardea also works with partner school districts to engage parents. School districts in Washington are required to offer parents the opportunity to review curriculum, and Cardea assists with that process. Additionally, when a school district wants to have a parent/caregiver workshop, Cardea helps make that happen. Parents and caregivers who participate in these workshops report how informative, well-grounded, and common sense they are. This should not

come as a surprise, as polling shows that professional sexual education is a priority for communities nationwide, even in the most conservative counties in the U.S. Parents, as well as educators, want this curriculum, and not only because educators need it. Many parents feel unequipped to deliver sexual health information to their children. They want a greater understanding of gender identity for themselves. And they are happy to have vetted, reliable sexual health information provided to their students.

15. Cardea is well positioned to provide this training and engagement. Training on gender identity is a foundational piece of any comprehensive sexual health education program, reflects best practice, and has been included in Cardea's programming since at least 2016, when Washington State adopted its Health and Physical Education Standards pursuant to Wash. State Rev. § 28A.655.070. These learning standards explicitly include gender identity as a component of sexual health education. A crucial part of the work Cardea does with school districts is to support them in meeting the state standards.

Communications from Federal Government

16. Cardea is aware that on or about April 14, 2025, DOH received a letter from ACF's Family and Youth Services Bureau (FYSB)'s Division of Positive Youth Development indicating that ACF was performing a "medical accuracy review" and requesting submission of "any current curricula and programmatic materials" related to state PREP grants. FYSB stated that the "purpose for the medical accuracy review of program materials is to ensure the information being shared with program participants is medically accurate and complete." Cardea assisted DOH in submitting PREP curricula and other materials through the ACF DropBox on or before April 22, 2025. This included curricula from four publishers, as well as supplemental materials and slides from a fifth publisher.

17. Cardea is also aware that on August 6, 2025, DOH received a notice of Award (NOA) describing the financial information associated with Washington State's PREP grant award fund, identified as 2501WAPREP. The NOA for 2501WAPREP states, "[t]he use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions." In the Remarks section, the NOA states, "Recipients are prohibited from including gender ideology in any program or service that is funded with this award." The Terms and Conditions section states, in part, "[t]he 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."

18. Cardea is aware that, in contrast to the NOA for 2501WAPREP, a NOA for the most recently awarded PREP grant actually requires DOH to provide programming to LGBTQ+ youth. Under other T&C, the NOA for FFY24 states that by accepting the grant award, the grantee agrees to "Provide PREP programming to youth populations that…have…special circumstances including culturally underrepresented youth populations such as...youth who identify as lesbian, gay, bisexual, transgender, and/or questioning (LGBTQ+)[.]" That NOA, for the 2401WAPREP award, is attached hereto as Exhibit 1.

19. Cardea is also aware that on August 7, 2025, ACF published Supplemental T&Cs applicable to awards and award modifications that add funding. The Supplemental T&Cs prohibit

grant recipients from including so-called "gender ideology" in PREP-funded programs and services. Per ACF's notice, these Supplemental T&Cs are effective immediately.

20. Cardea is also aware that on August 26, 2025, DOH received another letter from ACF (the PREP Directive) stating that Washington State's "current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified" because Washington State's curriculum and materials include "gender ideology." The identified content, ACF claims, is "outside of the scope of PREP's authorizing statute…and all references to it must be removed from [the] PREP curricula and program materials." ACF further instructs Washington State "**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.**" ACF asserts that it may take "additional enforcement action," and listed as possibilities "allowing HHS to withhold, disallow, suspend, or terminate Federal awards."

Harms to Cardea

21. Cardea is currently experiencing and will continue to experience harm as a result of the NOA, the Supplemental T&Cs, and the PREP Directive. The NOA, Supplemental T&Cs, and the PREP Directive have created immense confusion and negatively impacted our organization's ability to plan for the future.

22. The federal government's threat to Washington State to restrict federal financial assistance if content concerning "gender ideology" is not removed puts at risk at $2,271,426 in funding, the vast majority of which supports Cardea's continued professional development training and capacity building for school district partners. This would have a catastrophic effect on Cardea's work.

23. PREP grant funding pays 15% of Cardea's Washington State employee salaries, which covers four PREP-focused employees out of a nine-employee Washington workforce. With the uncertainty of the PREP grant's continuation past October 27, 2025, our organization is being forced to contemplate reducing or terminating these valuable employees' positions. Additionally, Cardea has already invested in staff labor expenses it will not be able to recoup without a contract with DOH.

Harms to Cardea's Local School District Partners

24. Cardea's local school district partners must follow the laws of Washington State. If districts were to cease use of the curricula found objectionable by HHS, as indicated in the NOA, Supplemental T&Cs, and the PREP Directive, districts would be deprived of resources (including curricula that require licensing fees) for which they have already paid, and which were previously found compliant with PREP program goals. Without access to these curricula, school districts could not comply with Washington's comprehensive sexual health education law (Wash. State Rev. § 28A.300.475), which requires that the curricula, instruction, and materials used to provide sexual health education be medically and scientifically accurate, age-appropriate, and inclusive of all students, and also meet state learning standards. In relevant part, Washington's K-12 learning standards require that students learn there is a range of gender identities and expressions, and that biological sex is distinct from gender identity. The HHS attack on the sexual health education curricula that local school districts have chosen puts them in an untenable position. Withdrawing Cardea's PREP-funded training and professional development from districts compounds this harm. Beginning in October, districts will be deprived of services they have already been promised, and are expecting. They are not in a place where they can build and sustain this work alone. Ripping away PREP funding means ripping away sexual health programming altogether for many

of the districts we work with, or rather, forcing them to attempt to comply with state standards with little to zero support, training, and guidance.

Harms to High-Risk Youth in Washington

25. If DOH loses PREP funding, Cardea would be unable to meet its obligations to train our local Washington State partners to provide age-appropriate and medically accurate education to youth who are at particular risk of becoming pregnant or contracting HIV and other STIs. Youth in Washington, especially high-risk youth, will suffer.

26. The disruption of PREP grant work jeopardizes the health and safety of LGBTQ+ youth in Washington State, and undermines 15+ years of investment in building the skills of educators, service providers, and community partners to provide affirming care and education. The urgency is clear: LGBTQ+ youth are already disproportionately at risk for negative health and wellness outcomes due to stigma, discrimination, and lack of affirming supports. Interrupting our programming now would strip away a critical safety net. Without PREP funding, LGBTQ+ youth and the adults who support them will lose access to essential tools, training, and community resources at a time when hostile political climates are escalating threats to their health, safety, and well-being.

27. It is traumatic to see communities that we directly serve and care about subjected to such harm. Being deprived of medically-accurate information about themselves and peers will have a devastating impact for young people in classrooms—information that is still viewed as a state standard, and until recently we understood to be compliant with federal requirements. It is extremely problematic for HHS and ACF to assert that gender identity information in Washington curricula isn't medically accurate, because science says the opposite. Cardea is proud of the work we do to train our local partners to deliver medically and scientifically accurate, age-appropriate,

and inclusive sexual health information, including information about gender identity. The data is clear: in places where inclusive sexual health information isn't provided to gender expansive youth, rates of suicidal ideation and suicide are higher. Our work is lifesaving work, as is the work of our local school district partners.

28. DOH, Cardea, and our local partners agree that we want young people to experience joy, affirmation and safety. We want students to have a life past graduation. The sexual health and personal responsibility content taught in Washington schools is instrumental in achieving these goals. Depriving our local partners of this content undermines their ability to communicate other, unrelated curricula, for example lessons on biology, human development, and social emotional learning. Cardea believes it is important for teachers to understand gender identity every day—not only in terms of sexual health education. Cardea references gender identity in its "train-the-trainer" materials because it is not possible to talk about being a human without talking about gender. This is true in all parts of Washington, from Moses Lake to Seattle.

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

Executed on September 24, 2025, at New York City, New York.

Ryan Sharnbroich

RYAN SHARNBROICH
Director of Professional Learning and Sexuality Education, Cardea Services

Exhibit 1

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 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
Rabeeha Ghaffar
Project Director
rabeeha.ghaffar@doh.wa.gov

8. Authorized Official
*See Remarks

Federal Agency Information

9. Awarding Agency Contact Information
Janice Caldwell
Director, Family Protection & Resilience Portfolio
janice.caldwell@acf.hhs.gov
214-767-2965

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
2401WAPREP

12. Unique Federal Award Identification Number (FAIN)
2401WAPREP

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
Supplement

18. Is the Award R&D?
*See Remarks

Summary Federal Award	Financial Information
19. Budget Period Start Date 10-01-2023	**End Date** 09-30-2026
20. Total Amount of Federal Funds Obligated by this Action	$897,102.00
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	$1,138,194.00
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 10-01-2023 -	**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

E-sign
Manolo Salgueiro
Supervisory Grants Management Specialist

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 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	2024,G99SU24	$1,138,194.00	$897,102.00	$1,138,194.00	2401WAPREP	Formula

Terms and Conditions

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2401WAPREP
FAIN# 2401WAPREP
Federal Award Date: April 15, 2024

State PREP Terms and Conditions
FY2024

By acceptance of awards for this program, the grantee 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)

PERSONAL RESPONSIBILITY EDUCATION PROGRAM
Catalog of Federal Domestic Assistance (CFDA) Program No. 93.092

APPLICABLE LEGISLATION, STATUTE, REGULATIONS

1. The administration of this program is authorized under Title V, Section 513, of the Social Security Act.

2. The program is codified at 42 U.S.C. §713.

3. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards is located under 45 CFR Part 75. In accordance with 45 CFR §75.101 Applicability, this program must comply with 45 CFR Part 75 in its entirety. No exceptions were identified.

4. Additional applicable regulations and requirements can be found in the General Terms and Conditions for Mandatory: Formula, Block and Entitlement Grants.

COST SHARING OR MATCHING (NON-FEDERAL SHARE) OF PROGRAM FUNDING

5. This program has a Maintenance of Effort (MOE) requirement per Public Law 111-148 and Title V, Section 513(a)(5), of the Social Security Act. No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under 513(a)(4), if the expenditure of non-federal funds by the State, organization, or entity for activities, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2024 (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 grant 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 grant 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 which they were awarded and within the time period allotted.

8. The OMB approved Financial Reporting form for this program is the Financial Federal Report SF-425. The SF-425 is due annually and no later than December 30, which is 90 days after the end of each project period.

9. Funding (project) period and obligation period. In accordance with Title V, Section 513 of the Act, this program has a 3-year project/obligation period starting the first day of the Federal Fiscal Year, October 1, for which funds were awarded and ending the last day of the second following Federal Fiscal Year, September 30. Any Federal funds not obligated by the end of the respective obligation period will be recouped by this Department.

10. Liquidation period. In accordance with 2 CFR200.344 provision, effective October 1, 2023, all obligated Federal funds awarded under this grant must be liquidated no later than 120 days after the end of the funding/obligation period. Any Federal funds not liquidated by January 30 will be recouped by this Department.

11. Submission Methodology: All periodic SF-425 financial reports for all grant programs must be submitted electronically through the Payment Management System (PMS). Recipiens must not submit duplicate copies either by mail, by fax or as an email attachment of any reports submitted.

12. 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.

a. An interim financial report (covering Year 1 of the project period) is due 90 days following the end of Federal Fiscal Year 1;
b. An interim financial report (covering Year 2 of the project period) is due 90 days following the end of Federal Fiscal Year 2;
b. A final financial report (cumulative, covering the entire 3-year project period) is due 120 days following the end of Federal Fiscal Year 3.

PROGRAM REPORTING

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 grant. 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). Electronic online program management report submission through GrantSolutions/On-line Data Outreach (OLDC) is required.

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-profitsRecipients must collect and report on these measures approximately twice a year.

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 required to submit an IRB letter of determination within 90 days of award. 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.

REAL PROPERTY AND TANGIBLE PERSONAL PROPERTY REPORTING

1. The OMB approved Real Property and Tangible Personal 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 renovation are not an allowable activity or expenditure under this grant.

b. Tangible Property Report (SF-428s). The SF-428 Tangible Personal Property forms must be submitted as described in the General Terms and Conditions.

OTHER TERMS AND CONDITIONS

1. Have the project fully functioning and serving youth within at least 90 days following the issuance of the Notice of Award.

2. 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.

3. 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, AfricanAmerican, 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.
4. Send at least two key staff persons to the 3-day Adolescent Pregnancy Prevention (APP) Program Grantee Conference held in the San Francisco, CA area in 2024, and tentatively in the Washington, DC, area in 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; Portland, Oregon; and Boston, Massachusetts.

5. Collect and report on all OMB cleared federal PREP performance measures (recipient, partners and sub-recipients). PREP Performance Measures are currently approved under OMB # 0970-0497, expiration date 07/31/2026.

6. For states and sub-recipients conducting local evaluations, participate in training and TA provided by the federal government and follow related guidance provided by ACF/FYSB.

7. 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.

EFFECTIVE PERIOD

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

Points of contact for additional information or questions concerning either the operation of the program or related financial are:
a. Program Office:
Tecia Sellers
Program Specialist
330 C St., SW.
Washington, DC 20201
Tecia.Sellers@acf.hhs.gov
202-401-5733

b. Office Grants Management:
Manolo Salgueiro
Grants Management Officer,
330 C St., SW.
Washington, DC. 20201
Manolo.salgueiro@acf.hhs.gov
202-690-5811

Remarks

* This field is intended to be included in the standardized Notice of Award and will be displayed in subsequent quarters.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF LAURIE DILS

DECLARATION OF LAURIE DILS

I, Laurie Dils, pursuant to 28 U.S.C. § 1746 declare as follows:

1. I am a resident of Washington State. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge, and the records of the Washington State Office of the Superintendent of Public Instruction (OSPI) to which I have access.

2. I am the Associate Director for Content, Health & Sexual Health, in the Washington State Office of the Superintendent of Public Instruction (OSPI). I have held my position for 13 years. Previously, I worked in the non-profit sector. I have a Masters in Social Work from the University of Washington.

3. I submit this declaration in connection with Plaintiff States' Motion for Preliminary Injunction and Complaint for Injunctive and Declaratory Relief pertaining to the August 6, 2025 Notice of Award (NOA) from the United States Department of Health and Human Services (HHS) Administration for Children and Families (ACF) regarding state Personal Responsibility Education Program (PREP) grants; the August 7, 2025 PREP Supplemental Terms and Conditions (Supplemental T&Cs), and the August 26, 2025 directive letter from ACF to grantees (the PREP Directive).

History and Role of PREP Grant Funding in Washington State

4. I was hired in 2012 as a half-time PREP coordinator for OSPI. My office had a different relationship with the PREP grant at that time. My predecessor at OSPI co-wrote the application to the federal government for PREP funding for Washington State. My role on hiring was to recruit schools to participate in the PREP program. OSPI had a receivables contract with DOH, which ended in 2019.

5. Today, I perform some informal recruiting of schools to participate, sometimes referring school districts to the PREP Program, or to DOH's contractor, Cardea. I perform "temperature checks" concerning sex education around Washington State, to identify school districts that are having trouble meeting state law requirements, based on my interactions with schools. However, I do not co-coordinate the PREP Program in Washington now, as I did in the past.

6. Beginning in 2012, OSPI subcontracted with DOH and acted as a liaison to recruit schools to participate in PREP. Washington State has nine Educational Service Districts (ESD) that provide services to schools regionally. OSPI recruited local school district partners through ESD to get the word out about the PREP Program. Our office worked with school nurses, counselors, and teachers. We also placed notices in official agency communications that PREP funding was available to support sexual health and personal responsibility education. I personally performed site visits to several local partner schools. I also recruited PREP Program participants through institutional education programs, for example county-level juvenile justice programs that educate youth. I then fed the resulting contacts to Cardea, which engaged partners and did the bulk of the work to get sites up and running, ready to deliver sexual health and personal responsibility education to students.

7. State statute mandates that OSPI must review sexual health instructional materials to make sure the instructional materials used by schools are consistent with state requirements. At the time (2012), there was a restricted list of curricula states could choose from for use in the PREP program. It was a lengthy list, but states were required to choose from that list. Today there is no such list, but states and their local partners must identify and use curricula that comply with PREP Program requirements. In Washington, these must also comply with state law and state learning

standards. Currently there are five curricula approved by the PREP program for use in Washington that comply with applicable requirements. If for some reason new materials were being considered today, OSPI would be required to perform the same state compliance review.

8. I understand that today, the only materials developed by Cardea are the training materials provided to local partners. These materials may be general, or specific to curriculum. For example, if a school district partner is struggling with instruction on gender identity or affirmative consent, Cardea may develop training on that topic. In other instances, Cardea provides training materials from publishers. Otherwise, the instructional materials come from the publishers, which operate nationwide**.**

9. Historically, Washington State has had a positive partnership with the federal government in administering the PREP Program, because the program provided support to implement sexual health and personal responsibility education consistent with Washington law, in particular the requirement that public schools provide comprehensive sexual education that is medically accurate, inclusive of all students, age-appropriate, and consistent with state learning standards (Wash. State Rev. § 28A.300.475). This requirement was passed by the Washington legislature and state voters in 2020, and has been in effect since December 3, 2020.

Communications from Federal Government

10. I understand that on or about April 14, 2025, DOH received via email a letter from ACF's Family and Youth Services Bureau (FYSB)'s Division of Positive Youth Development indicating that ACF was performing a "medical accuracy review" and requesting submission of "any current curricula and programmatic materials" related to state PREP grants. FYSB stated that the "purpose for the medical accuracy review of program materials is to ensure the information being shared with program participants is medically accurate and complete."

11. I understand that on August 6, 2025, DOH received a Notice of Award (NOA) describing the financial information associated with Washington State's PREP grant award funds. The NOA states, "[t]he use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions." In the Remarks section, the NOA states, "Recipients are prohibited from including gender ideology in any program or service that is funded with this award." The Terms and Conditions section states, in part, "[t]he 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."

12. I understand that on August 7, 2025, ACF published Supplemental T&Cs applicable to PREP awards and award modifications that add funding. The Supplemental T&Cs prohibit grant recipients from including so-called "gender ideology" in PREP-funded programs and services. Per ACF's notice, these Supplemental T&Cs are effective immediately.

13. Per the August 6, 2025 NOA and the Supplemental T&Cs, the "gender ideology" terms and conditions of the NOA and Supplemental T&Cs are not accepted until the grantee uses federal funds to which the terms and conditions apply.

14. I understand that on August 26, 2025, DOH received via email another letter from ACF (the PREP Directive) stating that Washington State's "current PREP curricula and program materials are out of compliance with the PREP statute and HHS regulations and must be modified"

because Washington State's curriculum and materials include "gender ideology." The identified content, ACF claims, is "outside of the scope of PREP's authorizing statute…and all references to it must be removed from [the] PREP curricula and program materials." ACF further instructs Washington State "**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.**" ACF asserts that it may take "additional enforcement action," and lists as possibilities "allowing HHS to withhold, disallow, suspend, or terminate Federal awards."

Harms to Washington State

15. Washington State is currently and will continue to experience harm as a result of the NOA, the Supplemental T&Cs, and the PREP Directive. The NOA, Supplemental T&Cs, and PREP Directive have created immense confusion for the state and its local partners. The state and its local partners' ability to plan for the future is severely negatively impacted.

16. Washington State previously submitted five packages of PREP Program curricula and related materials to the U.S. Department of Health and Human Services, and explained how these materials aligned with national and state sexual health education standards. Respectively, these curricula are titled "FLASH," "Rights Respect Responsibility," "Puberty the Wonder Years," "Un/Hush," and "Positive Prevention Plus." In a local control state such as Washington State, every school district has the right to select which title to use. Accordingly, schools have had the option of using any of these sexual health and personal responsibility curricula, as until now they have complied with both state and federal requirements.

17. To qualify for PREP funding, Washington State has been required to guarantee that schools teach with fidelity. In other words, partner schools need to deliver the instructional materials as they are presented by the publishers, if those materials are what was approved under

the PREP Program. Educators may choose to select only certain lessons, however they are not permitted to change the content.

18. These sexual health and personal responsibility titles discussed above are copyrighted by their respective publishers. Neither OSPI nor DOH has any control over their contents. Since we cannot control the publishers, we cannot know whether they will revise their content to comply with new federal demands. This leaves Washington State and its local partners in an uncertain place, just as the school year has begun. It is possible we will be left with no viable options in terms of sexual health and personal responsibility instructional materials.

19. Without using the curricula that were previously approved, or similar curricula, local school districts cannot cover some topics required by Washington law related to students' gender identity. That puts the state and its partners in a bind, because if instructional materials can no longer be inclusive of all students, school districts cannot use the materials to meet state requirements. This puts a severe burden on schools. It makes it less feasible for districts to use PREP Program material and meet applicable requirements. School district will have to jump through more hoops.

20. A major focus of the PREP Program has been preventing teen pregnancy. Washington State has focused its PREP program on populations that the federal government expected and required us to reach through the PREP Program, for example pregnant teens, rural youth, areas with significant minority populations, youth in foster care, and young people with other risk factors. Throughout years of implementing PREP grant funds, the state's goal has been to ensure that underserved communities were being served and that students at highest risk of unintended pregnancy received sexual health and personal responsibility instruction.

21. If Washington State's local partners had to amend sexual health and personal responsibility curriculum, this would cause severe harm to local partners. In my opinion, there is essentially no way that the ACF demand could be met and allow the state's local partners to meet all applicable state and federal requirements.

22. OSPI does not know whether publishers would modify their copyrighted curricula. However, supposing that a publisher removed portions of its curriculum, at that point OSPI would be required by law to review the curriculum in light of Washington State's law and K-12 learning standards. Curricula that did not include medically accurate lessons acknowledging diversity of gender identities would not comply with state law or learning standards. The outcome would be that a school district could not teach comprehensive sexual health lessons using that publisher's curriculum. Through that failure, the school district would violate state law.

23. For OSPI, and for my role personally, the effect would be to reduce the technical assistance, professional development and support for comprehensive sexual health education in Washington schools. Our state has been able to provide significantly more support to schools statewide because of our partnership with DOH, Cardea, and the PREP program. While OSPI has been able to provide professional development, technical assistance and general support for the delivery of comprehensive sexual health education, with only one designated staff position, we have not been able to provide the level of personalized and targeted support that the PREP program has. PREP has supported school districts to ensure that their sexual health instruction meets both the requirements of state statutes as well as the needs of local communities.

24. I cannot identify a way in which Washington State could effectively respond to the PREP Directive. For school districts, any effort to give effect to the PREP Directive would create

confusion and administrative burden at the beginning of the school year, when districts need it least.

25. If PREP funding is pulled from Washington State, local school district partners would still have access to curricula for the current school year, but would be deprived of training and technical support from DOH contractor Cardea. The impact of a disruption in funds and services would be devastating. OSPI has a separate, more general Cardea contract for (non-PREP) professional development, to help school districts implement state law more generally. However, these contracts cannot accommodate the services lost through withdrawn PREP Program funds. With Washington State's current state budget shortfall, the state would either be unable to replace the lost federal funding, or would be severely burdened by moving funds from another valuable program to replace the lost PREP funds.

26. Given everything I know about the delivery of sexual health and personal responsibility education by local school districts, and districts' need for ongoing professional development and other support, I can confidently state that if PREP funding were to be withdrawn or if Washington was forced to amend its curriculum in line with the PREP Directive, DOH and its partners will not be as effective in administering and providing age-appropriate and medically accurate education to youth who are at particular risk of becoming pregnant or contracting HIV and other STIs. As a result, youth in Washington State, especially high-risk youth, will suffer.

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

Executed on September 23, 2025, at Olympia, Washington.

LAURIE DILS
Associate Director for Content, Health & Sexual Health
Washington State Office of the Superintendent of Public Instruction

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF BRIDGET ROSSMAN

DECLARATION OF BRIDGET ROSSMAN

I, BRIDGET ROSSMAN, pursuant to 28 U.S.C. § 1746 declare as follows:

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

2. I am the Executive Director of Teaching and Learning for the Mount Baker School District in Washington State (MBSD). I have worked for MBSD for approximately 20 years, first as a special education instructor, and later as a school principal. I have been in my current position since 2017. I have a Bachelor of Science Degree in speech pathology and audiology, a Bachelor of Science Degree in education, a Master's Degree in special education, and a Master's Degree in educational administration.

3. In my current position, I oversee the federal Title IX program for MBSD, counseling services, library services, highly capable programs, outdoor education, HIB compliance, curriculum assessment and development, and educational technology. I also am the administrator for the district's parent partnership program, which supports families with students in remote learning. My duties involve working closely with principals, teachers, and staff at schools in the district. I also interact with students as much as possible.

4. I submit this declaration in connection with Plaintiff States' Motion for Preliminary Injunction and Complaint for Injunctive and Declaratory Relief pertaining to the August 6, 2025 Notice of Award (NOA) from the United States Department of Health and Human Services (HHS) Administration for Children and Families (ACF) regarding state Personal Responsibility Education Program (PREP) grants; the August 7, 2025 PREP Supplemental Terms and Conditions (Supplemental T&Cs), and the August 26, 2025 directive letter from ACF to grantees (the PREP Directive). I have personal knowledge of the matters set

forth below, or with respect to the matters for which I do not have personal knowledge, I have reviewed information gathered from MBSD records by others within district.

5. MBSD is aware that ACF is seeking to place new conditions on PREP funding, which means that this funding may be in danger. As part of my work on curriculum assessment and development, I've worked closely with Cardea to implement the PREP program in our school district. Cardea has been an invaluable support to MBSD as we have navigated curriculum changes and comprehensive sexual health education training for our educators.

6. In 2020, MBSD began the process of updating its school curriculum to better meet students' needs and the requirements of RCW 28A.300.475, which requires public schools in Washington to provide comprehensive sexual health education. We involved community members as well as district staff in this process. A task force was developed with community and staff representation. The effort took four months to complete, as we began a review of our current sexual health curriculum in the summer and made a presentation and recommendation on updated curriculum to our elected school board at the end of August.

7. This curriculum change was the first time that MBSD had worked with Cardea. A colleague from a different school district mentioned Cardea to me and described the benefits of working with them. I reached out to Cardea and asked them to assist MBSD in updating our curriculum. Our partnership with Cardea has been going strong since that time.

8. Cardea are extremely knowledgeable and effective partners. They are highly familiar with curriculum resources and options. They bring an unbiased approach to group work facilitation. They are skilled at supporting individuals in district operations as well as our school district organization as a whole.

9. For the 2024-25 school year, Cardea provided MBSD with a $5,000 stipend to help support the implementation of the new curriculum and provide professional development as needed. MBSD has not yet accessed this stipend. Cardea assisted us in updating our "FLASH" sexual health and personal responsibility curriculum, which is sourced from King County. Updates to the curriculum for grades 9 and 11 were extensive. Cardea supported MBSD with information and support throughout implementation. They developed resource folders connected to the updated curriculum, for families and caregivers as well as teaching staff. Cardea's work helped our teachers develop a deeper knowledge and purpose, and to deliver the curriculum more effectively. In addition, Cardea provided core content training, which is separate from curriculum training. This training is helpful to staff in understanding how to respond to student questions, remove an individual teacher's own bias, and to create a safe and inclusive learning environment. In 2025, Cardea staff assisted in a professional development day at MBSD on the foundational concepts and terminology about gender and sexuality, with the goal of increasing confidence in teaching gender and sexually-diverse youth. Topics included the dimensions of gender and sexuality, creating an inclusive classroom, answering sensitive questions, and supporting transgender students. Teaching staff reported that the event was very helpful.

10. Cardea provides other services in addition to training and professional development. They assist MBSD with communications to parents and caregivers, including by providing informational recordings on sexual health education that the district can disseminate. They help us network with agencies locally. They provide scaffolding for low incident, high needs students population, for example students who have a different learning modality, or who need instructional materials in multiple languages. They have consulted with us on other areas of educational curricula. For example, Cardea consulted with the district on a 9th grade biology

instruction, to help ensure that materials on human biology and development were medically and scientifically accurate. In general, if I have a need for support related to sexual health education, I am confident that Cardea would deliver that support within days of being contacted.

11. MBSD conducts survey research to gauge reactions to Cardea's training and support. Survey results have been uniformly positive. Teaching staff have been receptive to training. They report that they feel empowered by the PREP program training and curriculum, that it helps them feel supported in addressing sensitive sexual health and personal responsibility topics with students. They appreciate Cardea's dedicated and knowledgeable support, and Cardea's collaborative methods.

12. As required under RCW 28A.300.475, parents may opt their children out of any lessons in the sexual health education curriculum. In the MBSD there is a straightforward process for this. Our district asks families and caregivers to visit their student's school to review the curriculum in its entirety before opting their student out. This is important in case there are misconceptions about the curriculum and it provides an opportunity for discussion. If a parent/caregiver is unable to come to the school we will send or digitally share the lessons so they can make an informed decision. The curriculum doesn't endorse any behavior, sexual or otherwise, instead it equips students to make informed, responsible decisions about their health and development. In general, I get few questions about the contents of our sexual health and personal responsibility educational materials. However, there is a process in place for families to opt out if they wish, and some families choose that option.

13. MBSD data on student populations indicates that our district is home to segments of high-risk youth that the PREP Program is intended to reach. MBSD is a small, rural district

and is both a childcare desert and a food desert. 56% of our students qualify for free or reduced lunch.

14. ACF's threatened enforcement actions have led to confusion among district staff. Some of our curriculum discusses gender and sexuality. Along with strong disappointment, we feel great uncertainty. Teachers wonder how they can comply with our state law and encourage growth and understanding for students, in the face of opposition from the federal government. It's disheartening. With the ACF challenge to our comprehensive sexual health curriculum and Cardea's invaluable support, it feels like one more resource is being taken away from teachers. It is another setback among many changes that the federal government is trying to implement, and that MBSD is having to respond to. MBSD is a small district, and our staff lacks expertise in the effective implementation of sexual health and personal responsibility education. I personally would feel a loss if Cardea's support were no longer available.

15. I am aware that our high school teachers and students in particular would also feel the difference. Our 9th and 10th grade teachers sometimes rely on Cardea to teach students when they are short-staffed, and that would no longer be an option. The quality of the students' education would suffer without Cardea's professional development support. This has a real impact on student lives. It benefits LGBTQ+ students to have Cardea involved in MBSD professional development efforts. Cardea's guidance helps sexual health education be more inclusive. This guidance reaches and educates adults who are still developing their own understanding of what it means to be a transgender, gender diverse, or other LGBTQ+ person.

16. Cardea's support for sexual health education is also vital to reducing teen pregnancies, while we do not track teen pregnancies the impact of fact based sexual health education supports students. In our district students are typically in the same cohort from early

youth to graduation. They need support from outside specialized educators, as a resource and partner in developing a healthy sexual outlook and personal responsibility skills and knowledge. Our teaching staff can provide that influence, but they need the support of an organization like Cardea to do so. Without a partnership with Cardea, youth in our school district, especially high-risk youth, will suffer.

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

Executed on September 24, 2025, at Deming, Washington.

BRIDGET ROSSMAN
Executive Director of Teaching and Learning
Mount Baker School District

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF DANA SMITH

DECLARATION OF DANA SMITH

I, DANA SMITH, pursuant to 28 U.S.C. § 1746 declare as follows:

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

2. I am the Assistant Director of Communications and Community Relations for Bellingham Public Schools in Washington State. I have been in my current position since 2018. I have a bachelor's degree in secondary English education and a master's degree in journalism education. I have been an educator for 23 years. Prior to my current position, I taught high school English and journalism for Bellingham Public Schools for 17 years.

3. In my current position, I am Bellingham Public Schools' spokesperson and media liaison. I coordinate and support communications work for the district, with a particular focus on the Department of Teaching and Learning. The work involves writing and editing, crisis management, communications on key district initiatives such as curricula adoption, and consulting on key messaging and communications campaigns. I am also the district's public records officer. I work closely with program directors, principals, teachers, and staff at schools in the district as well as community partners and members of the community.

4. I submit this declaration in connection with the above captioned case. I have personal knowledge of the matters set forth below, or with respect to the matters for which I do not have personal knowledge, I have reviewed information gathered from Bellingham Public Schools's records by others within the district.

5. Bellingham Public Schools is aware that ACF is seeking to place new conditions on PREP funding, which means that this funding may be in danger. As part of my work with Bellingham Public Schools, I observed the work with Cardea on curriculum adoption and am aware of their continued professional development for our teachers. Cardea has been an invaluable

support to us as we've navigated student needs related to sexual health education, healthy relationships, and student safety, and our engagement with parents, caregivers, and families.

6. Bellingham Public Schools began working with Cardea in approximately 2022, in connection with the new statutory requirement for school districts to provide comprehensive sexual health education (CSHE) that is medically accurate, inclusive of all students, age-appropriate, and consistent with state learning standards. Wash. State Rev. § 28A.300.475. Cardea partnered with district Teaching and Learning staff to co-facilitate our process for selecting a CSHE curriculum from a set of options that the Office of the Washington Superintendent of Public Instruction (OSPI) pre-vetted for compliance with state law and learning standards. Cardea planned and co-facilitated the entire process in consultation with two previous district directors of teaching and learning. With Cardea's help, our district convened stakeholders including educators, parents, and medical professionals into a curriculum review and adoption task force. This task force evaluated the curricula options and then made a recommendation to our superintendent, which he approved, and was then processed through our Instructional Materials Committee for adoption in alignment with district policy and procedure.

7. In addition to this one-time, foundational support for the review and selection of curriculum that aligns with Washington law and OSPI learning standards, Cardea helped the district engage parents and caregivers around sexual health education, providing a range of materials that the district still uses. For example, Cardea helped produce an informational video, which I narrated, to inform parents about the legal requirements for Comprehensive Sexual Health Education in Washington state and in our district. This video is still available on our website today.

8. Beyond these services, the primary benefit our district receives from Cardea is ongoing training and professional development for teachers. Cardea provides initial training on the

delivery of the sexual health curriculum, as well as refresher courses. They also provide individualized consultations, when questions come up that a teacher doesn't know how to answer. These services are beneficial to help teachers provide better quality instruction and a richer experience for students. These services also lead to a more inclusive and welcoming environment for all students.

9. Generally, teachers are practiced and professional at implementing lesson plans and addressing the needs and questions that arise for learners during a lesson. Teachers lean on Cardea's expertise to effectively deliver age-appropriate sexual health education in a way that is accessible to all students, including answering questions in inclusive, medically-accurate, and age-appropriate ways. Sometimes students may ask questions, including questions related to gender identity or sexual orientation. Cardea's training and consultancy helps teachers identify when to refer youth to families and caregivers, their health care providers, or a trusted adult for help with questions that are outside the scope of the curriculum. . Cardea plays a critical role in providing teachers with more confidence to answer and/or redirect student questions.

10. Cardea conducts entry- and exit- surveys for their professional development and training, to numerically score educators' comfort level with sexual health curricula prior to training and afterwards; for example, teachers may self-identify as a level two on a five point scale prior to training. Cardea works hard to improve every teacher's comfort with the material by one or two levels during trainings. Teachers have commented that Cardea's training is helpful and empowering and ultimately made them feel more comfortable as sexual health educators.

11. Losing Cardea's support would be a significant loss. Our district would have to figure out how to support our teaching staff in meeting CSHE requirements. Under our current staffing model and capacity, I am certain that we could not replicate Cardea's services. No school

district can adopt a curriculum, be trained once, and deliver it effectively forever, due to continued new hiring, teachers changing grade levels, or other factors. Cardea's ongoing professional development support is essential in numerous ways.

12. We estimate that Bellingham Public Schools staff receive from 8-12 hours of professional development each year from Cardea, an estimated value of $300-$400 per hour. Staff also benefit from an estimated 15-20 hours per year of consultation services, at an estimated $200/hour value. Bellingham Public Schools receive this assistance through PREP funding. If Cardea's support was unavailable, our school district could not replicate Cardea's expertise, training and consultation within our district teaching and learning resources.

13. Additionally, there would be harms that are difficult to quantify. There would likely be a degraded comfort level for teachers with sexual health education. Teachers would likely remain with their baseline comfort level, often reported as two on a five-point scale prior to training, and stay there, instead of increasing to a higher comfort level as is typically reported after engaging in Cardea-led professional development.

14. This difference would reach kids eventually and affect their health and safety. Sexual health education is a powerful prevention tool that teaches body awareness, communication and decision-making skills to keep students safe and healthy and maintain boundaries with peers and adults. This knowledge makes children less vulnerable to abuse and more likely to speak up. Further, effective sexual health instruction serves as a foundational prevention method to prevent bullying and sexual harassment.

15. It is important that professional development around sexual health education include training on gender identity, gender diversity, and issues facing LGBTQ+ youth. This instruction is required by state law and state learning standards, which our school district is bound

to follow. This includes following antidiscrimination law and standards. Our lessons must be inclusive—including regarding gender and sexual orientation—to meet state law requirements.

16. Beyond this, the importance of gender-inclusive and LGBTQ+-inclusive education is constantly underlined in our engagement with parents, and during professional development. Participants in Cardea trainings reflect on their own sexual health education experiences. In the past, students were in segregated sexual health education classes. That is a major difference from the way that CSHE is taught in our district today, under Cardea's guidance. Gender is a spectrum—this is supported by science and recognized in Washington law and learning standards. Students of all gender identities need to know about all anatomies. Regardless of gender identity and from a public health lens, when we help students to understand changes that will happen in their bodies based on the anatomy that they have, this helps keep them safe and healthy. It also helps students to make informed choices about their own bodies.

17. It is important to understand that district teachers don't steer students' choices. Instead, for questions regarding values, or what choices to make, we refer students to their families and caregivers, their health care providers, or other trusted adults. These are not decisions that are made at school by educators. They're made by the person whose body it is.

18. This teaching is important for cisgender students as well as well as gender-diverse students. For example, cisgender men need to know about female development to exist with women in partnership and family, and vice versa. The professional development that Cardea provides helps Bellingham Public Schools apply a public health lens to sexual health education, to communicate that every student has a body, and that as a district, we care about every student's safety and health. Teaching about human bodies in a gender-inclusive way is one way we do that.

19. The more effective teachers feel in delivering sexual health education, the more they and their supervisors can confidently engage with families, who have a variety of opinions and values. This is shown even in Bellingham Public Schools's opt-out process for sexual health education instruction. Our district has an established process through which parents and guardians can opt a student out of sexual health education, and there are families who have comfortably used that process. But even in such instances, a parent has had a conversation with educators around sexual health education. When parents talk with an educator that they feel is trained and knowledgeable on this topic, from the knowledge we've gleaned from Cardea, it builds trust between that parent and their student's school community.

20. PREP funding has improved the way we teach sexual health education to our students. Our teachers and staff are better equipped to teach students in a way that is inclusive, age-appropriate, medically accurate, and culturally appropriate. The number one core belief in The Bellingham Promise, our district's strategic plan, is "All children should be loved." Our educators are committed to creating a safe and inclusive space for every kid who walks through the school doors, including gender diverse kids. The quality education that we are able to provide through our partnership with Cardea and the use of PREP funding is vital. Without that assistance, youth in our school district, especially high-risk youth, will suffer.

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

Executed on September 24, 2025, at Bellingham, Washington.

DANA SMITH
Assistant Director of Communications and
Community Relations
Bellingham Public Schools

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

STATE OF WASHINGTON; STATE OF OREGON; STATE OF MINNESOTA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; DISTRICT OF COLUMBIA; STATE OF HAWAI'I; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MARYLAND; COMMONWEALTH OF MASSACHUSETTS; STATE OF MICHIGAN; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF RHODE ISLAND; STATE OF WISCONSIN,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., in his official capacity as Secretary of U.S. Department of Health and Human Services; UNITED STATES HEALTH AND HUMAN SERVICES ADMINISTRATION FOR CHILDREN AND FAMILIES; and ANDREW GRADISON, in his official capacity as Acting Assistant Secretary of U.S. Health and Human Services Administration for Children and Families,

Defendants.

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

DECLARATION OF WILLIAM BANEY

DECLARATION OF WILLIAM BANEY

I, William Baney, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a resident of Oregon. 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 have served children, families and communities for over 30 years in various roles including teacher, therapist, school administrator, consultant, and manager of state and county human service programs. I currently serve as Design and Implementation Manager for the Oregon Department of Human Services (ODHS) – Self Sufficiency Programs. In this role, I have managed My Future My Choice (MFMC) since 2017. MFMC is a program that teaches middle school students about sexual health that uses a comprehensive, accurate, inclusive and trauma-informed approach. Prior to Joining ODHS in 2017, I was Director of the Portland State University's (PSU) Systems of Care Institute (SOCI). SOCI provided training, consultation and technical assistance to state and local communities to support an integrated and comprehensive service delivery structure. While at PSU, I founded the Center for Healthy Inclusive Parenting (CHIP) in the Graduate School of Education. CHIP focused on the development of services and systems to better represent underserved or misrepresented families such as incarcerated parents, grandparents, teen parents, fathers, multigenerational caregivers, and LGBTQIA+ parents. Over the past 20 years, I have actively supported efforts around youth development and comprehensive youth sexual education as Co-Chair for, and Member of, the Oregon Teen Pregnancy Task Force; Co-Chair for, and Member of, the Oregon Teen Pregnancy Prevention/Sexual Health Partnership; Member of the Oregon Attorney General Sexual Assault Task Force (Prevention and Education Committee); Co-Convenor for the Communities Supporting Youth – Cradle to Career Collaborative of

Multnomah County. In addition, I served as PTA President at Portland Public Schools – Abernethy Elementary School, Hosford Middle School, and Cleveland High School.

3. I submit this declaration in connection with the above-captioned matter. I have personal knowledge of the matters set forth below, or with respect to the matters for which I do not have personal knowledge, I have reviewed information gathered from the Oregon Department of Human Services' (ODHS's) records by others within the organization.

4. In Oregon, ODHS supports medically accurate and complete, age-appropriate educational programming to Oregonians ages 10-19 that is focused on avoiding non-marital sexual activity with the goals of reducing pregnancy, HIV and other sexually transmitted infections (STIs), and birth rates among teens. By extension, reducing teen pregnancy advances ODHS's related goal of reducing poverty, as teen parents are more likely to enter or remain in poverty. Moreover, ODHS's focus is on ensuring youth understand consent, bodily autonomy, and healthy relationships. That understanding helps young Oregonians identify and prevent sexual abuse, relationship abuse, and suicide. With Title V SRAE funding, ODHS provides this education to youth at nineteen school districts, two education service districts, and local public health authorities. Last year, across the State, 3,402 youth were served by the programs we implemented with Title V SRAE funding. An additional 1,182 youth received the curriculum whose creation was funded in part by the Title V SRAE grant.

5. In applying for Title V SRAE grants, ODHS has complied with the program's application requirements, which include assurances that programming is evidence-informed, medically accurate, age-appropriate, and culturally appropriate, and recognizes the experiences of youth from diverse communities, backgrounds, and experiences. The programming focuses on normalizing the optimal health behavior of avoiding non-marital sexual activity and teaching

personal responsibility, self-regulation, goal-setting, healthy decision-making, healthy relationships, and other topics, as described in 42 U.S.C. § 710(b)(3). In its grant applications, ODHS also demonstrates how Oregon uses positive youth development principles when offering trauma-informed prevention programming. Federal officials most recently conducted a site monitoring visit of Oregon's SRAE-funded program, My Future My Choice (MFMC), on January 21–23, 2025. The report from that site visit rated MFMC's curriculum as outstanding and recommended that ODHS seek out opportunities to publish or present on its curriculum, including at national conferences. The Site Monitoring Visit Report is attached as **Exhibit 1**.

Federal Funding Relied on by ODHS

6. In 2018, Oregon submitted a Title V SRAE grant application in response to ACF's Funding Opportunity Announcement (FOA). At least annually since then, Oregon has submitted either a letter of intent or an updated state plan regarding that funding. ACF extends funding to grantees for two-year grant terms, resulting in overlapping awards. Oregon has received these funds since 1996.[1] The most recent state plan is attached as **Exhibit 2**.

7. ACF has issued to ODHS two currently active Title V SRAE awards: one covers the period from October 1, 2023, through September 30, 2025; the other covers the period from October 1, 2024, through September 30, 2026. For the most recent award, ACF is providing $566,885 in Title V SRAE funding to Oregon.

8. ACF disburses Title V SRAE funding as reimbursements are requested by ODHS. Reimbursable expenses are accrued throughout the year.

9. Oregon has well-established partnerships with the subgrantees of its Title V SRAE awards, who are school districts, education service districts, and local public health authorities.

[1] From 1996 until 2018, SRAE was known as the Title V Abstinence Education Grant Program.

Oregon has worked with these subgrantees to train, provide technical assistance to, and consult with teachers and peer educators so they have the tools and information necessary to teach sex education and personal responsibility to high-risk students. Title V SRAE funding also helps ODHS develop the curriculum and supplemental materials used by those subgrantees. The curriculum, which was reviewed and deemed "outstanding" by ACF reviewers, includes information about gender identity, and teaches an inclusive approach to the topic of gender.

Communications from Federal Government

10. On or around August 20, 2025, ODHS received a Notice of Award (NOA) dated August 6, 2025, describing the financial information associated with Oregon's Title V SRAE grant award funds. The NOA states, "[t]he use of Federal funds from this award constitutes the grantee's acceptance of the listed terms and conditions." In the Remarks section, the NOA states, "Recipients are prohibited from including gender ideology in any program or service that is funded with this award." The Terms and Conditions section states, in part, "[t]he 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." The NOA is attached as **Exhibit 3**.

11. On August 7, 2025, ACF published Supplemental T&Cs applicable to Title V SRAE awards and award modifications that add funding. The Supplemental T&Cs prohibit grant

recipients from including so-called "gender ideology" in Title V SRAE-funded programs and services. Per ACF's notice, these Supplemental T&Cs are effective immediately. ODHS was notified of the Supplemental T&Cs by an email that also attached the August 2025 NOA. The email is attached as **Exhibit 4**.

Harms to Oregon

12. Oregon is currently and will continue to experience harm as a result of the NOA and the Supplemental T&Cs. The NOA and Supplemental T&Cs have created immense confusion for our agency and partners. Our agency's ability to plan for the future is severely negatively impacted. For example, our Title V SRAE grant covers the salary and benefits equivalent to 4.75 full-time employees at ODHS. With the uncertainty of the Title V SRAE grant's continuation, our agency is being forced to contemplate terminating or reducing the hours of valuable employees whose positions are funded by the grant. Without SRAE funding, ODHS would also be unable to provide trainings for teachers and peer educators and update its program materials to ensure medical accuracy. And without Title V SRAE funding, our subgrantees would themselves lose funding that they use for full or part-time positions, training, and other functions related to implementing the MFMC program.

13. The impact of a disruption in funds would be devastating to the program. Given my experience, without the continued and uninterrupted funding of Title V SRAE grants, ODHS and its partners will not be as effective in administering and providing age-appropriate and medically accurate education to youth who are at particular risk of pregnancy, HIV and other STIs, sexual abuse, relationship abuse, and suicide. As a result, youth in Oregon, especially high-risk youth, will suffer.

14. Conversely, changing the approach in the curriculum would be time-consuming, expensive, and at odds with Oregon's approach to gender identity in its sexual health education. Should a new curriculum be required, the MFMC program would need to hire an external contractor to produce the updated curriculum, send the curriculum through a design process to match current formatting, review the curriculum to align with ADA compliance and produce a newly translated version. New curriculum materials would need to be printed and shipped to grantees across the state. Training models would need to be changed to match the updated curriculum, and the curriculum would no longer comply with sexual health state standards.

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

Executed on September 24, 2025, at New York, New York.

s/ William Baney
WILLIAM BANEY
Design and Implementation Manager for the
Oregon Department of Human Services (ODHS) –
Self Sufficiency Programs.

Exhibit 1

Adolescent Pregnancy Prevention Program

Site Monitoring Visit Report

Oregon Department of Human Services
Sexual Risk Avoidance Education (SRAE) Program

U.S. Department of Health and Human Services
Administration for Children and Families ● Administration on Children, Youth and Families Family and Youth Services Bureau
Division of Positive Youth Development

PERSONAL RESPONSIBILITY EDUCATION PROGRAM

SEXUAL RISK AVOIDANCE EDUCATION PROGRAM

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth, and Families
Family and Youth Services Bureau
Site Monitoring Visit Information

Grantee name: Oregon Department of Human Services

Grant number: 2503ORSRAE

Grant year: 1

Site monitoring visit team members/affiliations:

Nakia Martin-Wright, MS, CHES, Family and Youth Services Bureau (FYSB) Federal Project Officer (FPO)

Andrea Vazzano, MPH, Child Trends, Technical Assistance (TA) Provider

Dates of site monitoring visit: January 21, 2025 – January 23, 2025

Type of visit conducted: ☒ **Virtual** ☐ **In Person**

Sites visited: N/A

Documentation gathered/reviewed prior to or during site visit:

1. Administration
    - Advisory Group description
    - Teen Advisory Board Charter
    - Program description
    - My Future My Choice Organizational Chart
    - Resumes for: Elizabeth Sampedro/My Future My Choice (MFMC) Team Lead, Leah Haas/MFMC Program Analyst, Andy Dettinger/MFMC Program Analyst,

Austin Lea/MFMC-GD SRAE Program Analyst, Dhyana Nesler-Perez/MFMC-GD SRAE Program Analyst
- Job description for Program Analyst
- State Plan

2. Collaboration, Partnership, & Referral Sources
   - Program Description
   - MFMC Collaborations and Partnerships
   - Referral Sources
   - Letters of Support from Oregon Department of Education (ODE) and Oregon Health Authority (OHA)
3. Quality Improvement, Internal Assessment
   - List of contract losses and lesson opt-outs
   - 2012 report from pilot evaluation of MFMC
   - 2015 report from evaluation of Teen Leader and Teen Advisory Board programs
   - 2018 report from implementation evaluation of MFMC
   - Select site implementation plans
   - Teen Advisory Board (TAB) member feedback on lesson 5
   - Teen Leader Trainings Post Evaluations from 2023-2024
4. Participation, Recruitment, & Retention
   - Incentive structure and plan
   - Recruitment plan (general – not subgrantee specific)
   - Retention plan (general – not subgrantee specific)
   - Program supports for non-grantees
   - Guide for TAB
   - Stipend structure for TAB
5. Staffing, Staff Development
   - Oregon Department of Human Services (ODHS) Self Sufficiency Programs New Employee Orientation
   - List of Professional Development (PD) events offered by MFMC
   - List of PD events attended by staff recently
6. Curriculum Features
   - Links to MFMC Curriculum Materials → Overview, curriculum and materials, medical accuracy updates, resources
   - Table describing A-F in Curriculum
7. Fidelity, Fidelity Monitoring
   - Tracking sheet for grant monitoring meetings for each grantee
   - Rubric for MFMC Curriculum Adaptations
8. Data Collection
   - Letter of Determination from Institutional Review Board (IRB; does not qualify as human subjects)
   - IRB Submission form
   - Letter to all subgrantees on survey compliance
   - Performance Measure submission protocol
9. Research & Evaluation
   - MFMC Program logic model
   - 2012 report from pilot evaluation of MFMC
   - 2015 report from evaluation of Teen Leader and TAB programs
   - 2018 report from implementation evaluation of MFMC
10. Sustainability

- MFMC Sustainability Plan

11. Fiscal Management
    - Link to Oregon State policies and procedures for monitoring grant spending
    - Proof of submission of financial reports
    - Two examples of Monthly Expenditure Reports

Number of staff members Interviewed at main grantee organization:

- William Baney, Human Services Manager
- Elizabeth Sampedro, MFMC Team Lead
- Leah Haas, MFMC Program Analyst
- Andy Dettinger, MFMC Program Analyst
- Austin Lea, MFMC/GD SRAE Program Analyst
- Dhyana Nesler-Perez, MFMC/GD SRAE Program Analyst
- Fiscal Agent/Budget team: Vera Fuller, Katie Edwards, Alanna Bailey-Kelly
- **Partner 1:** Sasha Grenier, ODE (collaborator/trainer and Advisory Group members)
- **Partner 2:** Lindsay Weaver and Margaux Cameron, OHA (collaborator and Advisory Group members)
- **Partner 3:** Brylee Kiminski, Intern
- **Partner 4:** Eli Cox, Teen Advisor Board mentor
- **Partner 5:** Kris Gowen, Advisory Group member and former evaluator

Number of staff interviewed at each subrecipient organization:

- **Subrecipient 1:** Nicole Pierce**,** Jefferson County Health Department
- **Subrecipient 2:** Carolina Guerrero-Lara, Clatsop County

Number of project participants interviewed: 1

Number of project sessions observed: 1

1. Administration

How effective is the grantee's/subrecipient(s)' administration in supporting the implementation of quality services to participants?

☐ **Outstanding** ☒ **Satisfactory** ☐ **Needs Support**

A.	**Has a clear and functional governance structure with detailed descriptions of the roles and responsibilities for key staff members. .....**	☒ **Yes**	☐ **No**	☐ **N/A**
B.	**Has a clearly defined procedure for monitoring subrecipient and/or program implementation across the catchment area which may include regular visits to all subrecipients' implementation sites… .....**	☐ **Yes**	☒ **No**	☐ **N/A**
C.	**Has a clear procedure for providing programmatic and fiscal supervision of subrecipient(s) .....**	☐ **Yes**	☒ **No**	☐ **N/A**
D.	**Has policies and procedures to address potential controversy, such as negative community reaction and/or laws and policies adversely impacting programming .....**	☒ **Yes**	☐ **No**	☐ **N/A**
E.	**Administrators are routinely involved in decisions to make modifications to project to ensure conformance with program requirements .....**	☒ **Yes**	☐ **No**	☐ **N/A**
F.	**Demonstrated capacity to manage challenges with administration .....**	☒ **Yes**	☐ **No**	☐ **N/A**

Evidence reviewed to assess administration (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the State Plan, program description, Advisory Group description, TAB Charter, MFMC Organizational Chart, Opening Presentation, job descriptions, and resumes. Interviews were conducted with Human Services Manager William Barney and Team Lead Elizabeth Sampedro.

Summary/observations of grantee activities:

ODHS implements the MFMC program with 10 subrecipients across the state; 3,557 students received the program in 2023–2024. In addition to managing subgrantees, ODHS works with partners to train teachers and Teen Leaders to deliver MFMC and convenes a statewide TAB and a statewide expert Advisory Group.

The ODHS is well-organized to support program implementation and decision-making for MFMC. This grantee also serves multiple funding streams, which are identified throughout this report. However, for this report we will focus on the Title V State SRAE programming. The two Program Analysts and one Team Lead of this program report to a Human Services Manager, who also oversees two Program Analysts funded under the GD SRAE grant; these teams work together to ensure cross-learning. For the State SRAE grant, each team member oversees a portfolio of subrecipient sites. The Team Lead holds weekly meetings with the Program Analysts to remain up to date on program implementation and remains in regular communication with the Human Services Manager. The full team holds full-day planning meetings on a quarterly basis to allow adequate time to discuss plans and improvements. The team has a strong rapport, with each member quick to point out the skills and value of other team members. The Human Services Manager and Team Lead meet monthly with the fiscal team help to ensure that funds are being spent appropriately.

All subgrantees receive a subgrant agreement (called a program description) from their state contact that includes language about requirements. For example, they must submit a budget and spending plan. In addition, they must reach out to ODHS in writing to make any modifications. Each subgrantee site receives at least one site visit, where they review requirements, budgets, allowable program expenses, and data collection. ODHS staff monitor subgrantees through virtual/phone check-ins conducted at least quarterly, if not more depending on support needed. The grantee stressed that they take a personalized approach to managing subrecipients and that management looks different for each grantee. We were unable to confirm standardized, clearly defined procedures for monitoring implementation and fiscal supervision; no standard monitoring manual or written protocol were provided.

For misinformation and controversies, ODHS staff work in close collaboration with their central office and press secretary. If they receive questions or hear of controversy, they make sure that central office is aware of what is happening. There is procedure within the state to escalate certain things up to the press secretary and collect documentation.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

The Site Monitoring Visit (SMV) team was unable to confirm standardized, clearly defined procedures for monitoring subrecipient or program implementation and providing programmatic and fiscal supervision of subrecipient(s). According to the Notice of Funding Opportunity (NOFO), each grantee is required to have these procedures in place. We appreciate that the team aims to be flexible and tailored for each subrecipient; however, we recommend that they establish and document core steps for monitoring implementation and financials to ensure integrity of program monitoring.

General recommendations:

None identified.

2. Collaboration/Partnerships/Referral Sources

How effective is the grantee's collaboration with subrecipient(s), other community partners, and referral resources in developing, coordinating, and supporting the implementation of quality services to participants?

☐ **Outstanding** ☒ **Satisfactory** ☐ **Needs Support**

A. Signed memorandum of understanding (MOU) or other official agreement with each subrecipient/partner, including information gathering on the level of routine reporting on the status of project related activities	☒ **Yes**	☐ **No**	☐ **N/A**
B. Appropriate referral sources identified for health and social services	☒ **Yes**	☐ **No**	☐ **N/A**
C. Has a list of referral sources and a method for linking youth and/or parents	☐ **Yes**	☒ **No**	☐ **N/A**
D. [For SRAE grantees only] How does the grantee ensure referral services that are youth-friendly and do not normalize teen sexual activity?	☐ **Yes**	☒ **No**	☐ **N/A**
E. Demonstrated capacity to manage challenges with establishing and maintaining collaborations/partnership/referral sources	☒ **Yes**	☐ **No**	☐ **N/A**
F. Has a process to include youth feedback on partners and referral sources	☒ **Yes**	☐ **No**	☐ **N/A**

Evidence reviewed to assess collaboration/partnerships/referral sources (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the program description, MFMC Collaborations and Partnerships, Referral Sources, and Letters of Support from ODE and OHA. Interviews were conducted with Human Services Manager William Barney, Team Lead Elizabeth Sampedro,

partners from ODE and OHA who serve on the Advisory Group, TAB mentor Eli Cox, and Intern Brylee Kiminski.

Summary/observations of grantee activities:

ODHS has spent years building strong relationships within the state. The team reports using proactive and creative strategies to build and maintain these relationships and partnerships. These strategies include convening a statewide Advisory Group to inform curriculum content and program implementation that meets quarterly; holding regular meetings with other state agencies that do similar programming to troubleshoot and collaborate; forging relationships with non-contracted entities interested in implementing MFMC in the future, providing ad hoc support to these entities as capacity allows; working with the local school of public health to take on interns to support better data analysis and use; and running a TAB to ensure active partnership with youth in the state. Meetings with subgrantees also pointed to positive relationships with subgrantee contacts.

The TAB provides ODHS with a clear and comprehensive means of receiving feedback on current partnerships or referral sources. In addition, the TAB is working on a community resource mapping project this year. Each member is currently looking into the resources that exist in their areas, and the hope is to map these services and provide the map to subgrantees.

As a state agency, ODHS provides referrals, which they ensure are youth-friendly. However, they do not currently have a system to ensure these services do not normalize teen sexual activity. In addition, they do not currently have a requirement or system for subgrantees to track referrals and follow-ups.

Promising practices identified:

ODHS has had many successes building state, local, and youth partnerships. Interviews with partners and subrecipients confirmed that ODHS and MFMC are a strong and well-regarded presence in the state. Particularly promising practices include the following:

- Maintaining a statewide Advisory Group to inform curriculum content and program implementation.
- Building a TAB into their program model, which ensures active partnership with youth in the state. The TAB is an opportunity for Teen Leaders involved in MFMC to develop leadership skills and act as the youth voice of the program. TAB members work with a local mentor to carry out a leadership project over the school year as well as provide program feedback.
- Conducting outreach and providing ad hoc assistance to non-grantee organizations that may be interested in exploring implementing MFMC. This practice expands the reach of the MFMC curriculum and plants seeds for subgrantee partnerships down the road.

- Holding regular meetings with other state agencies to collaborate. This includes meeting with OHA, which administers a State Personal Responsibility Education Program (PREP) grant. These two agencies aim to complement each other to fill gaps; MFMC focuses SRAE programming on middle schools, whereas OHA focuses on PREP programming for older youth. As one example of their collaborative relationship, they pooled participant data from their respective sites and looked at the data collectively. This exercise also led to one agency sharing code with the other agency to help them better manage their data.

Conformance issues identified and recommended solutions:

The team does not currently maintain a formal tracking and follow-up system for referrals or a process for ensuring referrals do not normalize teen sexual activity, at either the state or subgrantee level. It is required according to the NOFO that the grantee establish a tracking system for internal and external referrals and to ensure referrals do not normalize teen sexual activity. We recommend that the team establish a simple but effective system for each of these items that can be replicated across subgrantee sites. Were it not for this omission, the grantee would be marked as “Outstanding” in this category.

General recommendations:

The SMV team recommends that ODHS consider publishing or presenting on the promising practices identified, particularly the TAB and collaborative relationships with other state agencies. We believe other State SRAE grantees could benefit from learning about these successful efforts.

3. <u>Quality Improvement/Internal Assessment</u>

How effective is the grantee's/subrecipient(s)’ internal assessment in supporting the implementation of quality services to participants?

☒ **Outstanding** ☐ **Satisfactory** ☐ **Needs Support**

A. Adequate process to assess the effectiveness of program implementation	☒ **Yes**	☐ **No**	☐ **N/A**
B. Feedback regularly sought from staff regarding program implementation	☒ **Yes**	☐ **No**	☐ **N/A**
C. Feedback used to make changes to the project	☒ **Yes**	☐ **No**	☐ **N/A**
D. Effectively and consistently engages youth and families in program improvement	☒ **Yes**	☐ **No**	☐ **N/A**
E. Process for ensuring that changes made to program are in keeping with fidelity requirements	☐ **Yes**	☒ **No**	☐ **N/A**

F. Demonstrated capacity to manage challenges with quality improvement/internal assessment ..... ☒ Yes ☐ No ☐ N/A

Evidence reviewed to assess quality improvement and internal assessment (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the list of contract losses and lesson opt-outs, 2012 report from pilot evaluation of MFMC, 2015 report from evaluation of Teen Leader and Teen Advisory Board programs, 2018 report from implementation evaluation of MFMC, Select site implementation plans, TAB member feedback on lesson 5, Teen Leader Trainings Post Evaluations from 2023-2024, rubric for MFMC curriculum adaptations. Interviews were conducted with Team Lead Elizabeth Sampedro and Intern Brylee Kiminski

Summary/observations of grantee activities:

Program implementation at the state level is monitored via weekly meetings, which also provide an opportunity for team members to offer feedback on how things are going. Program implementation at the site level is monitored via quarterly calls and site visits, which are conducted by state staff at least once per cohort.

Student feedback is collected throughout the program as well as through an anonymous box in the classroom for students to submit questions or concerns. Students also complete a survey at the end of the program, with questions asking what they liked or did not like about the program. These questions are in addition to the required performance measures survey and are preceded by the appropriate language to indicate to students that these questions will not be reported to FYSB. One subrecipient also described meetings with teachers and school counselors to discuss the feedback they have received from students.

ODHS works closely with the TAB to collect data and help monitor/improve the project. Because TAB members are also Teen Leaders, they are often engaged by the program team to discuss the curriculum and homework assignments. They complete feedback forms to talk about the curriculum flow and how things could be made clearer. One team member reported that lesson 7 on healthy and unhealthy relationships was “completely rewritten by the TAB.” TAB also conduct data collection activities; they are currently interviewing students within their counties/regions;a local MPH student from University of Washington plans to summarize findings from these interviews to inform programming.

Currently, there is no formal process for ensuring that changes made to the program keep with fidelity requirements, though subrecipients are directed to reach out to ODHS staff to make modifications. However, the team recently developed a detailed rubric for MFMC curriculum adaptations. The rubric outlines common types of curriculum adaptations that school districts or individual sites may make and identifies which changes alter a lessons’ compliance with the MFMC program requirements and with Oregon State Sexuality Education Standards. Although the document has not yet been implemented, it appears it will helpful moving forward.

Promising practices identified:

The partnership with the MPH program at the University of Washington is a promising practice. Many grantees have noted that it is not always feasible to hire an outside evaluator; however, partnering with a local school for a practicum is a smart, mutually beneficial solution. Through this partnership, ODHS's intern was able to create data profiles for various schools/districts using participation data from 2018–2024. She was able to identify important trends that have been discussed by the broader team, such as overall participation, number of Teen Leaders trained, opt-out trends, and total available lessons delivered, which she will soon be presenting to the full team for discussion.

Conformance issues identified and recommended solutions:

ODHS did not report a formal process for ensuring that changes made to the program are in keeping with fidelity requirements. The SMV team recommends that this process be documented, as stipulated in the NOFO. Because this is underway with the rubric for MFMC curriculum adaptations and all other criteria are met, the grantee is still marked as "Outstanding" in this category. We also recommend continuing to move forward with a clear, written process for ensuring that changes made to the program keep with fidelity requirements.

General recommendations:

None identified.

4. <u>Participant Recruitment and Retention</u>

How effective is the grantee's recruitment and retention of program participants?

☐ **Outstanding** ☐ **Satisfactory** ☒ **Needs Support**

A.	**Clearly defined eligibility requirements ... .**	☒ **Yes**	☐ **No**	☐ **N/A**
B.	**Services targeted to vulnerable youth populations, including but not limited to, youth living in under resourced regions and areas with high rates of teen births and STIs, youth in or aging out of foster care or adjudication systems, youth who are victims of trafficking, runaway and homeless youth, and other vulnerable populations.....**	☒ **Yes**	☐ **No**	☐ **N/A**
C.	**Have a written plan for effective participant recruitment and retention that includes specific tasks/activities.....**	☐ **Yes**	☒ **No**	☐ **N/A**

D. Have a written plan for effectively, consistently, and supportively engaging youth participants in specific tasks/activities intended for each population they proposed to serve….. ☒ **Yes** ☐ **No** ☐ **N/A**

E. Reasons for participant dropout are documented..... ☐ **Yes** ☒ **No** ☐ **N/A**

F. Adequate recruitment/retention plan ..... ☐ **Yes** ☒ **No** ☐ **N/A**

G. Plan to monitor effectiveness of recruitment/retention strategies, to include at least 75% participation by youth enrolled in the project..... ☐ **Yes** ☒ **No** ☐ **N/A**

H. Plan to monitor effectiveness of participant recruitment and retention ..... ☐ **Yes** ☒ **No** ☐ **N/A**

I. Plan includes program participant feedback on improving recruitment and retention strategies ..... ☐ **Yes** ☒ **No** ☐ **N/A**

J. Demonstrated capacity to manage recruitment/retention challenges ..... ☒ **Yes** ☐ **No** ☐ **N/A**

Evidence reviewed to assess participant recruitment and retention (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the State Plan, Incentive structure and plan, Recruitment plan (general – not subgrantee specific), retention plan (general – not subgrantee-specific), Program supports for non-grantees, Guide for TAB, and Stipend structure for TAB. Interviews were conducted with Team Lead Elizabeth Sampedro and Subrecipient Nicole Pierce of Jefferson County Health Department.

Summary/observations of grantee activities

MFMC focuses on 6th and 7th grade students statewide, before they typically become sexually active.. The program is implemented in middle school classrooms, a model that enables them to reach multiple vulnerable populations within the target age group, including youth in foster care, youth living in areas with high rates of STIs, youth living in rural or frontier areas of the state, and youth from culturally underrepresented groups.

This program requires recruitment and retention at multiple levels: ODHS recruitment of schools/sites; subgrantee/school recruitment of middle school participants; subgrantee/school recruitment of Teen Leaders from high schools; and ODHS recruitment of TAB members. The ODHS State Plan, Recruitment Plan, and retention plan indicate who is responsible for which level of recruitment/retention but do not offer specific tasks/activities. For example, plans say that recruitment for Teen Leaders should strive to be reflective of the school community but do not offer strategies for doing so.

In her interview, one subgrantee noted that there is no written plan at the subgrantee level for middle school and Teen Leader recruitment because it varies according to what the school will allow. She explained that "we need to be flexible and work with the needs of the school." ODHS and subgrantee staff also explained that the retention plan for middle school students is limited because implementation happens in school during regularly scheduled classes. The subgrantee said that the teacher does track attendance and who opts out of the program, though they do not document reasons for dropout. The documentation that they do have is given to the subgrantee at the end of the program, who then submits this to ODHS. To our knowledge, there is no specific plan to monitor recruitment and retention, though some ad hoc data collection and analyses have been completed in the past (e.g., focus groups exploring recruitment strategies for the TAB).

Promising practices identified:

The subrecipient mentioned two promising practices in recruiting Teen Leaders. First, the subrecipient has found that she has good luck recruiting from leadership classes or clubs within the schools. Second, the subgrantee mentioned that the county maintains their own youth advisory board. This board, which is separate from the ODHS TAB, helps the county with implementation, and youth are often interested in serving on their board and as a Teen Leader.

Conformance issues identified and recommended solutions:

We appreciate that recruitment needs to be flexible for subgrantees. However, the SMV team recommends that ODHS create a recruitment and retention plan that has specific tasks/activities, which subgrantees can tailor to their context. We also recommend that this plan have the required elements from the NOFO, including a plan to monitor effectiveness of recruitment/retention strategies, a plan to gather participant feedback on improving recruitment and retention strategies, and a plan to document reasons for dropout.

General recommendations:

No additional recommendations.

5. <u>Staffing/Staff Development</u>

How effective is the grantee's hiring and training program in supporting implementation of quality services to participants?

☒ **Outstanding** ☐ **Satisfactory** ☐ **Needs Support**

A. Verified that all project staff (including subrecipient staff) meet eligibility requirements, including background checks ..... ☒ Yes ☐ No ☐ N/A

B. Grantee-level staffing appears to be adequate for program oversight ☒ Yes ☐ No ☐ N/A

C. Sufficient number of educators to meet program delivery needs (e.g., what is the educator/facilitator to youth ratio?) ☒ Yes ☐ No ☐ N/A

D. Training plan, training calendar, and tracking system are in place to ensure all staff members (including subrecipient staff) have training and materials needed to implement the program ☒ Yes ☐ No ☐ N/A

E. Refresher trainings are part of the training plan ☒ Yes ☐ No ☐ N/A

F. Ongoing training topics/sessions are available to provide staff with information related to required program topics and the social, physical, and emotional development and well-being of youth ☒ Yes ☐ No ☐ N/A

G. Training provided on trauma-informed practices ☒ Yes ☐ No ☐ N/A

H. Has a plan for effectively engaging past youth participants when possible (e.g. guest speaker, role modeling, community organization connector, facilitator) ☒ Yes ☐ No ☐ N/A

I. Demonstrated capacity to manage challenges with staffing/staff development ☒ Yes ☐ No ☐ N/A

Evidence reviewed to assess staffing/staff development (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the ODHS Self Sufficiency Programs New Employee Orientation, List of PD offered by MFMC, and List of PD events attended by staff recently. Interviews were conducted with Human Services Manager William Barney and Team Lead Elizabeth Sampedro.

Summary/observations of grantee activities:

The ODHS has a strong onboarding, training, and staff development process. Upon hire, all employees participate in a newly created onboarding training to familiarize them with the program and agency. This onboarding was created because leadership noted that new staff had strong experience and knowledge but were new to non-advocacy roles and implementing programming at a state agency. ODHS offers access to a range of PD events and courses. Internal trainings are tracked within the state's Workday system; external events and trainings are recorded in a running log. Notably, ODHS is very clearly committed

to personal and professional development in staff. The Human Services Manager meets one-on-one with each member of the team monthly, providing dedicated time for team members to discuss PD needs, career paths, and any other issues.

Training requirements in the curriculum are clearly outlined for subrecipients in the program description. All Classroom Facilitators are required to attend an in-person or virtual training. Refresher trainings are required after a major revision such as adding or removing lesson content, introducing new activities, worksheets, supporting laminated materials or PowerPoints, and other major changes as defined by MFMC Staff. Teen Leaders are required to attend a one-day annual in-person training or 2-day virtual training provided by ODHS; those who have been trained previously can attend a shorter Alumni Teen Leader Training.

The MFMC effectively engages past youth participants, when possible, most notably through the Teen Leader model and the TAB. Teen Leaders are high school students from across the state who co-teach five of the 10 MFMC lessons. TAB members are current or former Teen Leaders who want to develop leadership skills and act as the youth voice of the program. TAB members work with a local mentor to carry out a leadership project over the school year as well as provide program feedback.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

None identified.

General recommendations:

None identified.

6. <u>Curriculum Features</u>

Curriculum 1 (enter title): My Future, My Choice

How effective is the grantee/subrecipient(s) in implementing a curriculum that addresses the age-related and culturally specific needs of the population(s) served?

☒ **Outstanding** ☐ **Satisfactory** ☐ **Needs Support**

A. Rationale/means for ensuring that the curriculum selected is the best fit for the program and in is alignment with needs of the population(s) served and program requirements ..... ☒ Yes ☐ No ☐ N/A

B. The curriculum and supplemental education materials address all program requirements ☒ Yes ☐ No ☐ N/A

C. The curriculum uses or substantially incorporates an evidence-based or evidence-informed programming ☒ Yes ☐ No ☐ N/A

D. Curriculum has been reviewed for medical accuracy and completeness of information ☒ Yes ☐ No ☐ N/A

E. Curriculum and supplemental materials incorporate positive youth development and trauma-informed approaches, including addressing risk and protective factors, as part of the sexual risk avoidance or personal responsibility education strategy ☒ Yes ☐ No ☐ N/A

F. Has a process or strategies for increasing youth participation and/or stimulating engagement during periods of waning interest (e.g., unrelated, fun activities to allow participants to rest and refocus) ☒ Yes ☐ No ☐ N/A

G. Has a plan for identifying and assisting youth who, based on a perceived lack of understanding or engagement with the program, may require additional assistance and support to facilitate understanding ☒ Yes ☐ No ☐ N/A

H. Has a process for allowing youth to reflect on program activities and curriculum content that they learn throughout the program ☒ Yes ☐ No ☐ N/A

I. Has a plan for encouraging youth to consider ways to apply what they learn during the sessions or share their learnings with friends/peers ☒ Yes ☐ No ☐ N/A

J. [For Title V State and Competitive grantees only] Curriculum ensures the unambiguous and primary emphasis and context for each of the six required topics that do not normalize teen sexual activity ☒ Yes ☐ No ☐ N/A

K. [For PREP Grantees Only] Addresses abstinence, contraception, responsibilities and consequences of parenting, and risks of STD/HIV and includes at least three adult preparation subjects ☐ Yes ☐ No ☒ N/A

L. [For SRAE Grantees only] provides information on contraception that is medically accurate and complete, conveys the message that contraception offers physical risk reduction, and not risk elimination, and is free of demonstrations, simulations, or distribution of contraceptive devices ☒ **Yes** ☐ **No** ☐ **N/A**

Evidence reviewed to assess curriculum features (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the MFMC Curriculum Materials from website (Overview, Classroom Guide Lessons 1-10, Lessons 1-10, 2024 Medical Accuracy Update Summary), and table describing A-F in Curriculum. Interviews were conducted with Team Lead Elizabeth Sampedro, Program Analyst Leah Haas, and Subrecipient Carolina Guerrero-Lara

Summary/observations of grantee activities:

MFMC is a comprehensive, medically accurate, and trauma-informed sexuality education curriculum for middle schoolers. It was developed by ODHS, piloted in 2012, and has been continuously improved since then. For example, it has grown from five to 10 lessons. It has been through Medical Accuracy Review in its current form. Importantly, MFMC is the only curriculum that meets the 6th grade requirements of Oregon's Health Education Standards, making it especially well-suited for Oregon schools.

MFMC provides middle school students with tools to have healthy relationships that includes setting and respecting personal boundaries and treating each other with respect and dignity. It offers skills to resist peer and social pressure, including messages from the media and teaches students how to prevent sexually transmitted infections and pregnancy. When feasible, and in line with its Positive Youth Development (PYD) approach, MFMC trains high school Teen Leaders across Oregon to deliver half of the curriculum; usually one to two Teen Leaders are assigned to each class. Teen Leaders act as role models to middle school students and improve the classroom experience. These Teen Leaders also have the opportunity to act as members of the TAB.

Subgrantees praised the curriculum's ability to fulfill Oregon Department of Health standards. One said, "That's usually what schools reach out for. This curriculum is great because it indicates which lesson meets which requirements." Subgrantees also praised youth-friendly elements such as activities that give youth a chance to hear from other peers. They especially praised the Teen Leader model, noting that Teen Leaders "take things to the next level – [students] pay more attention to them than to [an adult]." This was echoed in interviews with a Teen Leader and TAB member, who said "Grown-ups don't understand what middles schoolers are going through. [But] middle schoolers look up to the high

schoolers, they feel like they understand them. I've had a couple middle schoolers tell me about what's happening in their life because they don't want to talk to an adult."

Promising practices identified:

The Teen Leader model is an impressive and promising practice, as it builds leadership through principles of PYD while also reportedly increasing program engagement. The Teen Leader and TAB member said, "I would recommend the [Teen Leader] program if you…want to change how middle schoolers experience the world. You can change a middle schooler's life."

Conformance issues identified and recommended solutions:

None identified.

General recommendations:

The SMV recommends this grantee seek opportunities to further evaluate and publish or present on this curriculum. We particularly feel that the Teen Leader model will be of great interest to other FYSB grantees whose programs follow a Peer Educator/Teen Leader model, or for those who are interested in adopting this model. Presenting at events such as the Adolescent Pregnancy Prevention (APP) conference would provide other FYSB grantees an opportunity to learn more about the successes and challenges of a thriving program that could serve as a model for their own. Including evaluation data in presentations and publications would further demonstrate the value of this program.

6. Fidelity/Fidelity Monitoring

How effective are the grantee's/subrecipient(s)' efforts to monitor, track, and improve upon fidelity in ongoing program delivery?

☐ **Outstanding** ☐ **Satisfactory** ☒ **Needs Support**

A. Written plan to conduct fidelity monitoring.....	☐ **Yes**	☒ **No**	☐ **N/A**
B. Have a process to routinely involve youth in modifications to program activities to make them more meaningful and relatable while maintaining fidelity	☒ **Yes**	☐ **No**	☐ **N/A**
C. Is there a tracking system to ensure fidelity monitoring occurs as planned.....	☐ **Yes**	☒ **No**	☐ **N/A**
D. Facilitators/educators complete a fidelity log after each session.....	☐ **Yes**	☒ **No**	☐ **N/A**

E. Facilitation sessions are regularly observed to assess curricula/model fidelity ..... ☐ Yes ☒ No ☐ N/A

F. Training in fidelity and fidelity monitoring provided to all appropriate program staff and facilitators ..... ☒ Yes ☐ No ☐ N/A

G. Fidelity monitoring tools ask facilitators to document deviations from the program model and reasons for deviations ..... ☐ Yes ☒ No ☐ N/A

H. All red-light adaptations approved by grantee's project officer and model developer ..... ☒ Yes ☐ No ☐ N/A

I. Based on an indicated need for improvement, data have been used to enhance program performance ..... ☒ Yes ☐ No ☐ N/A

J. Timely feedback about program fidelity provided to program staff and facilitators ..... ☐ Yes ☒ No ☐ N/A

K. Demonstrated capacity to manage challenges with fidelity/fidelity monitoring ..... ☐ Yes ☒ No ☐ N/A

Evidence reviewed to assess fidelity/fidelity monitoring (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the tracking sheet for grant monitoring meetings for each grantee and rubric for MFMC curriculum adaptations. Interviews were conducted with Team Lead Elizabeth Sampedro and Program Analyst Leah Haas.

Summary/observations of grantee activities:

Program fidelity is reported to be monitored through grant monitoring meetings between ODHS and subgrantees. Before school begins, ODHS staff review subgrant agreements, roles and responsibilities, Oregon requirements, Title V SRAE grant requirements, and red/yellow/green curriculum adaptations. Ongoing grant monitoring meetings are then held at least quarterly, or more often if needed, to understand what full program implementation looks like. The grantee reports that sites collect data on attendance, number of sessions, and parent opt-outs. However, the SMV team could not verify existence of a written fidelity monitoring plan or running fidelity log.

Fidelity training is reported to be included in the curriculum trainings. The only modifications noted in the curriculum guides are time-saving options. Program staff reported that they do not currently have fidelity monitoring tools such as observation logs to be completed by program coordinators or fidelity logs to be complete by facilitators. ODHS reported that "usually" the subrecipients observe lessons, which are then discussed with state staff in

grantee meetings. However, this process is not standardized, and it is unclear whether and how facilitators receive feedback.

As reported in *Section 3. Quality Improvement/Internal Assessment*, ODHS meaningfully engages youth in program improvement through the TAB. The TAB will often complete feedback forms about the program content and flow, or else conduct surveys or interviews with participants, and this feedback is used for program improvement.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

The SMV team recommends that the grantee take the following steps: (1) establish a written policy for fidelity monitoring at the state and subgrantee levels; (2) require that facilitators complete a simple fidelity log after each session; and (3) require that program coordinators conduct observations using standardized observation tools. It may be helpful to work with your FPO to submit a TA request to assist with this.

General recommendations:

None identified.

7. Data Collection

How effectively is the grantee/subrecipient(s) collecting data to conduct performance management?

☐ **Outstanding** ☒ **Satisfactory** ☐ **Needs Support**

A.	**Has a written plan to conduct and track internal performance measures including the 5 broad classes of measures (Output measures, fidelity/adaptation, implementation, short-term outcome measures, and community data) .....**	☒ **Yes**	☐ **No**	☐ **N/A**
B.	**Submits OMB approved performance measurement data in accordance with FYSB's requirements .....**	☒ **Yes**	☐ **No**	☐ **N/A**
C.	**Reviews performance measure data to ensure continued compliance with approved project plan.....**	☒ **Yes**	☐ **No**	☐ **N/A**
D.	**If necessary, Institutional Review Board (IRB) approvals have been obtained to collect participant data .....**	☒ **Yes**	☐ **No**	☐ **N/A**

E. Demonstrated capacity to manage challenges with data collection ..... ☒ **Yes** ☐ **No** ☐ **N/A**

Evidence reviewed to assess data collection (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the Letter of Determination from IRB, IRB Submission form, Letter to all subgrantees on survey compliance, and performance measure submission protocol. Interviews were conducted with Team Lead Elizabeth Sampedro, Program Analyst Dhyana Nesler-Perez, and Advisory Group member Kris Gowen.

Summary/observations of grantee activities:

According to interviews, data collection and performance measurement are overseen by Kris Gowen (a consultant and Advisory Board Member) and Dhyana Nesler-Perez, a Program Analyst. For performance measures not collected through entry/exit surveys, ODHS team members send out spreadsheets to each subrecipient. Subrecipients then populate these spreadsheets based on data received from teachers. ODHS team members review submitted data to ensure compliance, then send these spreadsheets to Ms. Gowen and Ms. Nesler-Perez for cleaning, collation, and submission.

For performance measures collected entry/exit surveys, ODHS creates electronic links and sends these to subgrantees to share with students before and after the program. ODHS staff report aiming for 70%–90% survey completion. They compare survey responses with data on the spreadsheets populated by subrecipients to check for accuracy and completeness.

All subrecipients are required to submit plans for survey compliance; although we did not see a written plan, we did see the letter sent to subgrantees requesting this plan. ODHS has historically submitted OMB-approved performance measurement data in accordance with FYSB's requirements. The team received an IRB determination letter that concluded the entry and exit surveys did not constitute human subjects research.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

None identified.

General recommendations:

No identified.

8. Research and Evaluation

If the grantee/subrecipient(s) is conducting a local evaluation, has progress been consistent with the approved plan?

☒ **Outstanding** ☐ **Satisfactory** ☐ **Needs Support**

A. Is the logic model utilized to guide the project and have updates have been made since the award of the grant was awarded……..	☒ **Yes**	☐ **No**	☐ **N/A**
B. [If applicable] The grantee's/subrecipients' local evaluation design is one of the following:			
• **Impact Evaluation.....**	☐ **Yes**	☐ **No**	☒ **N/A**
• **Comprehensive needs assessment**	☐ **Yes**	☐ **No**	☒ **N/A**
• **Descriptive study .....**	☐ **Yes**	☐ **No**	☒ **N/A**
C. The plan includes the following:			
• **A logic model .....**	☐ **Yes**	☐ **No**	☒ **N/A**
• **How dosage and reach will be measured .....**	☐ **Yes**	☐ **No**	☒ **N/A**
• **A description of the process for conducting the evaluation (including data collection and analysis methods).....**	☐ **Yes**	☐ **No**	☒ **N/A**
• **Local staff capacity to support evaluation efforts .**	☐ **Yes**	☐ **No**	☒ **N/A**
D. Institutional Review Board (IRB) approvals have been obtained to collect data for the evaluation, if required	☐ **Yes**	☐ **No**	☒ **N/A**
E. Demonstrated capacity to manage challenges with conducting research and evaluation	☐ **Yes**	☐ **No**	☒ **N/A**

Evidence reviewed to assess research and evaluation (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the logic model, 2012 report from pilot evaluation of MFMC, 2015 report from evaluation of Teen Leader and TAB programs, and 2018 report from implementation evaluation of MFMC. Interviews were conducted with Team Lead Elizabeth Sampedro, Program Analyst Dhyana Nesler-Perez, and Advisory Group member Kris Gowen.

Summary/observations of grantee activities:

The grantee is not conducting a local evaluation. However, they work on an ad hoc basis with a research consultant, Kris Gowen, to assist the team with evaluation work. This consultant has in-depth knowledge of the program and has conducted various evaluations of the MFMC curriculum over the past decade. Although there was not room in the budget to conduct a local evaluation for this grant, Ms. Gowen currently assists the team with performance management.

ODHS has a logic model that identifies clear inputs, activities, outputs, and short- and long-term outcomes. The logic model reflects the current version of the program. As described in the previous section, dosage and reach are measured via attendance reports; individual teachers report attendance to subrecipients, who populate ODHS spreadsheets with these data.

Promising practices identified:

None Identified.

Conformance issues identified and recommended solutions:

None Identified.

General recommendations:

We recommend that the grantee update their logic model annually to reflect any changes made to programming inputs, activities, and outputs. This can be done at one of the full-day planning meetings held quarterly.

9. <u>Sustainability</u>

How effective is the grantee's sustainability plan and efforts to continue providing quality services to participants beyond the life of the grant?

☐ **Outstanding** ☒ **Satisfactory** ☐ **Needs Support**

A.	**Has a plan in place for sustaining efforts beyond federal funding .....**	☒ **Yes**	☐ **No**	☐ **N/A**
B.	**Has (or plans to) identified subrecipients or partners that are key for long-term sustainability. Who are the key stakeholders (program champions) for this effort? .....**	☒ **Yes**	☐ **No**	☐ **N/A**
C.	**Has assessed community buy-in for this program. and it is likely that the community will support sustaining the project beyond federal funding .....**	☐ **Yes**	☒ **No**	☐ **N/A**

D. Demonstrated capacity to manage challenges with sustainability planning ..... ☒ Yes ☐ No ☐ N/A

Evidence reviewed to assess sustainability (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the MFMC Sustainability Plan. Interviews were conducted with Human Services Manager William Baney and Team Lead Elizabeth Sampedro.

Summary/observations of grantee activities:

ODHS' sustainability plan highlights aspects of their implementation plan that promote sustainability of MCMF. These include (1) making MFMC curricula and materials available online at no cost to users; (2) partnering with ODE to provide curriculum and skills training to local teachers and county health educators as well as with OHA and ODE to provide skills trainings to health educators and youth-serving professionals so that they are equipped to implement MFMC programming; and (3) exploring partnership opportunities with local organizations to determine whether these organizations could take on MFMC logistics and facilitation. In interviews, the grantee indicated that a loss in federal funding would likely warrant a pivot to a train the trainer model with local program coordinators trained on implementation to continue programming. Local program coordinators have already participated in trainings, making them well-equipped to take on this role. The grantee reported that they have not formally assessed community buy-in. However, they are confident that their subgrantees are champions of the program.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

Although ODHS clearly has very strong subgrantee and community relationships, we recommend that ODHS complete an assessment of community buy-in for MFMC sustainability. This could be done in partnership with the TAB or in collaboration with other state agencies.

General recommendations:

The SMV team recommends ODHS continue to update their sustainability plan, including adding information on a potential pivot to a train the trainer model.

10. Fiscal Management

How effective is the grantee's fiscal management in supporting the implementation of quality services to participants?

☐ **Outstanding** ☒ **Satisfactory** ☐ **Needs Support**

A. Has internal controls and auditing controls to safeguard federal funds and track administrative and programmatic costs/expenditures that are allowable and allocable to the grant	☒ **Yes**	☐ **No**	☐ **N/A**
B. Financial reports are submitted in accordance with requirements set by terms and conditions of awards	☒ **Yes**	☐ **No**	☐ **N/A**
C. Has an appropriate accounting system to track administrative and programmatic costs	☒ **Yes**	☐ **No**	☐ **N/A**
D. Required approvals are requested and obtained before making budgetary and programmatic revisions	☒ **Yes**	☐ **No**	☐ **N/A**
E. Demonstrated capacity to manage challenges with fiscal management	☒ **Yes**	☐ **No**	☐ **N/A**
F. Written policies are in place to monitor subrecipients' fiscal records to ensure their compliance with requirements for pass-through entities according to CFR 200.331	☒ **Yes**	☐ **No**	☐ **N/A**

Evidence reviewed to assess fiscal management (e.g., documents reviewed, staff/participants interviewed):

The site monitoring team reviewed the Oregon State policies and procedures for monitoring grant spending, proof of submission of financial reports, and examples of Monthly Expenditure Reports. Interviews were conducted with Team Lead Elizabeth Sampedro and the Fiscal Team (Vera Fuller, Katie Edwards, Alanna Bailey-Kelly).

Summary/observations of grantee activities:

ODHS has clear and comprehensive internal controls and auditing controls outlined in their policies in the Oregon Accounting Manual. The team uses OurStar to track expenditures and revenue, which has long been used by the state government. Ms. Fuller is responsible for tracking expenditures and notes that there are different cost codes for administrative vs. program expenditures. Monthly Expenditure Reports clearly indicate administrative and programmatic costs/expenditures that are allowable and allocable to the grant.

Both the manual and team interviews indicate that there are multiple levels of approvals required before making purchases. The Oregon Accounting Manual also contains written policies on monitoring subrecipients' fiscal records, which the grantee describes as a joint

effort between the program and fiscal teams. The program and fiscal teams hold monthly meetings to discuss finances.

Promising practices identified:

None identified.

Conformance issues identified and recommended solutions:

None identified.

General recommendations

None identified.

Exhibit 2

Title V State SRAE Grant: State Plan

Project Name: My Future-My Choice

Oregon Department of Human Services

Services

Area: Statewide

Fiscal Year: 2024

Amount: $538,793

ODHS Self Sufficiency Programs

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Abstract

The Oregon Department of Human Services (ODHS) proposes to continue offering and supporting the implementation of *My Future-My Choice* (MFMC), which has been implemented in rural, suburban and urban parts of Oregon since 2009. MFMC is an Oregon developed, abstinence-based, medically accurate, trauma-informed, culturally inclusive, age-appropriate, and evidence-informed, middle school curriculum that meets the Oregon health education standards and Sexual Risk Avoidance Education (SRAE) program criteria.

My Future-My Choice is a ten-lesson curriculum delivered in the 6th grade. Lessons 4-8 are designed to be led by trained high school peer educators, called Teen Leaders, who are accompanied by a trained adult health educator called a Classroom Facilitator. Lessons 1-3 and 9-10 are designed to be taught by the Classroom Facilitator.

The MFMC curriculum includes instruction, activities and discussions developed from evidence informed strategies. Lesson topics include gender and gender roles, puberty, respect, sexual risk avoidance skills, self-regulation, goal setting, peer pressure, assertive communication, boundary setting, healthy relationships, risk reduction and consent. All lessons normalize the decision to delay sexual involvement and emphasize sexual risk avoidance as the best choice to prevent teen pregnancy, sexually transmitted infections (STI) and other youth risk behaviors such as underage drinking and illicit drug use.

Subgrant agreements will be awarded to participating Oregon health departments, school districts, and community-based organizations who will provide local program coordination and data collection. All Teen Leaders and Classroom Facilitators will attend a training provided by ODHS Project Staff. ODHS will partner with the Oregon Department of Education (ODE) to provide evidence-informed and equity-based training to classroom teachers to ensure fidelity of

delivery and increased comfort teaching sexual health education. Project Staff will have ongoing communication with subgrantees to provide technical assistance, ensure program consistency, curriculum fidelity, and adherence to the SRAE requirements.

Implementation will be supported by two advisory groups. The first group is the adult led MFMC Advisory Group comprised of state agencies, MFMC Program Coordinators, schools and local community partners. The second group is comprised of select Teen Leaders who serve one year on the statewide Teen Advisory Board (TAB) working on a local youth sexual health leadership project and providing curriculum feedback. Following the principals of Positive Youth Development, TAB members will be assigned a local mentor to provide them with positive adult support and guidance during their service on the board.

The project goal is to promote sexual risk avoidance as the healthiest choice for young people, increase knowledge of sexual health, and promote the benefits of delaying sexual activity. ODHS intends to reach 8,000 middle school students during the school year, train 150 Teen Leaders and 75 Classroom Facilitators annually.

Contract and Grant Request Information

State: Oregon

Fiscal Year: 2024

Grant Allocation Amount: $538,793

Role	Prefix	First and Last name	Title	Telephone	Email address
Contact Person	Ms.	Elizabeth Sampedro	Lead Project Staff	971-388-1383	elizabeth.sampedro@odhs.oregon.gov
Project Director And Authorized Representative	Mr.	William Baney	Human Services Manager II	503-508-2039	WILLIAM.BANEY@dhsoha.state.or.us

State Plan/ Program Narrative

Description of Problem and Need

While teenage pregnancy rates have been on the decline since the early 2000s, there is a disparity in rates of decline in counties and regions across Oregon. In 2021, the counties with the highest teen pregnancy rates were Morrow County, Malheur County, and Crook County, with rates of 7.0 per 1,000, 5.7 per 1,000 and 5.6 per 1,000 respectively. This is in comparison to the state average of 2.3 per 1,000, indicating a continued need to focus on rural and frontier counties within the state of Oregon[1]. These counties with the highest teen pregnancy rates also have higher percentages of minority populations and households below the poverty line than the state overall[2].

[1] OHA. (2021). *Number and rate of Oregon teen pregnancies (ages 10-17) by county of residence 2021 final data.* https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/TEENPREGNANCY/Documents/2021_10-17roll.pdf

[2] The Ford Family Foundation. (2022). *Oregon by the Numbers: Key measures for Oregon and its counties.* https://www.tfff.org/wp-content/uploads/OBTN_2022_101022-Digital.pdf

Of all Oregon live births to mothers under 20 in 2016, 55% were to white mothers, 36 % were to Hispanic mothers, 4% were to Black mothers, 4% were to American Indian or Alaska Native mothers and 3% were to Asian or Pacific Islander mothers[3]. Of these mothers, 78.3 % of these mothers qualified for Medicaid – which indicates that they had low income. These demographics demonstrate the need to a culturally inclusive curriculum and to offer the curriculum in both public schools and community settings free of charge – particularly in communities with large disparities in teen pregnancy rates and higher rates of poverty.

The risks associated with teen pregnancy remain high; pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery and low birth weight, increasing the risk of child developmental delay, illness, and mortality. Pregnant teens are more likely than their non-parenting peers to drop out of high school and experience poor economic outcomes[4]. Lack of high school completion and lower lifetime incomes leads to higher levels of poverty and greater dependency on government-supported financial supports. If teens can delay parenthood, they are more likely to be able to focus their time and resources on their education and career training, which are crucial to socioeconomic stability and mobility, and to a productive workforce[5].

Rates of sexually transmitted infections have been increasing nationwide. Oregon has the 10th highest rate of primary and secondary syphilis (26.3 per 100k compared to the overall 17.7

[3] OHA. (2016). Demographic characteristics of mother by age, Oregon residents, 2014-2016. https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/TEENPREGNANCY/Documents/teenbirth/1416/TOTALBd1416.pdf

[4] Sedgh, G., Finer, L., Bankole, A., Eilers, M., and S. Singh. (2014). *Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends*. https://www.jahonline.org/article/S1054-139X(14)00387-5/pdf.

[5] Maynard, R. (1996). *Kids Having Kids. A Special Report on the Costs of Adolescent Childbearing.* *https*://www.researchgate.net/publication/234721421_Kids_Having_Kids_A_Special_Report_on_the_Costs_of_Adolescent_Childbearing

per 100k) and 16th highest rate of congenital syphilis in the United States[6]. The rate of primary and secondary syphilis in Oregon has more than doubled since 2019. Within this increase there are substantial disparities that need to be addressed, especially among marginalized populations. In 2022, American Indian/Alaska Native Oregonians had a rate of 217.2 per 100k, almost quadruple the statewide rate of 55.6 per 100k. For congenital syphilis, Native Hawaiian or Other Pacific Islander Oregonians the rate quadrupled in one year, going from 291.5 per 100k pregnant people in 2021 to 1,061 per 100k in 2022[7].

In 2022 there were 15,508 cases of chlamydia, 5,494 cases of gonorrhea, 35 cases of congenital syphilis, and 2,395 cases of primary and secondary syphilis in Oregon compared to 2013 in which there were 14,256, 1,751, 0, and 272 cases respectively[8]. Adolescents and young adults have the highest infection rates. Most sexually transmitted infections and diseases, if not identified and managed appropriately, can cause serious health complications such as infertility and cancer. Woman and newborns bear an inordinate share of these complications.

Oregon's prevention efforts must also address rates of dating violence among young people. More than 1 in 8 Oregon students experience dating violence before the age of 18. Moreover, 1 in 2 Oregon females and 1 out of 10 Oregon males will experience sexual violence in their lifetime[9]. These rates disproportionately impact LGBTQIA2S+ students and students of

[6] CDC. (2022). *2022 STD Surveillance Report.* https://www.cdc.gov/std/statistics/2022/tables/2022-STI-Surveillance-State-Ranking-Tables.pdf
[7] OHA: Oregon Public Health Division (2022). https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/viz/STI_17068215959980/790State-LevelCasesandIR
[8] OHA: Oregon Public Health Division. (2022). https://public.tableau.com/app/profile/oregon.health.authority.public.health.divison/vizzes
[9] ODE. (n.d.) *Sexuality Education FAQs.* https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/sexedfaq.pdf

Color[10]. Experiences of violence is a major risk factor for Oregonians, and the education system has a responsibility to address these data trends through education and prevention efforts.

Young people today are reaching reproductive maturity at younger ages than in the past. It is difficult for adolescent brains to understand how their choices and actions today could lead to life-long consequences. Research demonstrates a relationship between teen pregnancy and prior substance use, and that rates of substance use are particularly high among early adolescents (age 12-14)[11]. Young people need to be equipped to make informed, thoughtful choices for themselves so they can lead healthy lives and reach their goals. This highlights the need for a curriculum that focuses on the importance of sexual risk avoidance, healthy relationship traits, boundary setting, consent, goal setting, self-regulation and healthy decision-making skills for future goals and prevention of high-risk health behaviors.

The State of Oregon has supported strong youth sexual health policies that have paved the way for improvements. In 2009, the Oregon legislature passed a revised statute and adopted a new administrative rule requiring all publicly funded schools to provide age-appropriate, medically accurate, and comprehensive sexual health education. This instruction should be provided at least annually for grades Kindergarten-12th grade[12]. In 2013, the Oregon Healthy Teen Relationship Act was passed, and the state standards were updated requiring schools to incorporate age-appropriate education materials on teen dating violence.

[10] OSSCC. (2020). *State of Safe Schools Report*. https://www.oregonsafeschools.org/_files/ugd/4b2650_c61181ff1ce14edc99687498596ae213.pdf
[11] Christopher P. Salas-Wright, et al (2015). *"Substance Use and Teen Pregnancy in the United States: Evidence from the NSDUH 2002-2012."* Addictive Behaviors Vol. 45: p 218-225. Web. 23 May 2024
[12] Oregon Secretary of State. (n.d.) Oregon Secretary of State Administrative Rules. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=145221

In 2015, this administrative rule was modified to include sexual abuse prevention instruction under SB 856[13]. The state standards were updated yet again in 2016 requiring schools to incorporate sexual abuse prevention programing using a trauma-informed approach. This update required a larger list of performance indicators (benchmarks) to be addressed once in 6th grade, once in 7th grade, and once in 8th grade. With these additions from 2009 to 2016, Oregon's laws and health standards are in alignment with current research on effective practice for pregnancy and STI/STD prevention programs. MFMC aligns with Oregon's laws and health standards, which means that it is in alignment with current research and best practices. When youth are exposed to these lessons, they will understand how their bodies work, how to communicate their boundaries and their decisions; the basis of consent; they understand how to be a healthy partner, how to handle rejection and how to have positive self-worth[14].

While the requirements for Oregon's sexual health education have increased, resources for schools to support and implement these requirements has not. Oregon is a recipient of the Personal Responsibility and Education Programs (PREP) grant, however the target population for PREP programming is currently transition age youth with intellectual and developmental disabilities (IDD). Many school districts around the state, particularly those in rural communities, are still working to meet Oregon's middle school requirements for sexual health education[15]. Many districts have traditionally taught sexual health in high school but not in middle or elementary school. Some schools do not even have a health teacher available to teach

[13] Oregon Department of Education. (n.d.) SB 856 (Sex Abuse Prevention Instruction). https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/facesheet.pdf
[14] Rollston, R. (2020). *Comprehensive Sex Education as Violence Prevention.* https://info.primarycare.hms.harvard.edu/review/sexual-education-violence-prevention
[15] OHA Rape Prevention and Education Resource Map 2023 https://experience.arcgis.com/experience/2ab23beced0045579294517e524d7b70/

this subject, have added health education to the assigned teaching duties of another subject teacher or lack the resources to purchase new and updated curricula.

In 2017 and again in 2021, school districts were surveyed and asked whether they had a plan of instruction to teach comprehensive sex education, and if not, what the barriers were. Of those surveyed, barriers to having a comprehensive plan of instruction included lack of culturally relevant curriculum, shortage of staff and professional development, lack of community support or parental involvement, and lack of reliable funding among others[16]. For these reasons, the Oregon Department of Human Services (ODHS) knows that schools need sexual health curriculum that not only meets state requirements but that also comes with additional technical assistance and support at the local level.

Goals

The goal of the My Future-My Choice program is to create future societal benefits for teens and communities across Oregon by promoting sexual risk avoidance as the healthiest choice for young people, increasing youth's knowledge of sexual health topics, and promoting the benefits of delaying sexual activity. To achieve this goal, MFMC provides a free 6th grade curriculum that aligns with Oregon health education standards, and MFMC offers trainings and technical assistance to teachers and peer educators across Oregon. The curriculum is trauma-informed, medically accurate, age-appropriate, and LGBTQIA2S+ inclusive, and it focus on the following skills: recognizing traits of a healthy relationship, understanding changes in the body during puberty, knowing the characteristics of consent, and practicing refusal skills and communicating boundaries.

[16] Public Health Division, Injury and Violence Prevention Program. (2021). *Sexual Violence Prevention Resource Map: Oregon Comprehensive Sexual Education.* https://geo.maps.arcgis.com/apps/MapSeries/index.html?appid=4bf3974813d4436793660897cb923311

The MFMC program will train 150 peer educators and 75 instructors to provide the curriculum, thereby serving over 8,000 students across the state of Oregon by the end of each school year.

There are four main objectives of the program:

1. By the end of each school year, MFMC staff will train at least 150 peer educators known as Teen Leaders across the state of Oregon.
2. By the end of each school year, MFMC staff will train at least 75 teachers or health educators known as Classroom Facilitators across the state of Oregon.
3. By the end of each school year, middle school youth will be able to identify three traits of a healthy relationship, and one benefit to delaying sexual activity.
4. By the end of each school year, middle school youth will be able to identify one way to resist giving into peer pressure and identify one of their short-term and long-term goals.

Logic Model

Title V State SRAE

My Future-My Choice Program Logic Model

Program Goal: To promote sexual risk avoidance as the healthiest choice for young people, increase knowledge of sexual health and promote the benefits of delaying sexual activity. This will be accomplished by implementing MFMC and training 150 peer educators, and 75 instructors to provide the curriculum, thereby serving over 8,000 students across the state of Oregon by the end of each school year.

Population Served: Middle school students across Oregon, served by MFMC Subgrantee Program Coordinators and by MFMC-trained Health Educators, Teachers (Classroom Facilitators) and Peer Educators (Teen Leaders).

INPUTS

- Title V State Sexual Risk Avoidance Education (SRAE) Grant funds
- MFMC Program Staff (2.75 FTE)
- Oregon Department of Human Services (ODHS)
- MFMC Local Program Coordinators
- Subgrantees (Health Departments, ESDS, School Districts)
- High School Peer Educators (Teen Leaders)
- Teachers and local health educators (Classroom Facilitators)
- Community and state partners (ODE, OHA)

ACTIVITIES

- MFMC Staff Train Teen Leaders and Classroom Facilitators on the MFMC curriculum
- MFMC Staff provide technical assistance and support to local program coordinators and health educators implementing the curriculum
- Promotion of MFMC curriculum to schools and SDs not meeting health standards
- Subgrants are formed with county health departments, ESDs, and SDs to financially support implementation
- Teen Leaders teach MFMC lessons in their local middle school classes
- Teachers & Health Educators deliver MFMC curriculum

OUTPUTS

- Middle school students receive the MFMC curriculum
- Participation data, entry and exit surveys are collected
- Schools served by subgrantees will have access to medically accurate, inclusive and age-appropriate curriculum
- Number of schools meeting new state health standards will increase
- Classroom Facilitators will have access to resources, PD/training and core skills development
- Curriculum is made accessible to all Oregonians through the ODHS website

SHORT-TERM OUTCOMES

- Middle school students will have increased knowledge and understanding of sexual health topics such as healthy relationship traits, elements of consent, communication of boundaries, and importance of goal setting
- Sexual health education teaching skills and capacity increases among Teen Leaders and Classroom Facilitators
- Both Teen Leaders and middle school students understand the benefits of delaying sexual activity
- Health teachers grow and improve their skills for sexual health education through TA/PD/training

LONG-TERM OUTCOMES

- Delayed initiation of sex among youth
- Increased condom uses at first intercourse
- Decrease in number of unplanned pregnancies among youth
- Reduced STD and STI prevalence among youth
- Decreased rates of dating violence, suicide and gender-based bullying
- Lower rates of drop-out / HS non completion due to unplanned pregnancies

Program Goal: To promote sexual risk avoidance as the healthiest choice for young people, increase knowledge of sexual health and promote the benefits of delaying sexual activity. This will be accomplished by implementing MFMC and training 150 peer educators, and 75 instructors to provide the curriculum, thereby serving over 8,000 students across the state of Oregon by the end of each school year.

Population served: Middle school students across Oregon, served by MFMC Subgrantee Program Coordinators and by MFMC-trained Health Educators, Teachers (Classroom Facilitators) and Peer Educators (Teen Leaders).

Assumptions:

- Schools not yet meeting state health standards are interested in adopting the MFMC curriculum to achieve compliance with standards.
- Teachers will not face recruitment issues of middle school participants and students will attend classes on a regular basis.
- Schools will continue to be able to recruit Teen Leaders from high schools, and TLs will be available to teach in middle school classes.
- Teachers and Peer Educators will be fully capable of curriculum delivery after MFMC training.
- Districts will support teachers and Teen Leaders in attending required trainings.
- The peer-led MFMC curriculum, which is based on best practice and research, will have an impact on desired outcomes.

Implementation Plan

Project Description

Title V State SRAE funding currently supports the My Future-My Choice (MFMC) middle school curriculum and has been implemented across the state of Oregon since 2009. MFMC is a trauma-informed, age-appropriate medically accurate, and inclusive peer education program developed by the Oregon Department of Human Services (ODHS). This program serves an average of 8,000 students and trains about 150 peer educators, known as Teen Leaders, annually. ODHS has ten established subgrant agreements through Title V SRAE State funding and two subgrant agreements through GD SRAE funding serving students throughout Oregon.

The MFMC Curriculum incorporates an evidence informed approach that has demonstrated impacts on young people delaying sexual activity. MFMC was developed to adhere to the *CDCs Characteristics of an Effective Health Education Curriculum* and aligns with the national and state health education standards. MFMC is based on the tenets of Social Learning Theory, Social Cognitive Theory, as well as the Social Ecological model of prevention.

The MFMC program uses a trauma-informed approach that is inclusive to its target populations. The program covers topics that have been linked with improved positive health impacts and behavior changes. It incorporates a variety of learning strategies and teaching methods that are engaging and relevant. Additionally, it includes clear health goals and behavioral outcomes, medically accurate and developmentally appropriate information, skill building, and reinforces positive behaviors. Teachers are provided curriculum training to enhance their effectiveness in the classroom. As such, the program includes many characteristics of effective sexual health education.

MFMC addresses puberty, gender and gender roles, the importance of respecting others, the impacts of media on attitudes about sex, and emphasizes the advantages of postponing sexual involvement. The curriculum helps students identify and handle social pressure and peer pressure and teaches students about healthy decision making. The lessons are designed to help students develop communication skills, such as refusal and negotiation skills, which have been shown to delay sexual intercourse among adolescents. Lastly, the curriculum covers consent, recognizing the characteristics of healthy and unhealthy relationships, and identifying risky sexual behavior. All of these topics have been shown to be characteristics of effective sexual health education and STD/STI prevention[17].

Sexual Risk Avoidance Education

The State of Oregon supports the position that sexual risk avoidance is the only 100% effective method of preventing pregnancy and STIs. To promote this message effectively, ODHS proposes to continue focusing on reaching youth before they typically become sexually active. To this end, the program will target 6th grade students (with the intention of eventually serving 7th and 8th grade) in communities with elevated rates of teen pregnancy and STIs. This gives young people the opportunity to learn and practice the necessary skills to resist peer and societal pressures before sexual debut and creates an atmosphere that is supportive of normalizing the delay of sexual activity.

Specifically, MFMC will prioritize reaching youth that experience disparities in teen pregnancy rates and STI/STD rates, including youth in rural and underserved communities, including English language learners and students of Color. ODHS will also prioritize sexual risk

[17] Advocates for Youth. *Characteristics of Effective Sex Education.* http://www.advocatesforyouth.org/component/content/article/450-effective-sex-education

avoidance education for young people with other marginalized identities such as students with intellectual and developmental disabilities and students in foster care through collaboration and partnerships with organizations that are focusing on this work. The MFMC curriculum emphasizes the importance of assertive communication, healthy decision-making, goal setting (and how sex can impact goals), and risk reduction to further normalize the delay of teenage sexual activity.

Parent/Guardian/Family Involvement

Parents and caregivers are partners in sexuality education. Each lesson was created with "Learning Outside the Classroom" assignments to be completed with a parent/caregiver. These homework assignments were designed to foster age-appropriate conversations between parents/caregivers and their child. These assignments address the topics covered in each lesson such as puberty, healthy relationships, healthy decision making, peer pressure, media influences, reducing risks and delaying sexual activity, assertive communication, and goal setting.

While schools are required to offer sexuality education K-12, parents and caregivers can opt their child out of specific lessons and all programming is voluntary. Schools delivering MFMC send a parents/caregiver notification letter with the option to opt their child out of specific MFMC lessons. Most Oregon parents are supportive of MFMC implementation, however, there are some opt outs of specific lessons; roughly 4.2% of participants are opted out of at least one lesson by a parent or caregiver.

Service Delivery

Implementation of the MFMC curriculum is supported by a structured program team model comprised of an assigned Program Specialist (ODHS MFMC Project Staff), local

Program Coordinator (subgrantee staff), Classroom Facilitators (teachers or health educators) and high school peer educators called Teen Leaders. All curriculum materials are provided by ODHS to ensure school districts are using the most current version of curriculum materials. As a collaborative effort, ODHS and the Oregon Department of Education (ODE) will provide training and support for classroom educators, school administrators, and local Program Coordinators as they prepare for and implement the curriculum.

Service Recipient Involvement

Implementation is supported by the MFMC Advisory Group comprised of state and local partners that meets quarterly. Local program updates, implementation challenges, programming shifts or decisions, and general discussion questions are shared with this group. Members of this group include representation from: Oregon Department of Education; Oregon Health Authority Adolescent Health Section; County Health Departments; Oregon Sexual Assault Task Force, local MFMC Program Coordinators and private non-profits. As key partners in the MFMC community, Advisory Group members help disseminate program findings, resources and opportunities. A statewide Teen Advisory Board of peer educators participating in the program is enlisted to liaison between the state program administration and local program implementers. The Teen Advisory Board provides ongoing feedback on curriculum content, works on a local youth sexual health leadership project with a local mentor, and collects data on the quality of sex education in Oregon. In an effort to make the state plan public, MFMC staff will share the final state plan with both the Advisory Group and the Teen Advisory Board to solicit feedback on current programming.

Program Structure

The Project Director - William Baney - will serve as administrator and liaison to the Oregon Department of Human Services Self-Sufficiency Programs management structure. Mr. Baney will communicate program reports and updates to ODHS administration and the Oregon legislature, as well as oversee the overall project. Mr. Baney is currently the Manager of Self-Sufficiency Design and Implementation, Self-Sufficiency Training Unit, and the My Future-My Choice program. In addition, Mr. Baney administers key program and administrative operations within the Oregon Department of Human Services.

The Project Lead Staff, Elizabeth Sampedro will be responsible for all day-to-day project implementation functions. As the Project Lead Staff, Ms. Sampedro will: serve as liaison between the project director and all project activities; facilitate the state level MFMC Advisory Group meetings and project staff meetings which provide opportunity for staff and partners to review project improvements to ensure consistent decision-making processes are in place; oversee curriculum edits and revisions, training schedules, liaison with state project partners and contracted services; monitor local sites to facilitate and ensure consistency and accountability of program delivery.

Project Staff and Team Lead will provide training, technical assistance and updated materials to County Coordinators, Classroom Facilitators, and Teen Leaders. Required curriculum training for subgrantees consists of a 4-hour virtual or 8 – hour in-person training delivered in partnership with the ODE. The training addresses Oregon Health Education Standards and policies, MFMC curriculum and grantee instructions, and the development of core sex education skills that are inclusive and trauma- informed. Program Staff will support curriculum development and alignment to new Oregon Health Education Standards (released

October 2023), review and revise for medical accuracy, support data collection, and support the requirements of the Title V State SRAE grant. Staff will be available to support curriculum adoption processes and parent/caregiver nights upon request.

Project Staff will also be responsible for the recruitment, selection, and retention of the Teen Advisory Board members each school year. With the help of community coordinators and subgrantees, Teen Advisory Board members will be recruited from partnering school districts across the state, giving priority to trained peer educators that served as Teen Leaders in the previous school year. These teens may also come from communities that do not participate in the program but have a strong interest and desire to serve as leaders in their communities. Project staff will match all ten Teen Advisory Board members with a local mentor for support throughout the school year.

Project Staff will onboard new TAB members and mentors in preparation for the school year. MFMC Project staff will structure a youth-driven sexual health leadership project for the Teen Advisory Board members to complete, which includes collecting feedback on the curriculum. Project staff will develop guidance for TAB mentors on how best to support TAB members on their selected projects. staff will coordinate and provide two leadership events for members and mentors (one virtual and one in-person). During these meetings, board members will receive training and provide feedback on the curriculum.

The local Program Coordinator may manage multiple sites within the county in which they reside. They will ensure all the following responsibilities are met, either by completing them, delegating, or subcontracting them to another Site Coordinator or High School Teacher. Duties include but are not limited to:

- Ensuring that all grant agreement requirements are observed.
- Providing all materials for the classroom lessons (or ensure reimbursement for required materials to sites).
- Act as liaison between schools, community and ODHS Project Staff.
- Complete and submit required data reports to ODHS program office.
- Ensure teachers are collecting entry and exit surveys from their students.
- Identify Classroom Facilitators to assist Teen Leaders during classroom presentations.
- Scheduling and ordering necessary materials for Teen Leader training.
- Coordinating transportation for the Teen Leaders to and from the classroom site.

The role of the Site Coordinator is to support the training of Teen Leaders at a particular school (alternatively, this role could be fulfilled by the Program Coordinator). The Site Coordinator is responsible for the following:

- Recruiting and selecting a diverse group of high school Teen Leaders.
- Scheduling class times at the middle schools and scheduling Teen Leaders to come in during those allotted times.

The role of the Classroom Facilitator is to ensure Teen Leaders are supported during their presentation to ensure a smooth lesson delivery. The Classroom Facilitator is often the middle school teacher in which lessons are being delivered but could also be done by the Program Coordinator. Duties include, but are not limited to:

- Attending required program training.
- Performing all Classroom Facilitator pieces as outlined in the *Classroom Guide.*

- Assisting Teen Leaders with classroom management and with questions from students.
- Providing feedback to Teen Leaders following each lesson for continued leadership development.

Teen Leaders' duties include but are not limited to:

- Attending required training to deliver classroom lessons.
- Facilitating Teen Leader-led lessons in middle school classrooms.
- Communicating appropriately with Site Coordinator or Program Coordinator regarding scheduling and paperwork.

Site Monitoring Visits and Program Fidelity

Program fidelity will be monitored through annual grant monitoring meetings between ODHS and subgrantees before each school year begins. During these grant monitoring meetings, ODHS staff will review subgrant agreements, cover roles and responsibilities, Oregon requirements, Title V SRAE grant requirements, and red/yellow/green curriculum adaptations. These grant monitoring meetings are vital to ensuring both ODHS and local subgrantees have a clear understanding of program expectations (including data requirements and invoicing) and understand what full program implementation looks like. During these meetings, sites will be introduced to their assigned MFMC Project Specialist who will provide TA and check-in meetings through the grant year.

Overcoming Barriers and Challenges

Potential barriers for implementation include a continued decline in state and local resources such as staffing, and professional development due to budget reductions. With grant funding available through SRAE, MFMC can offer Oregon communities free curriculum

materials, training, and funding for local coordination. This addresses a significant barrier for schools which are faced with limited resources and varying priorities. In addition to this, Project Staff help mitigate the barriers to training that arise from time constraints and varied schedules by offering flexible training dates and options, including both virtual and in-person trainings.

Another barrier for Oregon schools is the inconsistency in local school district curriculum adoption policies, and inconsistencies around meeting the state health requirements. This is particularly challenging when new requirements are added. Oregon released updated sexual health education standards in October 2023 and schools are required to implement these requirements at the beginning of the 2025-2026 school year. MFMC program staff will adjust the curriculum to ensure the program meets the new requirements when they go into place. This provides a level of ease for schools using the curriculum or – thinking about adopting the curriculum – because they can rely on this programs' compliance with state requirements and the law.

The COVID-19 pandemic put tremendous strain and stress on schools. During this time, sex education became more politicized, particularly around supporting gender expansive youth. Sexual health became a deprioritized subject that schools didn't have time or capacity to teach. This led to a reduction in districts implementing MFMC, despite Oregon's requirements that sex education be taught kindergarten-12th grade. For schools that were able to implement MFMC, many stopped running their peer education program. As a result, MFMC has been working on rebuilding the program with the support of its Advisory Group, Teen Advisory Board, and the Oregon Youth Sexual Health Partnership (OYSHP). Because ODHS has long-term relationships with current sites, subgrantees have been committed to rebuilding My Future-My Choice and the

Teen Leader Program. Classroom participation data indicates that ODHS is on track to rebuilding the MFMC program.

Another barrier is the required implementation of SRAE entry and exit surveys in Oregon communities. There is high sensitivity in schools around collecting surveys from 6th graders that asks questions related to sexuality. Some school districts that formerly partnered with ODHS have declined their subgrant due to this requirement. Should this continue to be a concern for school districts, ODHS will work closely with our subgrantees to offer support and solutions such as helping grantees understand the purpose of performance measures, ensuring that parents/guardians have an opportunity to opt their child out of the surveys, and submitting a survey waiver to FYSB as needed.

Table 1: Goals, activities, mechanisms, and a short set of broad steps

Goals	**Activities**	**Mechanisms And Broad Steps**	**Outputs**	**Responsible Party**	**Timeline**
Make updated MFMC materials accessible	Provide updated materials to subgrantees	1. Update materials with medical accuracy changes 2. Redesign lessons with revised content to align with state health education standards 3. Update website with revised materials 4. Print new materials 5. New materials are distributed	Materials are revised, ready for distribution, and accessible on website	1. MFMC Project Staff 2.ODHS Publications 3. ODHS Website Team 4.ODHS Publications 5. MFMC Project Staff and Support Staff	1. May 2024 2. July-August 2024 3. August 2024 4. August 2024 5. August-September 2024
Support and fund local MFMC implementation	Renew subgrant agreements and provide grant monitoring visits	1.Update current subgrants 2.Subrecipients authorize subgrant agreements 3. Grant monitoring visits are conducted to review grant requirements and establish implementation roles	Subgrant agreements are established	1.Project Lead and ODHS Contract and Procurements 2.Subrecipients 3.MFMC Project Staff and Subrecipients	1.March-June 2024 2.May-June 2024 3. July-September 2024

Promote MFMC implementation	Identify new and current schools interested in curriculum implementation	1.Notify schools about availability of free MFMC curriculum and materials 2.Notify schools about Teen Leader Program availability and local support provided 3.Meet with teachers, administrators, and curriculum directors to support program implementation	Current and new schools implement MFMC curriculum Current and new schools implement the Teen Leader Program	1.Program Coordinator/Site Coordinator 2. Program Coordinator/Site Coordinator 3.Program Coordinator/Site Coordinator	1.September 2024–January 2025 2.September 2024-January 2025 3.September 2024-June 2025
Prepare schools to implement MFMC	Provide curriculum training and core skills trainings to Classroom Facilitators and educators, and train Teen Leaders.	1.Schedule and deliver curriculum trainings for Classroom Facilitators and educators 2. Schedule and deliver Teen Leader Trainings	1.Train new Classroom Facilitators and educators 2.Train new and returning Teen Leaders	1.Program Coordinator and MFMC Project Staff 2. Program Coordinator and MFMC Project Staff	1. September 2024-May 2025 2. September 2024 – May 2025
Incorporate youth voice into the MFMC program.	Onboard the 2024-2025 Teen Advisory Board and supporting mentor program	1.Recruit teens and mentors 2.Design new project 3.Plan and deliver Leadership Kick-Off and End of Year events	Have 10 teens from across Oregon serve on the 2024-2025 Teen Advisory Board and	1.Project Staff and MFMC network 2.Project staff with feedback from Advisory Group and Teen Advisory Board	1.May-June 2024 2.June-July 2024 3.May-September 2024 4.October-April 2025

		4.Collect youth feedback	provide program feedback	3.Project Staff 4.Teen Advisory Board	
Collect MFMC data	Collect MFMC classroom participation data and SRAE Entry and Exit Surveys	1.Review reporting requirements at grant monitoring visits 2.Create and distribute Entry/Exit Survey links to subrecipients 3. Collect classroom data at 3 reporting deadlines 4. Enter data	Collect classroom data and Entry/Exit Surveys for all subrecipients	1.Team Lead, Project Staff, and Subrecipients 2. Project Staff 3.Project Staff and Subrecipients 4.Project Staff	1.July-September 2024 2.August-September 3. 1/10/25, 4/10/25, 6/10/25

Description of Programmatic Assurances

The My Future-My Choice curriculum is an evidence-informed and Oregon-developed curriculum. Further exploration of the theories used in the development of the curriculum are listed under the *Project Description*. Over the years of implementation, the MFMC curriculum has made a practice of securing guidance and input from key voices and experts including state and community partners, youth, families, teachers and interested parties to ensure medical accuracy, relevance and clarity. In addition to continuing this practice to secure outside feedback, MFMC staff submit curriculum materials for medical accuracy reviews conducted by FYSB when requested. In February 2024, minor edits were requested and, in turn, integrated into a one page insert for sites to use when implementing the curriculum. MFMC staff will ensure all edits are integrated into curriculum materials prior to the following school year.

All sites interested in using the curriculum and receiving financial support for implementation must enter into a legal grant agreement stating that programming and materials will adhere to the Title V State SRAE grant requirements and Oregon Health Education Standards. All subgrantees will undergo annual grant monitoring meetings with MFMC program staff prior to the beginning of the school year to review grant requirements, data collection deadlines and share district plans for implementation. All printed curriculum and program materials will be sent and made available to subgrantees and posted on the ODHS website.

My Future-My Choice is a product of statewide collaboration through partnerships with the Advisory Group, health departments, and school districts across Oregon. These collaborations support program medical accuracy, age-appropriateness of materials and complete information. This collaboration has fostered improvement of program materials and established the framework for successful implementation among the ten MFMC subgrantees. If at any time

the MFMC curriculum is found to contain inaccurate medical information, ODHS will take any necessary steps to correct inaccurate information discovered by FYSB during the state plan review process or at any time during the grant project period.

Medically Appropriate Materials and Culturally and Age-Appropriate Approaches

Medical Accuracy

Medical accuracy of this project will be assured through the support of members of the MFMC Advisory Group including partners from the Oregon Health Authority, Oregon Department of Education, and the Oregon Attorney General's Sexual Assault Task Force. During the curriculum development process and for any future revisions, members will be asked to review MFMC for medical accuracy. To ensure medical accuracy is achieved, MFMC contracts with sexual health education experts to conduct reviews and MFMC program staff make necessary medical accuracy revisions annually.

Trauma-Informed and Reducing Risk Factors

The MFMC program uses a trauma-informed approach that is inclusive of its target populations as stated in the *Project Description*. The program covers topics that have been linked with improved positive health impacts and behavior changes. It incorporates a variety of learning strategies and teaching methods that are engaging, relevant, and meets the learning needs of students. Additionally, it includes clear health goals and behavioral outcomes, medically accurate and developmentally appropriate information, skill building, and reinforces positive behaviors. Each lesson was developed using a trauma-informed approach to ensure students who have experienced trauma feel affirmed while receiving this content. Teachers are provided trauma-

informed curriculum training to enhance their effectiveness and learn how to create a safer space for students.

A key component of MFMC is addressing teen dating violence prevention. This includes teaching middle schoolers information about and skills for healthy relationships, consent and resisting sexual coercion, all of which can help prevent teen dating violence. Understanding consent, bodily autonomy and the traits of a healthy relationship helps youth identify sexual abuse and assault so they can get the help and support necessary to begin the healing process and end the cycle of abuse. The curriculum also emphasizes the importance of identifying trusted adults such as a parent/guardian, teacher, faith leader or coach to get support with trauma, abusive relationships, and other challenging life experiences.

The curriculum also focuses on teen pregnancy prevention, which is critical to preventing young people from having to manage the responsibilities of teen parenthood prior to high school graduation. Teen parents are more likely to enter or remain in poverty, to experience dependency on government-supported financial supports and drop out of high school. These are outcomes that MFMC aims to prevent through its programming. By providing students with necessary information for future decisions, such as complete, medically accurate information on contraceptives as a method of risk reduction but not risk elimination, the advantages of waiting to be sexually involved and the benefits of setting goals with a focus on the future, ODHS will foster a sense of empowerment in youth to make healthy decisions over their bodies and their futures.

Culturally Responsive, Equity-Based, and LGBTQIA2S+ Inclusive

The MFMC curriculum was written to be LGBTQIA2S+ inclusive and culturally affirming. It is revised regularly by MFMC staff, MFMC Advisory Group members, and contracted sexual health educators of Color who identify as LGBTQIA2S+ to ensure it continues to be intersectional and meet the diverse needs of students. MFMC has partnered with LGBTQIA2S+, BIPOC, and disabled sex educators to review and make MFMC revision recommendations for inclusivity and relatability. ODHS aims to center marginalized students including youth of Color such as Native American, Latinx, Asian and Black American youth, as well as youth with marginalized identities such as LGBTQIA2S+ youth and youth from foster care settings, who are not centered in traditional public-school settings. These students typically have higher rates of unintended pregnancy, STIs, teen dating violence, and suicidality, and tailoring education to fit their needs can help close those gaps.

While parents and caregivers are often a source of sexual health education for youth, many youth - in particular youth in the foster care system – do not have consistent adult role models or caregivers who are willing or able to provide such education. The MFMC curriculum is a voluntary program implemented in middle school classrooms, enabling the program to reach multiple vulnerable populations with barriers to family-based sexual health education. MFMC provides them with information and guidance about the importance of healthy decision making, healthy relationships and risk reduction so they can focus on graduation, have healthier relationships and achieving future goals. MFMC plans to address the needs of foster youth and other students with targeted identities through its partnership with ODHS Child Welfare and by contracting with new community-based organizations. With additional GD SRAE funding,

curriculum adaptations and translations will also be a focus of curriculum development to ensure MFMC is culturally and linguistically responsive to its underserved marginalized populations.

For the past three years, MFMC has contracted with various sexual health educators to deliver its Sex Ed Workshop Series to MFMC Program Coordinators, health educators and youth-serving professionals across Oregon. Each 90-minute after-school virtual workshop is presented by a different expert that dives deep into a marginalized identity and how best to create an inclusive classroom for students with that identity. These workshops have served to enhance educator's ability to provide quality sexual health education that incorporates DEI. ODHS will continue to explore the possibility of hosting these workshops through its state and community partnerships. Supporting Oregon educators to be more affirming, inclusive, and intersectional helps ensure our students are receiving sex education that is inclusive and meets their needs.

The Teen Advisory Board (TAB) will support the program's efforts to be inclusive by working throughout the year on community-based projects on sexual health education that center equity. TAB members will receive diversity, equity and inclusivity sex education training at their annual Leadership Kick-Off and then design a project that addresses an area of inclusivity that is important to them. TAB members will collect surveys in their community to assess gaps in sex education and an Equity in Sex Education report will be created and shared with partners across the state to inform new approaches to inclusivity in sex education. TAB members will review and provide feedback on the MFMC curriculum, providing insight into how the program can be more inclusive and culturally affirming.

Age-Appropriate

In Oregon, state policy and the health education standards, which were developed by experts in the field of sexuality education, mandate that age-appropriate sexuality education be delivered Kindergarten-12th grade. The MFMC curriculum aligns with the age-appropriate sexual health topics as defined by the Oregon Department of Education's evaluation of the work of many researchers and organizations, including the Sexuality Instruction and Education Council of the United States. For the middle school age group, the first age-appropriate message is, "Young teenagers are not physically or emotionally prepared for a responsible sexual relationship that include intercourse."

Age-appropriate sexual health education incorporates both imparting knowledge that is adequate and aligned with developmental research, as well as building skills that are in line with adolescent social maturity and cognitive development. As such, the Oregon sexual health standards were written to be met through skills-based performance indicators that are age-appropriate. MFMC was written to align with these performance indicators and as such, meet these state standards to be age appropriate. At the beginning of each lesson, the health standards and performance indicators met are listed for reference. Through its partnership with ODE, ODHS plans to reach out to schools and school districts that are currently struggling to meet these requirements through other non-Oregon specific curricula.

Evidence-Informed Strategies

MFMC incorporates an evidence-informed approach that has demonstrated impacts on young people delaying sexual activity. MFMC was developed to adhere to the CDCs 25 Characteristics of an Effective Health Education Curriculum and aligns with the national and

state health education standards. MFMC is based on the tenets of Social Learning Theory, Social Cognitive Theory, as well as the Social Ecological model of prevention.

MFMC lessons highlight information and skill building around self-regulation, healthy decision making, resisting sexual coercion and dating violence and other risk behaviors. The curriculum lifts up the short and long-term benefits of taking personal responsibility and making healthy choices — primarily through sexual risk avoidance and choosing abstinence — and emphasizes sexual delay as a normative behavior for middle school students and older teens.

Parts of the MFMC curriculum have been adapted from the "Respecting Your Future" (RYF) and "Postponing Sexual Involvement" (PSI) curricula. Both the RYF and PSI curricula have made the list of recommended programs that have shown proven effectiveness from the Program Archive on Sexuality, Health and Adolescents (PASHA), the National Campaign to Prevent Teen and Unplanned Pregnancy, and Advocates for Youth. Adaptations to the combination of these curricula include language adjustment for delivery to 6th grade students, repetition of core messaging and building upon content introduced in previous lessons, complete redesign of the classroom guide for peer educators, use of posters and other visuals for activities, additional lessons on relationships and communication, and discussion guides and worksheets to be completed at home with parents or other supportive adults.

MFMC partnered with Portland State University in 2011 to conduct a pilot evaluation during the 2011-2012 school year. This evaluation was administered to over 1,000 sixth grade students from a rural Oregon community. Students were given a baseline and immediate post assessment on the first and last day of MFMC, respectively. This evaluation measured a total of fifteen outcome items that were condensed into six measures. Some statistically significant differences were found between the baseline and post assessments in the following scales:

attitudes about condoms, behavioral intentions, self-efficacy to control sexual behavior, and refusal skills. Therefore, evidence suggests that this curriculum will have the desired impact on positive youth behavior change that leads to preventing and reducing teen pregnancies, STIs, and sexual activity.

Training Methods

ODHS Project staff will provide evidence-informed training to teachers and health educators delivering MFMC. MFMC trainings will include curriculum implementation instructions and guidance to ensure state and federal educational standards and requirements are met in collaboration with the Oregon Department of Education. Training will cover state requirements, grant requirements such as entry and exit survey collection, equity and inclusivity-based approaches, using a question box and addressing student questions, interrupting classroom bullying, the Value Question Protocol, and lesson content and materials. Classroom Facilitators delivering lessons with Teen Leaders will receive specific guidance on how to support Teen Leaders during their lesson delivery. Training will increase skill and comfort teaching sexuality education, as well as familiarity with the MFMC curriculum. Technical assistance and optional topic-specific training will be offered to teachers and health educators delivering MFMC through this grant.

Day-long skills-based trainings will also be provided to high school Teen Leaders delivering half of the MFMC curriculum with the support of a trained Classroom Facilitator. These trainings will be required annually. Teen Leaders learn effective teaching strategies, classroom management, how to manage student questions, and practice delivering lesson content. Training both Teen Leaders and Classroom Facilitators reinforces the fidelity of curriculum delivery and comfort delivering MFMC.

Positive Youth Development (PYD) Framework/ Meaningful Youth Engagement

Youth voice is critical to the success of a program that serves young people. The MFMC program practices a positive youth development model by using a combination of high school peer educators and adult health instructors to deliver the curriculum. Studies have shown that using peer educators to teach sexual health topics and materials has an improvement of knowledge and attitudes related to sex education and HIV prevention[18]. Creating and promoting positive peer role models and connections for younger youth helps them avoid harmful behaviors, develop self-efficacy and normalize abstinence.

Incorporating high school peer educators in the delivery of MFMC has a dual impact on both the students being served as well as the peer educators themselves as research suggests that peer educators have more knowledge of sexual health issues, opportunities to practice negotiation and risk reduction skills and have greater intentions to implement behaviors associated with reduced risk of pregnancy, STIs and HIV[19]. High School youth are at elevated risk for unintended pregnancy and STD/STIs. According to the 2017 Oregon Healthy Teen Survey, 30.7 percent of students surveyed in the eleventh grade reported they have had sexual intercourse and young adults ages 15-24 have the highest infection rates[20].

MFMC creates a positive impact on the Teen Leaders delivering the curriculum by promoting the benefits of waiting to be sexually involved and the importance of setting goals for the future. In 2015, ODHS contracted with Portland State University to collect feedback from past and present MFMC Teen Leaders. Overall findings reflected that being a Teen Leader

[18] Dodd, S., Widnall, E., Russell, A.E. *et al.* (2022) *School-based peer education interventions to improve health: a global systematic review of effectiveness*. BMC Public Health **22**, 2247 . https://doi.org/10.1186/s12889-022-14688-3

[19] Jennings, J., Howard, S. and C. L. Perotte. (2014). Health Educ Res. *Effects of a school-based sexuality education program on peer educators: the Teen PEP model*. https://doi.org/10.1093%2Fher%2Fcyt153

[20] OHA Oregon Student Health Survey (SHS) Data Portal (2022) https://www.bach-harrison.com/SHSDataPortal/Variables.aspx

reinforced their own ability to make healthy choices and delay sexual activity. Being considered a leader, a role model and educator are all strong protective factors that have a positive impact on the Teen Leaders that serve in the program. Furthermore, middle school youth that receive the curriculum are often empowered to give back to their communities by serving as a Teen Leader during their high school years to educate their younger peers.

The positive youth development philosophy is further supported through the implementation of the MFMC Teen Advisory Board and Mentoring Program. Teen Leaders can apply for a statewide leadership opportunity, the Teen Advisory Board (TAB). Ten high school students from across Oregon are selected each year to serve on the board during which time they provide curriculum feedback, receive mentorship from a local community member, and work on developing or enhancing a piece of the MFMC program. These teens are recruited from high schools throughout the state. Further examples of how the MFMC program meets the various components of the PYD framework are outlined below in Table 2.

Table 2:

PYD Element	**How it shows up in MFMC Programming**
Appropriate Structures	This practice includes selecting activities and practices that match where youth are developmentally. Additionally, programs can work with youth to set clear and consistent rules and expectations, and age-appropriate monitoring. • Project frameworks are provided by MFMC staff, but specific tracks, topics and activities are developed by TAB members resulting in youth-directed projects in TAB. • TAB members are given clear and consistent expectations for projects in TAB. • TAB mentors provide supportive, age-appropriate monitoring of projects through consistent check-ins and adjustment of deadlines to accommodate TAB members' busy schedules. • Teen Leaders (TLs) are given clear and consistent rules regarding classroom facilitation, answering questions, and personal sharing in the classroom. • Scripted lessons for TLs aids in their developmental process by giving clear language and directions to middle school students.
Supportive Relationships	Caring relationships offer social support, use positive communication, and provide supportive guidance. These relationships include the connections between youth and adults as well as among young people. • TLs are partnered with peers to provide support during co-facilitation which fosters teamwork. • TLs are supported by a trained Classroom Facilitator, who provides instructional support and guidance in the form of post-teaching feedback. • TAB members are partnered with local mentors, who support them through the process of carrying out the project through monthly meetings, and provide supportive guidance on topics like data collection, research, presentation skills, and navigating systems/organizational hierarchies.
Opportunities to Belong	Apart from providing opportunities for the meaningful inclusion of all youth, programs can create opportunities for youth to explore their identities and support cultural and bicultural competence. • The MFMC curriculum is LGBTQIA2S+ inclusive and ensures content is reviewed for inclusivity of other marginalized identities.

	• TAB members are provided an opportunity to engage in two weekend events (one virtual and one in-person) where they dive deeper into the research of various sexual health topics presented by their peers, sexual health education topics relevant to high school students and leadership workshops all while building community with other TAB members and mentors.
Positive Social Norms	Positive social norms include behaviors and values that promote respect. Programs can encourage these norms by setting expectations and modeling behaviors. • MFMC lessons and group agreements teach respect for others and for oneself. • TLs role model positive behaviors, and message the benefits of sexual delay. • TLs display respect for middle school students, avoiding treating them like children and engage them in critical thinking that is age-appropriate
Opportunities to Make a Difference	A program can place youth in leadership roles and encourage youth choice to encourage youth to achieve meaningful change in their community. • TLs are in leadership roles, lead discussions, and teach in the classroom, making a difference in the lives of middle school students. • TAB members are in leadership roles, researching and presenting on issues in their communities, fostering their leadership skills and making meaningful change in their community.
Opportunities for Skill Development	Allowing opportunities for practice and connecting content to goals can help adolescents learn a range of skills that prepare them to make positive and informed decisions that affect their health, educational and career opportunities, and other aspects of their lives. • TLs are trained on classroom management skills, speaking skills and teaching engagement skills. • Scripted lessons allow TLs to focus on delivery, public speaking and reinforcing messages rather than on memorizing content. • MFMC lessons build in opportunities for skills practice and make clear connections between behaviors and outcomes to aid in informed decision making to promote healthy outcomes.

Integration of Family, School and Community Efforts	PYD is an approach for everyone. Program can emphasize coordination and collaboration with family, school, and community partners to strengthen their efforts. • MFMC homework emphasizes the connection and collaboration with parents/caregivers on important sexual health topics. • TLs serve as role models for middle school students and many middle school participants of the MFMC curriculum come back to serve as TLs when they reach high school further fostering the sense of community. • MFMC emphasizes the importance of identifying and turning to trusted adults for help and support on difficult decisions and potentially unhealthy situations.

Equity

The My Future-My Choice program achieves its equity goals in four primary ways: 1) Establishing subgrants in regions across Oregon with high levels of diversity, 2) recruiting and retaining youth participants from marginalized populations and underserved communities, 3) ensuring MFMC curriculum is inclusive of LGBTQIA2S+ youth and youth of diverse racial and cultural backgrounds, 4) engaging and coordinating with community-based organizations across the state that serve marginalized populations, and 5) providing ongoing professional development and trainings on inclusivity, equity and diversity for teachers, health educators and teen leaders.

The MFMC program works to serve students and communities across the state of Oregon through establishing subgrantee relationships with school district, educational service districts, and county health departments. The selection of subgrantees has included careful review of the demographic makeup of the region served, and priority has been given to regions with high levels of economic disparities, racial and ethnic marginalization, and linguistic differences. MFMC has also prioritized working with communities with higher than the states' average rate of teen pregnancy and/or STIs/STDs. For example, MFMC's subgrantee the Hillsboro School District in Washington County has much more racial / ethnic diversity than the average for the state or Oregon[21] [22].

- 41.3% Hispanic, versus 13.8% for Oregon
- 7.3% Asian, versus 4.4% for Oregon

[21] National Center for Health Statistics - Oregon, Web. 24 May 2024. https://www.cdc.gov/nchs/pressroom/states/oregon/or.htm
[22] Hillsboro School District Enrollment and Demographics. Web. 24 May 2024. https://www.hsd.k12.or.us/Page/5413

- 3.1% Black, versus 1.8% for Oregon
- 0.7% Pacific Islander, versus 0.003% for Oregon

In addition to prioritizing diverse regions of the state for subgrantee partnerships, MFMC recruits and retains diverse youth Teen Leaders (peer educators) to facilitate 6th grade lessons in local middle schools. MFMC works with school district staff to recruit cohorts of Teen Leaders in schools utilizing the peer education model. The guidelines established by MFMC for local recruitment include prioritizing recruitment of cohorts who are diverse in terms of race / ethnicity, cultural background, ages, genders and sexualities (if the youth have shared that identity). MFMC also encourages schools to not limit recruitment to academic high-achievers or to students who are already in leadership roles, which brings in a wider set of youth perspectives and lived experiences. MFMC also recruits for the Teen Advisory Board in a similar way, by partnering with local organizations around the state to share about the TAB opportunity with a wide range of youth. MFMC specifically coordinates on recruitment with organizations that serve Latinx/Hispanic youth, LGBTQIA2S+ youth, youth in foster care, and Native Hawaiian and Pacific Islander Youth.

The MFMC curriculum and lesson materials are continually reviewed for inclusivity and cultural relevance, including by MFMC staff and members of the MFMC Advisory Board and the Teen Advisory Board. The lessons' contents have been tailored to include information on topics such as gender identities, cultural differences, differences in communication styles, respect for others and for differences, and understanding how personal values effect health decisions. For example, when speaking of puberty, bodies are referred to as those that are assigned female at birth or male at birth (AFAB or AFAB) - both to be medically accurate and to be inclusive of youth who are intersex and/or gender diverse. Many of the names used in scenarios throughout

the curriculum are gender neutral and represent a range of ethnic and linguistic backgrounds. The scenario settings used in the worksheets are relevant to Oregon's youth population since they depict situations that youth may actually find themselves in. These methods are integrated throughout all lesson content for a more robust and integrated curriculum. MFMC is also available in Spanish for families and parents to view and participate in homework assignments.

In addition, MFMC has contracted with community organizations and independent sexual health experts that specialize in providing sexual health education that is inclusive of marginalized identities and underserved populations to provide ongoing topic trainings for teachers, health educators and MFMC Program Coordinators. Training topics have included (but are not limited to): How to better serve youth in virtual spaces; Sexual health education for youth with LGBTQIA2S+ identities and Latinx identities; Understanding how racism and other systems of oppression play a role in sexual health education; How to adapt lesson content for students with autism and other developmental disabilities; How to integrate a positive youth engagement framework in the classroom. These trainings on inclusivity and equity practices address a major gap in professional development that has been consistently identified by subgrantees and by teachers statewide in Oregon in both surveys and in conversations with MFMC Project Staff.

MFMC Staff continuously participate in training and professional development opportunities to increase knowledge of gender inequities, systems of oppression and the racial disparities among youth that have an impact on their health outcomes such as teen pregnancy, STI/STD rates, gender-based violence and bullying rates. Staff often take core concepts of these trainings and integrate them into the Classroom Facilitator and Teen Leader trainings so participants can further understand how these topics effects students in the classroom. MFMC

staff will continue to provide these professional development trainings based on requested needs from local coordinators, health educators and teachers, and in consultation with the MFMC Teen Advisory Board and MFMC Advisory Group.

Youth Populations Served

The State of Oregon supports the position that sexual risk avoidance is the only 100% effective method of preventing pregnancy and STIs/STDs. To promote this message effectively, MFMC focuses on youth before they typically become sexually active. To this end, we target 6th and 7th grade students statewide, giving them an opportunity to learn and practice the necessary skills to resist peer and societal pressures and create an atmosphere that is supportive of normalizing the delay of sexual activity.

The *My Future-My Choice* curriculum is implemented in a middle school classroom enabling us to reach multiple vulnerable populations including those in foster care, living in areas with high rates of STIs, youth living in rural or frontier areas of the state, and those in culturally underrepresented groups. The LGBTQ population will also continue to be a target priority. *My Future-My Choice* has collaborated with local LGBTQ focused organizations to ensure that program content and language is inclusive of this population of youth. *My Future-My Choice* will continue its efforts to provide services to the Native American population through its presence on the Warm Springs Indian Reservation and will work to build new tribal relationships to expand services to other reservations in Oregon.

Linkages and Referral to Health Care and Other Services

Appropriate health care referrals are built into MFMC lessons and are a component of the trainings provided to teachers and Classroom Facilitators. Program staff will work with local coordinators to ensure appropriate referrals are identified for training participants and a portion

of each training will be dedicated to identifying local resources. Because programming takes place in the school classroom setting, most immediate referrals will be made to the school counselor, nurse or school-based health center for assessment and follow up. School counselors and school medical personnel are best equipped to know which local healthcare resources are available to their students and can make appropriate referrals. The MFMC Teen Advisory Board has also been compiling a map of health resources that are easily available to youth in Oregon to ensure that referrals are accessible for youth.

Performance Measures

The My Future-My Choice program will continue to collect and submit SRAE performance measures twice yearly. When onboarding new sites MFMC staff will work with local coordinators to gain local buy-in or submit the proper waiver documentation.

ODHS plans to use FYSB sponsored performance measures to measure increases in knowledge and beliefs around the benefits of delaying sexual activity, healthy relationships, and decision-making. ODHS plans to use surveys to determine the skill gain for the trained high school peer educators regarding goal setting, decision-making, healthy relationships, communication, and resisting sexual coercion. This measurement will be achieved by the analysis of pre-post survey questions and training surveys for peer educators.

National Evaluation

Should the Oregon Department of Human Services My Future-My Choice program be selected to participate in the FYSB sponsored rigorous federal evaluation, Oregon will participate. It is also understood that this may include surveys, standardized forms, and templates subject to OMB approval under PRA.

Sustainability Plan

Oregon's implementation plan includes a partnership with the Oregon Department of Education (ODE) to provide curriculum and skills training to local teachers and county health educators, which will increase their ability to sustain program delivery. By focusing efforts on providing core sex education skills training to teachers, trained educators will have an increased comfort level and skill set to effectively teach sexual risk avoidance education for years to come. In addition, ODHS continues to partner with the Oregon Health Authority, and ODE to provide core sex ed skills trainings to health educators and youth serving professionals across Oregon. These established partnerships ensure that resources and trainings can continue to operate, thereby increasing success and transmittal of teaching skills. We plan to explore additional partnership opportunities with local organizations that could take on the logistics and facilitation of the Sex Ed Workshop Series. This community-based model may ultimately be more sustainable and will ensure that educators continue to have access to topical sex education trainings that relate to equity.

MFMC curriculum materials, including printed lessons, posters, and other physical instructional materials have been provided by ODHS to ensure school districts can sustain delivery beyond grant funding. Curriculum lessons and digital materials (e.g. PowerPoints, handouts) are also available at no cost to schools and maintained on the ODHS website to allow easy accessibility to materials and additional resources.

Subrecipients will be asked to submit a plan to sustain key elements of their funded My Future-My Choice project in the event that grant funding should end. Plans will outline how subrecipients will continue to deliver MFMC in their schools, maintain their Teen Leader Program, and support local adherence to Oregon's Health Education Standards. Plans will

identify key stakeholders, local leaders, and organizations who will help move this work forward in the future. Subrecipients will identify other avenues to support teacher training and ways to ensure schools know how to access materials on the MFMC website.

Budget Narrative

Object Class Categories

Personnel

This line item represents 2.75 FTE project staff, salary determined by standardized classification. Project staff include the Team Lead Elizabeth Sampedro (1.0 FTE), Andy Dettinger (1.0 FTE), and Leah Haas (0.75 FTE). Total annual cost reflects a 6.5% increase in COLA for the next fiscal year. Staff will train classroom facilitators and peer educators, coordinate the Teen Advisory Board, and monitor the delivery of the curriculum in assigned areas. In addition, the project staff is available to counties to provide quality assurance and technical assistance as needed. Each staff member supports at least 3 contracted areas of the state in addition to other non-contracted areas and communities that implement the curriculum.

Fringe Benefits

This includes standardized employee related board assessments, social security tax, worker's comp, unemployment, Public Employee's Retirement System (PERS) and flexible benefits to include medical and dental health insurance. OPE calculations are estimates based on legislative decisions.

Travel

This reflects the out-of-state travel required by this grant to send at least three key staff persons to the Adolescent Pregnancy Prevention Grantee Conference in Washington DC (or to-be-determined location). Mileage includes personal vehicle use to and from the local airport. Miscellaneous expenses include baggage fees, parking, airport shuttle to the hotel, taxi or uber fees. The cost of attending two of the three required topical trainings was not included in this estimate. Attendance to SRAE topical trainings will be included in the in-state travel costs. As there are only three staff members, who each provide support and technical assistance to 1/3 of program areas, full staff participation in the Adolescent Pregnancy Prevention Grantee Conference is key to successful program implementation across the state.

Equipment

This grant will not be used to purchase additional equipment.

Supplies

General office supplies cover general expenses for 2.75 FTE staff members to complete their work efficiently. These may include but are not limited to copy paper, notebooks, rolling carts, laptop bags, poster carrying cases and other expenses required to fulfill job training duties. Telecommunications includes cell phones as well as maintenance. Supplies are necessary for the technical assistance offered by staff members to contracted and new areas as well curriculum training and improvements.

Contractual

This budget item reflects sub-grant expenses for local organizations to implement and coordinate the MFMC program throughout their county or district. These include health departments, school districts and Educational Service Districts (ESDs). The allocations are

determined by the projected number of students participating in each site, staffing expectations and needs for the specific area. All sub-grants are awarded non-competitively to any area/organization that can provide proof of implementation, local coordinator role fulfillment and is able to meet SRAE requirements. Sub-grants are necessary for SRAE program completion as they are able to locally ensure that program is implemented with fidelity and new populations are brought into the program.

Construction

This grant will not fund any construction activities.

Other

This line item reflects costs for printing and publication of curriculum and supporting materials. It also includes financial support for the statewide Teen Advisory Board projects and events including activities and mentorship. The department also projects cost for each staff in areas of employee professional development, in-state travel, IT services, dues and subscriptions, facilities maintenance, and utilities, etc. Estimates are used for registration fees, and it is estimated that staff will attend three virtual and three in-person in-state professional development trainings. Consultant contracts, Teen Advisory Board, and training series costs are central to the continual improvement of curriculum, positive youth development, and engagement of underserved populations. Training and local travel costs are necessary for assurance of program fidelity and the positive youth development peer education aspect of the program.

Indirect

Indirect charges cover necessary infrastructure expenses of the Oregon Department of Human Services salaries for those higher-level administrators/managers not directly being paid

by one single program or grant but oversee all department programs, as well as expenses for all department shared services. This is billed at 10% of the total award.

Exhibit 3

Department of Health and Human Services
Adm nistration for C ildren and Families

Notice of Award
Award # 2503●RSRAE
FAIN# 2503●RSRAE
Federal Award Date: August 6, 2025

Recipient Information

eci ient Name
ADMINISTRATIVE SERVICES ●REG●N DEPARTMENT
500 Summer Street NE, D-48

SALEM, ●REG●N 97301

Con ressional District o eci ient
*See Remarks

a ment Account Number and T e
*See Remarks

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Data niversal Numberin stem D N
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ro ect Director or rinci al nvesti ator
illiam Baney

william.baney dhsoha.state.or.us

Authori ed icial
*See Remarks

Federal Agency Information

Awardin A enc Contact n ormation
David Lee
Grants Management ● cer
david.lee acf.hhs.gov
202-401-5461

ro ram icial Contact n ormation
erry Milner
Program Authori ng ● cial
ACYF - Family and Youth Services Bureau
Milner. erry acf.hhs.gov
111-111-1111

Federal Award Information

Award Number
2503●RSRAE

ni ue Federal Award denti ication Number FA N
2503●RSRAE

tatutor Authorit
The Bipar san Budget Act of 2018, Title V, Section 2954, Public Law 113-93, 42 US Code 710

Federal Award ro ect Title
*See Remarks

Assistance istin Number
93.235

Assistance istin ro ram Title
Sexual Risk Avoidance Education SRAE

Award Action T e
Supplement

s the Award D
*See Remarks

Summary Federal Award Financial Information

ud et eriod tart Date 10-01-2024	nd Date 09-30-2026
Total Amount o Federal Funds bli ated b this Action	$384,531.00
20a. Direct Cost Amount	*See Remarks
20b. Indirect Cost Am t Administrative ● et	*See Remarks
21. Authorized Carryover	*See Remarks
22. ● et	*See Remarks
23. Total Amount of Federal Funds ●bligated this budget period	$566,885.00
Total A roved Cost harin or atchin where a licable	*See Remarks
Total Federal and Non Federal A roved ro ect eriod tart Date	*See Remarks nd Date
Total Amount of the Federal Award including Approved Cost Sharing or Matching	*See Remarks

Authori ed Treatment o ro ram ncome
*See Remarks

Grants ana ement icer i nature

David Lee
Grants Management ● cer

Footnotes

Department of Health and Human Services
Administration for Children and Families

Notice of Award
Award # 2503●RSRAE
FAIN# 2503●RSRAE
Federal Award Date: August 6, 2025

Recipient Information
ADMINISTRATIVE SERVICES ●REG●N DEPARTMENT
500 Summer Street NE, D-48
SALEM, ●REG●N 97301
Employer Identification Number (EIN): 1936001958A3
Data Universal Numbering System (DUNS): 956343917
Recipient's Unique Entity Identifier: X5●GNEC5ASH4
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	$566,885.00	$384,531.00	$566,885.00	2503●RSRAE	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 4

From: Sampedro Elizabeth
Sent: Thursday, August 21, 2025 7:50 AM
To: Edwards Katie E; Baney William; Krummel Tamara S
Cc: Andy Dettinger; Austin Lea; Nesler-Perez Dhyana
Subject: FW: SSRAE NOA
Attachments: SRAE_OREGON_NOA.pdf

Hi all,

I received our NOA from our federal grant officer.

Sharing it with folks for your records. I will also save it in the shared drive under this year's award information.

~Elizabeth

From: Martin-Wright, Nakia (ACF) <Nakia.Martin-wright@acf.hhs.gov>
Sent: Wednesday, August 20, 2025 1:04 PM
To: Sampedro Elizabeth <ELIZABETH.SAMPEDRO@odhs.oregon.gov>
Subject: SSRAE NOA

Greetings Oregon SSRAE

Thank you so much for your patience! Your Notice of Award for the remainder of the FY 2025 Title V State Sexual Risk Avoidance Education funds is attached, along with links to the Terms and Conditions for your grant award.

As your assigned Federal Project Officer, I will continue to provide oversight for all programmatic aspects of your grant and will continue to be your primary point of contact for all grant-related issues. The Office of Grants Management (OGM) handles all financial aspects of your grant and issues the Notice of Award.

The contact information for your assigned OGM Grant Specialist is:
OGM Specialist: Trang Le
Email: trang.le@acf.hhs.gov
Phone: 202-690-7053

Links to the Terms and Conditions:
Standard Terms and Conditions - Award Terms and Conditions | The Administration for Children and Families
Program Specific Supplemental Terms and Conditions - Title V State Sexual Risk Avoidance Education (SRAE) Program

Best Regards,

Nakia Martin-Wright, MS, CHES
Program Specialist
Family and Youth Services Bureau
Administration for Children and Families
US Department of Health and Human Services