http://www.4woman.gov/OWH/pub/commit/c1.htm

America's Commitment: Federal Programs Benefiting Women and New Initiatives as follow-up to the UN 4th World Conference on Women

Programs and Initiatives of the US Department of Health and Human Services

June 2000

This report is arranged according to the twelve critical areas of concern as outlined in the Beijing Platform for Action, signed in 1995 by 189 countries. The Platform calls for economic opportunity and security for women, quality education and health care, full political and economic participation of women, equality, and the promotion of human rights for women.

The President's Interagency Council on Women, chaired by Secretary of State Madeleine Albright, has released a document entitled "America's Commitment: Women 2000," highlighting the efforts of the United States government since 1995 in supporting and creating programs and policies that benefit women and their families. To view this document, click here.

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WELFARE REFORM

The Department of Health and Human Services Administration for Children and Families (ACF) is responsible for federal programs which promote the economic and social wellbeing of families, children, individuals and communities. Through its federal leadership, ACF sees: families and individuals empowered to increase their own economic independence and productivity; strong, healthy, supportive communities having a positive impact on the quality of life and the development of children; partnerships with individuals, frontline service providers, communities, American Indian tribes, Native communities, states and Congress that enable solutions which transcend traditional agency boundaries; services planned, reformed, and integrated to improve needed access; and a strong commitment to working with people with developmental disabilities, refugees, and migrants to address their needs, strengths, and abilities.

The Welfare Reform Law. The "Personal Responsibility and Work Opportunity Reconciliation Act of 1996," the Welfare Reform Law, made dramatic changes in the nation's welfare system to realize the goal of supporting recipients' transition from welfare to work. The new law contains strong work requirements, a performance bonus to reward states for meeting the goals of the law, state maintenance of effort

requirements, and supports for eligible families - including increased funding for child care. Families who have received assistance for five cumulative years (or less, at state option) will be ineligible for federal cash aid. States are permitted to exempt 20% of their caseload from the time limit, and states have the option to provide continued assistance and ongoing supportive services to families that reach the time limit using state funds. The law guarantees that women eligible for welfare under the old rules will continue to be eligible for health coverage for their families, including at least one year of transitional Medicaid when they leave welfare for work. The law also strengthens the child support enforcement requirements. The Administration for Children and Families is responsible for implementation of these parts of the Welfare Reform law.

Work Requirements. With few exceptions, recipients under the new law must work after two years of assistance, or earlier at the state option. To count toward state work requirements, recipients are required to participate in unsubsidized or subsidized employment, onthejob training, work experience, community service, up to 12 months of vocational training, or provide child care service to individuals who are participating in community service. Single parents with a child under six who cannot find child care cannot be penalized for failure to meet the work requirements. States can exempt from the work requirement single parents with children under age one. States develop personal responsibility plans for recipients identifying the education, training, and job placement services needed to move them into the workforce. The law allows states to create jobs by taking money now used for welfare checks and using it to create community service jobs or to provide income subsidies or hiring incentives for potential employers.

CHILD CARE AND HEAD START

The Child Care and Development Fund. The Welfare Reform law also restructures child care into a single, integrated child care system, and funds state efforts to provide quality child care services for lowincome families with parents who work or who attend school. Administered by the Administration on Children and Families of the Department of Health and Human Services, the new welfare law provides $20 billion in child care funding over six years. The Child Care and Development Fund has made available $3.2 billion to states in FY 1999. Tribes received approximately $61 million for FY 1999. This award represents an increase in child care funding of approximately $100 million for States over FY 1998.

Head Start. This is a national program, administered by the Administration on Children and Families, providing comprehensive child development services primarily to low-income pre-school-aged children and their families. Specific services for children focus on education, socioemotional development, physical and mental health, and nutrition. In FY 1999, $4.66 billion enabled approximately 830,000 preschool children from low income families to participate in 1,480 local Head Start programs. For FY 2000, the Administration is proposing $5.267 billion for Head Start services. The goal of the program is to serve 1 million children by 2002. In 1999, $340 million went to Early Head Start Programs for infants, toddlers and pregnant women of low-income families.

A.2. Revise laws and administrative practices to ensure women's equal rights and access to economic resources.

A.3. Provide women with access to savings and credit mechanisms and institutions.

A.4. Develop gender-based methodologies and conduct research to address the feminization of poverty.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is concerned about the impact of welfare reform on families, primarily women and their children, who are affected by addictive and mental disorders. SAMHSA supports a wide range of activities designed to explore the intersection of welfare reform, substance abuse and mental illness. SAMHSA supports a cadre of studies, publications, conferences and grant programs focused on welfare recipients with substance abuse and mental health problems. These activities are designed to identify the issues; promote collaboration between the welfare, substance abuse and mental health fields; develop strategies to provide quality services; and disseminate information to the field.

B. Education and Training of Women

B.1. Ensure equal access to education.

B.2. Eradicate illiteracy among women

B.3. Improve women's access to vocational training, science, and technology, and continuing education.

Women's Reproductive Health Research Career Development Centers. The National Institute of Child Health and Human Development (NICHD), in collaboration with the Office of Research on Women's Health (ORWH), is leading efforts to promote women's reproductive health research, and encourage new means to translate these findings into clinical practice. As part of this effort, new Centers will be created to support the careers of obstetrician-gynecologists who have recently completed post-graduate clinical training and are beginning basic clinical research relevant to women's health. The Centers are located in Pennsylvania, Oregon, California, Ohio, Texas, Washington, and Michigan. The goal is not only to create a bridge between clinical practice and research, but to develop continuing generations of researchers who are dedicated to women's health.

The AAHP Minority Management Fellowship Program

The Health Resources and Services Administration (HRSA), the Office of Minority Health, and the Health Care Financing Administration (HCFA), in partnership with the American Association of Health Plans (AAHP) continue to support the Minority Management Development Fellowship Program, which was launched in 1994 to meet the need for a culturally diverse pool of managers and administrators in the managed care field. Of the 56 individuals trained in the first four classes, 33 were women of color.

B.4. Develop non-discriminatory education and training.

B.5. Allocate sufficient resources for and monitor the implementation of educational reforms.

B.6. Promote lifelong education and training for girls and women.

C. Women and Health

C.1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services.

ACCESS TO CARE

Access to Care for Rural Populations

Outreach to rural populations to expand and enhance the availability of essential health services in rural areas remains an important focus of the Health Resources and Services Administration (HRSA). Projects targeting pregnant women and their children, migrant workers, and the elderly are in the forefront. From FY95-FY98, HRSA's Office of Rural Health Policy (ORHP) funded a coalition of four organizations in rural Ohio to form the Rural Health Advantage to address the issues of access to STD screening, mental health counseling, prevention education, HIV case management and migrant health services for women and their families. Another ORHP project, the Women's Health and Managed Care Education Initiative, is an ongoing comprehensive program designed to educate consumers, particularly middle to low income women, about managed care. Educational outreach using local community meetings and discussions empower women to advocate for themselves and their families when interacting with managed care providers and organizations.

National Centers of Excellence in Women's Health. Seventeen National Centers of Excellence in Women's Health around the country provide state-of-the-art comprehensive and integrated health care services, multidisciplinary research and public and health care professional education targeted toward the special needs of women. In their academic settings, they also foster the recruitment, retention and promotion of women in academic medicine. Developed in 1996 and supported by the Office of Women's Health in the Department of Health and Human Services, the Centers serve as innovative national models that can be evaluated and duplicated across the country. Six of these centers focus especially on minority women's health, and are located at the University of Washington, Seattle; University of Wisconsin, Madison; University of Illinois at Chicago; Tulane/Xavier University; Harvard Medical School; and University of Puerto Rico. Other Centers of Excellence include Boston University; University of California at Los Angeles; University of California at San Francisco; Indiana University School of Medicine; Magee Women's Hospital at the University of Pittsburgh; MCP Hahnemann University, Institute for Women's Health; University of Michigan Health System; Ohio State University; University of

Pennsylvania, Philadelphia; Wake Forest University; and Yale University School of Medicine.

MEDICAID, CHILDREN'S HEALTH INSURANCE PROGRAM, AND MEDICARE

The Health Care Financing Administration (HCFA) is the Federal agency responsible for the oversight and management of programs to assure access to quality health care for children and adults with low incomes, persons with disabilities, and the aged. The specific programs administered by CMS (formerly HCFA) are Medicaid, Children's Health Insurance Program (CHIP), and Medicare.

Medicaid

The Federal Medicaid law (Title XIX of the Social Security Act) authorizes federal matching funds to assist the states in providing health care for certain low-income and medically needy persons. The states have considerable flexibility in structuring their programs, and there are substantial variations from state to state. However, certain basic services must be offered to the categorically needy population in any State program:

- inpatient hospital services;
- outpatient hospital services;
- physician services;
- medical and surgical dental services;
- nursing facility (NF) services for individuals aged 21 or older;
- home health care for persons eligible for nursing facility services;
- family planning services and supplies;
- rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan;
- laboratory and x-ray services;
- pediatric and family nurse practitioner services;
- federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the State plan;
- nurse-midwife services (to the extent authorized under State law); and

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for individuals under age 21.

EPSDT is the child health component of the Medicaid program. Under EPSDT, States are required to provide a broad range of medical and support services to eligible children under age 21. In addition, States must perform certain activities, such as informing eligible children and their families about EPSDT and reporting data annually to HCFA.

The Term EPSDT describes the program's goals and the services that it covers:

Early: Assessing a child's health early in life so that potential diseases and disabilities can e prevented or detected in the early stages, when they can be most effectively treated;

Periodic: Assessing children's health at key points to assure continued healthy development;

Screening: Using tests and procedure to determine if children s creened have conditions requiring closer medical or dental attention, including attention for mental health problems;

Diagnostic: Determining the nature and cause of conditions identified by screenings and those requiring further attention; and

Treatment: Providing services needed to control, correct, or reduce physical and mental health problems.

Approximately 31 million persons received health care in 1998 from the various state Medicaid programs. Approximately 60% of these recipients were women. The major groups that states are required to cover include but are not limited to:

- Low-income families with dependent children and whose family income resources are below standards set by states; and

- The aged, blind, and disabled receiving cash assistance from the federal Supplemental Security Income (SSI) program or eligible for Medicaid under more restrictive state criteria. Pregnant women and children up to age 6 whose family income does not exceed a certain standard.

On average, federal funds account for approximately 57% of the cost of the Medicaid program. For the 1997 fiscal year, the federal share of Medicaid expenditures was approximately $98.5 billion. State spending on Medicaid in FY 1997 was estimated at $74.3 billion. Total Medicaid expenditures in FY 1997, including state administrative costs, were about $173 billion.

In the past, families who received Aid to Families with Dependent Children (AFDC) cash assistance were automatically eligible for Medicaid. The Welfare Reform Act of 1996

eliminated the AFDC program and replaced it with a block grant program for temporary assistance for needy families (TANF). Receipt of cash assistance under TANF does not automatically entitle the family to Medicaid. However, under welfare reform, a new Medicaid eligibility program was established with eligibility requirements linked to the old AFDC program as it existed prior to the enactment of Welfare Reform on July 16, 1996.

Children's Health Insurance Program

The Balanced Budget Act of 1997 created Title XXI of the Social Security Act referred to as the State Children's Health Insurance Program (CHIP). CHIP is a Federal-State partnership program that allows States to expand health benefits to cover low-income, uninsured children whose families earn too much for Medicaid but too little to afford private coverage. States may choose to extend health coverage to uninsured children in one of three ways: through a separate child health insurance program, expanding their Medicaid program, or creating a combination of both.

States may cover children in families whose incomes are above the Medicaid eligibility threshold but less than 200 percent of poverty, or within 50 percentage points over the State's current Medicaid income limit for children. However, under the statute, States do have the flexibility to define the income limit so that more children may be covered.

Currently, all States and the Territories have an approved CHIP plan - 16 Separate State Child Health Plans, 26 Medicaid Expansions, and 14 Combination Plans.

Medicare

Medicare is a nationwide, federally administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related services for most persons over age 65. In 1972, coverage was extended to persons receiving Social Security Disability Insurance for 2 years and persons with end-stage renal failure, regardless of age. There are approximately 39 million Medicare beneficiaries, 57% of whom are women. Medicare currently provides health insurance coverage for 97% of older Americans. Nearly 4 million of these elderly beneficiaries are over the age of 85; 57% of these oldest Medicare recipients are women. In 1998, benefits paid for Medicare patients totaled $207 billion. There are approximately 6.5 million persons dually-enrolled in both Medicare and Medicaid.

Medicare Part A , or the Hospital Insurance (HI) program, helps pay for inpatient hospital services, post-institutional home health care, short-term care in skilled nursing facilities, and hospice care for the aged and disabled. In 1998, the HI program provided protection against the costs of hospital and other medical care to over 38 million people (33.4 million aged and 5 million disabled persons).

Medicare Part B, or the Supplementary Medical Insurance Program, (SMI) pays for home health care not covered by Part A, outpatient hospital services, and other services for the aged and disabled such as diagnostic tests, medical equipment, and ambulance service. SMI enrollees pay a monthly premium ($43.80 in 1998) for services. In 1998,

the SMI program provided protection against the costs of physician and other medical services to nearly 37 million people, (over 32 million aged and 4.5 million disabled persons).

Chronic Disease Screening Programs. The Diabetes Initiative is a Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care ongoing project targeted to minority women, age 40 and older, with non-insulin dependent diabetes. The Initiative, which includes a network of ten lead health centers with key supporting links to an additional twenty five health centers nationwide, is accomplished in collaboration with the Institute for Health Care Improvement.

CANCER SCREENING AND TREATMENT

Mammography Quality Standards.

The Food and Drug Administration published the final rules of the Mammography Quality Standards Act in October 1997. In them the FDA sets high standards for FDA certification of mammography facilities, including the standards for equipment and personnel. The names and locations of FDA certified facilities are available at no charge by calling the National Cancer Institute Cancer Information Service toll-free at 1-800-4-CANCER. In addition, a list of all certified facilities is on the FDA's Internet home page (http://www.fda.gov/cdrh/mammography/certified.html).

The FDA final regulations, effective April of 1999, expanded and strengthened protections that will improve the quality of mammography at facilities in the United States. These regulations require that facilities follow the standards, be accredited by an FDA-approved accreditation body, and be inspected annually.

New Mammography Law

The Food and Drug Administration has further strengthened the nation's standards for mammography centers by requiring that all women who have mammograms be directly notified in writing about their results.

This provision was added to the final regulations that implement the Mammography Quality Standards Act (MQSA) of 1992 and went into effect April 28, 1999. A similar provision was incorporated into the statute by the Mammography Quality Standards Reauthorization Act of 1998.

Although many mammography facilities already provided direct patient notification, the FDA rule ensures that written notification occurs promptly, in easy-to-understand language, and that it is provided by every mammography facility in the United States.

Promoting Mammography for Older Women. In May 1995, First Lady Hillary Rodham Clinton, DHHS, and CMS initiated a campaign to educate women over 65 that mammography saves lives. Research has shown that early detection decreases breast cancer death rates by 30% in this age group. With the enactment of the Balanced Budget Act (BBA) of 1997, Medicare expanded its mammography coverage. As of

January 1, 1998, Medicare covers annual mammograms for its beneficiaries at age 40 and over. In addition to expanding the coverage, the deductibles were changed to ensure that cost is less of a barrier to obtaining screening mammograms. Further, the Medicare educational campaign has also been expanded to target women beginning in their forties. The theme is Mammograms: Not Just Once, But for a Lifetime. More information about this educational campaign and other CMS programs can be obtained from the CMS website at http://cms.hhs.gov/.

National Breast and Cervical Cancer Early Detection Program. The Breast and Cervical Cancer Mortality Prevention Act of 1990 authorized CDC to establish a national program to ensure that women for whom screening is recommended receive regular screening for breast and cervical cancer, prompt follow-up if necessary, and assurance that the tests are performed in accordance with current recommendations. Such screening measures could prevent approximately 15%-30% of all deaths from breast cancer among women over the age of 40 and virtually all deaths from cervical cancer. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a landmark program that was developed to offer free or low-cost critical breast and cervical cancer screening services to underserved women, including older women, women with low income, and women of racial and ethnic minority groups, including American Indian/Alaska Native women. CDC supports early detection programs in all 50 states, five U.S. territories, the District of Columbia, and 15 American Indian/Alaska Native organizations. The goal is to reduce breast cancer deaths among these women by 30 percent, and cervical cancer deaths by more than 90 percent, through increased mammographies and Pap testing.

By October 1999, more than 2 million screening tests were provided by the NBCCEDP to over 1.3 million women. A total of 632,873 women received 962,300 mammograms and 706,281 women received 1,089,049 Pap tests. Through the program, 5,880 breast cancers, 31,266 cases of cervical intraepithelial neoplasia (CIN) I, II, or III, and 508 cases of invasive cervical cancer were diagnosed.

Fiscal year 1999 appropriations of approximately $159 million enable CDC to establish greater access to screening and follow-up services, increase education and outreach programs for women and health care providers, and improve quality assurance measures for screening.

CDC collaborates with state health agencies, health care professionals and organizations, human service and voluntary organizations, and academia to (1) establish and promote increased access to breast and cervical cancer screening among underserved women; (2) develop, implement, and evaluate national and community-based interventions for cancer prevention and early detection; and (3) test new methods and replicate proven strategies to educate underserved women about breast and cervical cancers. NBCCEDP has made significant progress in building state and community partnerships to serve women. Various outreach activities have been designed to educate women and motivate them to be screened.

Programs to Encourage Women to Become More Involved in Their Own Health

Management. Other programs are designed to encourage women to become more involved in their own health management by recognizing the need for routine cancer screening and testing procedures.

- Community projects are encouraged through "witness programs" where breast cancer survivors share their cancer experiences.

- Culturally sensitive activities are underway to determine specific approaches to benefit minority communities. Mammogram mobile units are increasing the number of women being screened for breast cancer. For example, the addition of women's clinics and female providers has increased the number of older American Indian women screened for breast and cervical cancers. Brochures encouraging women to get Pap smears and mammograms have been translated into seven Asian-Pacific languages. Other projects are based in African-American churches to teach women about cancer screening.

Treatments for Breast Cancer in the Elderly. The Agency for Health Care Policy and Research (AHCPR) is conducting a 5-year study to identify the determinants of, and calculate the cost-effectiveness ratios for, three alternative treatments for local breast cancer in the elderly: modified radical mastectomy, breast conserving surgery with radiotherapy, and breast conserving surgery without radiotherapy.

Evaluation of Cervical Cytology. The Agency for Health Care Policy and Research (AHCPR) supported an evidence report on evaluation of cervical cytology. This report, a systematic review of the literature on cervical cytology screening using the traditional PAP smear and newer technologies, was performed by researchers at Duke University, one of AHCPR's Evidence-based Practice Centers .

Indian Women's Health Initiative. The National Indian Women's Health Steering Committee (NIWHSC) has focused on direct services from 1997 to 1999. Direct services include increasing the number of female providers, improving access to women's health clinics, and promoting community outreach programs for prenatal care and immunizations. Partnerships with other agencies have resulted in grants for early detection of breast and cervical cancer and the appointment of Indian women to the Minority Women's Panel of Experts. The NIWHSC advises and makes recommendations to Indian Health Services (IHS) on Indian women's issues and sponsored "Indian Women in Action," a community mobilization training.

The National Resource Center on Native American Aging at the University of North Dakota -"Increasing Breast Cancer Awareness Among American Indian Women"

Funded by the Administration on Aging, the National Resource Center on Native American Aging at the University of North Dakota conducted two breast cancer awareness projects. The first, "Increasing Breast Cancer Awareness Among American Indian Women" was undertaken with nursing students at the University of North Dakota. Four students currently participating in the Quentin N. Burdick Indians Into Nursing Program (RAIN) developed and worked with elders from the Spirit Lake Nation to

encourage young women to perform monthly breast self-exams in order to prevent and detect early breast cancer. The second part of the project was a national conference bringing together elders and practitioners to address breast cancer concerns. "Elders Stand Against Breast Cancer: Awareness and Survival Into the 21st Century" conference was held August 24-25, 1998 in Bismarck, North Dakota. The purpose of the conference was to provide assistance and direction for starting local cancer awareness programs in the home communities of participants. A guide, "Elders Stand Against Breast Cancer: Community Support and Awareness; A Resource Guide for Program Development" was prepared to assist communities in the development of local programs. The guide was designed to answer basic questions about cancer in general and breast cancer in particular, as well as, such topics as treatment options, nutrition, and how to start a cancer awareness program. The resource guide is intended for replication at the local level. Mammography screenings were offered during the conference. The Center also added breast cancer awareness information to its Website at http://www.und.nodak.edu/dept/nrcnaa/.

The Native Elder Health Care Resource Center, Division of American Indian and Alaska Native Programs, at the University of Colorado Health Sciences Center: The Native Elder Health Care Resource Center (NEHCRC) serves as a technical assistance resource to the 223 tribal organizations funded by the Administration on Aging. NEHCRC's mission is to enhance the cultural competence of providers delivering health care to older American Indians and Alaska Natives through a multifaceted program of training and technical assistance, information dissemination, continuing education and applied research. NEHCRC has expanded its website (53 programs and 13 information/referral and advocacy groups) with information about the prevention, detection and management of breast cancer and by setting up hyper-links with breast cancer information sites such as the Native American Program of Excellence at the AMC Cancer Research Center, and has distributed 393 copies of the continuing education module entitled, "Cancer among Elder Native Americans" in cooperation with the Cancer Research Center. NEHCRC also participated in the development of personal diaries authored by American Indian and Alaska Native cancer survivors and cosponsored the development of a nationwide American Indian/Alaska Native Cancer Survivor Phone Line (1-800-361-9283) that enables survivors, family members and friends to link with other Native people who have experienced cancer.

Home and Community Based Cancer Outreach and Education for Older Women. Funded by the Administration on Aging, the National Association of State Units on Aging (NASUA) developed an initiative that demonstrates the effectiveness of home and community-based care programs and services to conduct breast cancer outreach and education for older women. The project goal was to activate home and community-based care systems to deliver breast cancer prevention to large numbers of active and homebound older women, thus also providing a replication model for outreach/prevention initiatives for other cancers or chronic diseases. Specifically, project staff is producing resource materials; developing effective outreach and education strategies appropriate for home and community-based care service system; identifying organizational linkages for local screening referrals; and conducting outreach demonstrations. NASUA developed and tested a home and community-based care

breast cancer outreach and education kit in five low-income and minority demonstration sites. The sites are:

1. Delaware, Sussex County -very rural, with a large Hispanic and Native American Indian population;

2. Georgia, Macon County -rural, with a large African American population;

3. Illinois, Springfield -mid-sized city with a mixed-ethnicity population;

4. New Jersey, Atlantic County -urban/suburban/rural mix; and,

5. New York, Albany County -targeted to Hispanic and African American communities.

A wide range of print materials on breast health awareness was tested with two different focus groups in each state. One focus group was comprised of 12-15 older women in the target group and the other focus group with community organizations related to health care for this population in the community. The materials included a broad scope of messages to increase awareness and motivate older women to action. The breast health awareness campaigns continued in each state through the spring of 1999, in order to measure the effectiveness of and some degree of outcomes for each campaign. NASUA staff provided onsite training in campaign implementation to the community-level participants in each state, and telephone technical assistance to the state-level project staff on a regular basis. Bimonthly conference calls enabled peer support, cross-fertilization of ideas and strategies and group problem solving to overcome barriers. The next steps in the project are to (1) revise and finalize the outreach and education kit, based on experiences in the five demonstration states, and promote replication in other states and (2) develop and carry out a process evaluation to determine the effectiveness of the various outreach strategies employed in the five state demonstrations, and to assess the efficacy of the resource materials developed for the project.

FDA Breast Cancer Product Approvals:

The Food and Drug Administration approved a new indication for Nolvadex (tamoxifen citrate) of reducing the incidence of breast cancer in women at high risk for developing the disease. This new indication for tamoxifen, which has been used as a breast cancer treatment for more than 20 years, resulted from a recent study of the drug, conducted by the National Cancer Institute (NCI), in women who were judged to be at increased risk of breast cancer. The study showed that tamoxifen reduced the chance of getting breast cancer by 44 percent. The data also showed that tamoxifen treatment did not completely eliminate breast cancer risk, and that its longer term effects are not known.

Trastuzumab (trade-name Herceptin), the first monoclonal antibody licensed for breast cancer, was approved in September 1998 for use alone for certain patients who have unsuccessfully tried other chemotherapies, or as a first-line treatment for metastatic disease when used in combination with paclitaxel (Taxol).

Other FDA Product Approvals:

Osteoarthritis and Menstrual Pain:

FDA has approved Vioxx (rofecoxib), a new drug for treatment of osteoarthritis, menstrual pain and for the management of acute pain in adults. Vioxx is a non-steroidal anti-inflammatory drug or NSAID, and is the second approved version in a class of drugs commonly referred to as a "Cox-2 inhibitor".

Two products were also approved for the treatment of rheumatoid arthritis. Leflunomide (Arava) is the first oral treatment approved for slowing the progression of active rheumatoid arthritis. Etanercept (Enebrel) is the first biotechnology product available which reduces the symptoms of individuals with moderate to severe active rheumatoid arthritis who have not responded well to other treatments.

Obesity

The Food and Drug Administration has approved orlistat, a new drug to treat obesity. Orlistat is the first drug in a new class of non-systemically acting anti-obesity drugs known as lipase inhibitors.

Unlike other obesity drugs, orlitstat prevents enzymes in the gastrointestinal tract from breaking down dietary fats into smaller molecules that can be absorbed by the body. Absorption of fat is decreased by about 30 percent. Since undigested triglycerides are not absorbed, the reduced caloric intake may have a positive effect on weight control

Contraception
A second emergency contraceptive called PLAN B was approved on July 28, 1999. The tablet contains the hormone levonorgestrel for the indication of emergency contraception

OLDER WOMEN

LifeCourse Planning: The Administration on Aging (AoA) is preparing a lifecourse planning initiative aimed at maximizing options related to: 1) economic security, including pensions and public benefits; 2) health insurance benefits, long term care arrangements; 3) living arrangements; 4) community participation and social engagement, including employment, volunteer, education, and active aging alternative; and, 5) consumer protection, including telemarketing and fraudulent investment scams. AoA's nationwide network of state and area agencies on aging and local service providers target populations in greatest economic and social need, with particular attention to low-income minorities. Through the network, information, counseling and assistance will be provided to mid-life and older Americans and their family members to enable them to engage in lifecourse planning.

National Policy and Resource Center on Women and Aging: The Administration on Aging funds the POWER Center, (Program on Women's Education for Retirement), a

joint project of the Women's Institute for a Secure Retirement and the National Center on Women & Aging at Brandeis University. The mission of the Power Center is to inform women about the issues that affect their long-term financial security and to stress the importance of taking an active role in planning for their retirement. The Power Center educates low income women and women of color about resources and materials available to them and serves as a clearinghouse for information on the financial issues that influence their lives. The POWER Center staff conducts training sessions and information panels for women nationwide; and identifies and provides access to a variety of financial planning tools such as fact sheets on how to choose a financial planner and descriptions of financial instruments. In addition, the POWER Center assists women in improving their financial status and encourages women in seeking better-paying and secure jobs with benefits and growth potential. The POWER Center can be contacted by calling 202-393-1990, toll free on 800-929-1995, via FAX on 202-638-1336 and at: http://www.wiser.heinz.org/powercenter.html. They, also, may be accessed from the AoA home page: http://www.aoa.gov.

Study of Women's Health Across the Nation (SWAN). Funded initially in September 1994 at $28 million for the first five years, SWAN uses a cooperative agreement mechanism and is supported by the National Institute on Aging (NIA) (GP and BSR), the National Institute of Nursing Research (NINR), the Office of Research on Women's Health (ORWH), NIMH, and the National Center for Complementary and Alternative Medicine (NCCAM). SWAN has 7 clinical field sites, a coordinating center and two central laboratories. This seven-site study generates collaborative epidemiologic studies characterizing the biological and psychosocial conditions preceding and following the menopausal transition and the effect of this transition on subsequent health and risk factors for age-related disease. Each site will study Caucasian women and bi-ethnic populations, with four sites targeting African-Americans, and three targeting Japanese-, Chinese- and Hispanic-Americans. Current plans call for the recruitment of over 3,700 mid-life women, at least half of whom will be minorities.

SWAN was designed in two phases: an initial cross-sectional survey, and prospective cohort study. All seven SWAN clinical field sites completed recruitment for the cohort by December 1997. Two annual follow-ups were completed and a third started during the first five year funding cycle that ended May 31, 1999. After a successful recompetition of its renewal application(s), the second five-year funding cycle begun on June 1, 1999 will continue the work started in SWAN I. SWAN II has also been allocated $28 million for five years. At the end of SWAN II, five annual follow-up visits will have been completed on the cohort. Progress on the two phases of the study design is as follows:

(a) The database from the initial cross-sectional survey was cleaned and the final version released in January 1999. Since then, sixteen manuscripts have been submitted for publication and over 70 writing groups have formed and are working on manuscripts (see Appendix). The final cross-sectional database consisted of completed telephone interviews from 16,047 women between the ages of 40 and 55 (7771 Caucasian, 4393 African American, 1942 Hispanic, 654 Chinese, 845 Japanese, and 442 women of mixed ancestry).

(b) The second, longitudinal phase, consisted of enrollment into the cohort of eligible premenopausal women (aged 42-52, "at risk" for a natural menopause [i.e., with a uterus and at least one intact ovary], menstrual period within the past three months and no hormone medications) from the cross-sectional phase. Enrollment into this phase began in January 1996 and was completed in December 1997. A total of 3,304 women were enrolled into the cohort and have completed the baseline study components (1550 Caucasian, 936 African American, 286 Hispanic, 251 Chinese and 281 Japanese). Writing groups have formed to develop priority manuscripts from the four scientific areas: cardiovascular, ovarian markers, bone mineral density and turnover, and lifestyles and behaviors. Data cleaning is nearly complete, and most of the baseline data has been released for analysis.

MENTAL ILLNESS AND SUBSTANCE ABUSE

The Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services supports knowledge application grant programs for residential substance abuse treatment for pregnant women and women with dependent children. SAMHSA also supports knowledge development programs for women with histories of violence and co-occurring mental health and substance abuse disorders.

Substance Abuse Prevention and Treatment Block Grant. Between 1998 and 1999, the Substance Abuse Prevention and Treatment block grant received a $225 million increase, for a total of $1.6 billion to support and maintain state substance abuse prevention and treatment systems. The block grant contains several provisions specifically related to women. States must ensure that all pregnant women in the state who seek or are referred to substance abuse services, and would benefit from such services, are given preference in admissions to treatment facilities receiving block grant funds. If no treatment facility has the capacity to admit a pregnant woman, states must make interim services available no later than 48 hours after the woman seeks treatment. States are required to maintain the level of block grant funds allocated to services for pregnant women and women with dependent children.

Through the **Community Mental Health Services Block Grant**, funded by the Substance Abuse and Mental Health Services Administration in FY 1999, the States develop mental health plans that create strong networks of families, providers, and consumers to direct Federal and non-Federal funds to local needs. Although this block grant does not contain specific provisions for women's services, it has a major impact on women's mental health due to the proportion of individuals with mental illness who are women.

REPRODUCTIVE HEALTH

Provision of Services. HHS directly supports the provision of reproductive health and family planning services through the Title X (of the Public Service Health Act) Family Planning program. Each year, approximately 4.5 million persons receive Title X-supported services, 85% of them from low-income households. In addition, other

programs such as Medicaid, Maternal and Child Health, and Social Service Block Grants provide some reproductive and family planning services.

Improved Access to Information. The federal government took steps, beginning in 1993, to ensure that all women cared for through federal family planning programs have access to complete and accurate information, including pregnancy options counseling when requested, by suspending a 1988 rule preventing federally funded clinics from providing full information.

Research on Access to Contraceptive Services and Prenatal Care. The National Institute of Child Health and Human Development (NICHD) continues to fund several studies to examine the relationship between health care services and women's choice of contraceptives. For example, NICHD-supported researchers are now evaluating whether contraceptive care initiated in sexually transmitted disease clinics (with transition to a primary care provider for ongoing family planning services) can improve: 1) the rate of long-term use of effective contraception, and 2) the rate of unintended pregnancy among high-risk women.

NICHD researchers are also collaborating in a randomized, controlled, clinical trial that compares a modified system of prenatal care to a conventional system of care currently in place in developing countries. Since perinatal experts and national groups have recommended limiting prenatal visits for low-risk women to conserve resources for women at high-risk of poor pregnancy outcomes, this study will help determine the most cost-effective model of prenatal care for low-risk women.

Fertility Clinic Report. Congress enacted P.L. 102-493, the Fertility Clinic Success Rate and Certification ACT of 1992, to provide information to the public concerning the success rates for individual fertility clinics providing assisted reproductive technology (ART) and to assure the quality of services by associated embryology laboratories, through inspection and certification. In 1997, the Centers for Disease Control and Prevention (CDC) worked closely with the American society for Reproductive Medicine (ASRM), the Society for Assisted Reproductive Technology (SART), and RESOLVE (a national consumer organization for couples experiencing infertility) to establish and adopt pregnancy success rate reporting definitions and procedures. CDC completed analysis of the 1995 data, and this transitional report was jointly released by CDC, RESOLVE, and SART 1997. The 1995 annual report consist of two parts: a national report that provides consumers with in depth information about factors that may influence their chances of pregnancy success, and a clinic-specific report that gives consumers information about pregnancy success rates and services offered for individual clinics. Among its findings, the report shows that the live birthrate after ART is about l9.6% and that the age of the woman is the single most important factor associated with success rate. A second report based on 1996 data was subsequently published in 1998. Both reports consist of:

- a national report that uses information from all U.S. fertility clinics to provide an in-depth national picture of assisted reproductive technology (ART);

- fertility clinic tables that provide ART success rates for each clinic that submitted and verified its data;

- an appendix containing a glossary of terms and lists of reporting and nonreporting clinics in the United States.

More than 20,600 babies were born as the result of ART being performed in 1996. According to this latest report, 300 clinics nationwide conducted 64,036 ART cycles. **About 1 in 4 (22.6%) ART cycles resulted in births for women using their own eggs.** According to the report, approximately 3 in 4 (77.4%) ART attempts did not result in a birth. Age of the woman was the single most important factor associated with success rate.

CDC has developed a Website at http://www.cdc.gov/nccdphp/drh/art.htm that enables consumers to research fertility clinics in their local area. In 1998, Consumer Reports recognized this Website for its contribution to educating consumers.

ACCESS TO INFORMATION AND RELATED SERVICES

National Women's Health Information Center. The National Women's Health Information Center (NWHIC), sponsored by the Office on Women's Health in the Department of Health and Human Services, is the only combined comprehensive health web site (www.4woman.gov) and toll-free service (1-800-994-WOMAN). The NWHIC web site provides links to more than 3,000 publications and 2,000 reputable organizations on women's health. NWHIC also provides answers to frequently asked questions on top health issues of concern to American women. The web site and toll-free service, both in operation for less than a year, have already received more than nine million hits and 10,000 phone calls, respectively, from women seeking information on a wide variety of women's health issues. The toll-free number, operational from 9 a.m. to 6 p.m. eastern time, connects the caller to an English or Spanish-speaking health information specialist who will refer the caller to the right source of information. Women and their health care providers can also order fact sheets, brochures and other printed materials by phone.

Health Hotline Database. The National Library of Medicine at the National Institutes of Health maintains an online searchable database of health-related organizations operating toll-free telephone services as a public resource. You can search this database by health issue, key words in the name or description of the organization, or by city, state, or zip code. This resource is located on the Internet at http://newsis.nlm.gov/hotlines/.

National Minority Women's Health Conference. "Bridging the Gap: Enhancing Partnerships to Improve Minority Women's Health," a major national health conference was convened by HHS in January, 1997 in Washington, D.C. to focus critical attention on special health issues affecting women of color and to develop partnerships to improve the health of minority women. The conference provided a national forum to (1) present information on the status of minority women's health; (2) discuss innovative partnership models from the academic, business, professional and community sectors,

and the federal, state, and local governments that target minority women; (3) conduct skills-building workshops for partnership programs; and (4) discuss strategies for key stakeholders to improve minority women's health.

Young Women's Health Promotion Program. *Get Real: Straight Talk on Women's Health* is a video kit that was developed in 1996 in collaboration with the Society for the Advancement of Women's Health Research by the Office on Women's Health. The video kit, which includes a facilitator's guide, is designed as a health promotion program for women between the ages of 18 and 24. Focusing on this age group provides an important opportunity for education about not only the immediate health issues for young women (e.g. HIV/AIDS and other STDs, contraception, alcohol and substance abuse, smoking, eating disorders, and violence) but also the diseases that may strike later in life including breast cancer, osteoporosis, and heart disease. The video kit provides relevant health information and encourages young women to practice healthier behaviors (e.g. appropriate nutrition and exercise, safe sex or abstinence, not smoking) in order to prevent or lower their risk for developing these diseases and other health problems. The video and facilitator's guide have been distributed widely across U.S. college campuses. The video is used in college roundtable panels and discussion groups, facilitated and funded by the Office on Women's Health, at colleges and universities around the country to engage college age women in awareness of healthy behaviors.

National Clearinghouse for Alcohol and Drug Information. The Clearinghouse, which is funded through SAMHSA's Center for Substance Abuse Prevention, designs, implements, and evaluates innovative knowledge transfer and communication strategies. It is the central national resource for the latest information on all aspects of substance abuse, answering millions of inquiries annually. The Clearinghouse distributes all of SAMHSA's major women's publications as well as numerous other materials relating to women's substance abuse prevention and treatment. It operates the Center's electronic communications systems, PrevLine, which is available via the Internet and via direct dial-up at (301) 770-0850. It also distributes many of SAMHSA's grants application kits to interested organizations. The main Clearinghouse number is 1-800-729-6686.

The National Institute on Drug Abuse (NIDA) has developed a web site dealing with women, gender differences, and drug abuse. The web site, "Women's Health and Gender Differences," became operational within NIDA's web site in April 1998 http://www.nida.nih.gov/WHGD/WHGDDirRep13.html. Topics include an overview of NIDA's research program in this area, research findings covering a wide range of topics, a list of publications that either focus on this subject or contain relevant information, and information on funding opportunities in the area of women and gender differences.

CancerNet. CancerNet was created to meet the need for up-to-date, accurate cancer information by the National Cancer Institute's (NCI) International Cancer Information Center and Office of Cancer Information, Communication and Education. Updated monthly, CancerNet provides you with easy access to the most current information on cancer. All of the information included in CancerNet is continually reviewed and revised

by oncology experts and is based on the latest research in the field. The web link to Cancernet is http://cancernet.nci.nih.gov/.

Breast Cancer Pilot Projects. The National Action Plan on Breast Cancer's (NAPBC) Information Action Council has established the Bridging the Gap Initiative pilot project, in which community-based organizations link informationally-underserved women with breast cancer information available through the Internet. This 2-year project is currently in the evaluation phase. More information about this initiative and the four community sites is available on the NAPBC's web site (www.4woman.gov/napbc).

[See H.2. for more information]

The Hereditary Susceptibility Working Group of the National Action Plan on Breast Cancer (NAPBC), in partnership with many professional organizations, developed an educational curriculum to provide high-quality, customized education and training for health care professionals on this complex and pressing issue. *Hereditary Susceptibility to Breast and Ovarian Cancer: An Outline of Fundamental Knowledge Needed by All Health Care Professionals* is available on the NAPBC's web site (http://www.4woman.gov/napbc). [See H.2. for more information]

Women's Health in Health Professions Education.

Medical School Model Curriculum. The Health Resources and Services Administration (HRSA), National Institutes of Health's Office of Research on Women's Health (ORWH) and the Office on Women's Health (OWH), in collaboration with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, completed the first comprehensive study that examines how women's health and gender-related issues are taught in the basic and clinical sciences. The report based on this study also provides recommendations for a model core women's health curriculum in order to bring women's health into the mainstream of medical education.

Dental and Nursing Curriculum

The Department of Health and Human Services (HHS) is continuing to assess women's health in health professions education, building on its recently completed study of medical school curriculum and recommendations for a model core women's health curriculum for medical schools. In February 1999, the Department released a new report "Women's Health in the Dental School Curriculum: Report of a Survey and Recommendations." The report provides the analytical results of a survey of U.S. and Canadian dental schools conducted during 1997 by the American Association of Dental Schools, and documents how women's health and oral health issues are addressed in dental education. As noted in this report, areas of concentration for women's health/oral health in dental school curricula include medical history, normal and abnormal female biology, and effects of the aging population on oral health care needs and services. A third HHS report, in collaboration with the American Association of Colleges of Nursing, is currently underway that will focus on women's health in the undergraduate nursing curriculum. These reports provide significant contributions to academic leaders and clinical program planners who are interested in taking steps toward the integration of

women's health issues into curricula and training. The reports are available through HRSA's Office of the Senior Advisor for Women's Health, 301-443-8695.

Directory of Women's Health Residency and Fellowship Opportunities. In 1996, the HHS Office of Women's Health began producing and widely disseminating a first-of-its-kind directory of women's health residency and fellowship opportunities in medicine. The directories are updated every spring and sent to all medical schools and osteopathic medical schools, as well as any interested individuals. The directory is available through the publications request service on the National Women's Health Information Center (NWHIC) [see description above for more information on NWHIC].

Women and Primary Care: An Agenda for Change. In November 1998, HRSA's Bureau of Primary Health Care (BPHC) released a new strategy entitled "Women and Primary Care: An Agenda for Change - Horizons for the 21st Century". The Agenda provides a broad-based vision for women's health to ensure access to primary care and eliminate health disparities for the more than 4.8 million medically underserved and minority women served annually by BPHC-funded programs. The development of a national multicultural women's health practice network, a national replication strategy for innovative women's health programs, and a council of multicultural women's health education, training and research are components of the Agenda.

Models That Work Campaign. HRSA's Models That Work Campaign is an innovative effort to bring attention to programs that provide community-based primary health care services to vulnerable populations. In an annual competition, programs are identified that fulfill key criteria, including ease of replication to other communities, strong community collaborations, and documentation of improved primary care outcomes. In FY2000, the Campaign will include a special honoree category for women's health and related services. Two service delivery models that provide a combination of coordinated preventive, primary and mental health care services for women will be recognized. Further information on the Models That Work Campaign is available on the world wide web at http://www.bphc.hrsa.gov/mtw/, or by calling 301-594-4310.

Reproductive Health Education Activities. HHS has a variety of other "health education" activities that provide consumers, health care providers, and others with information on such topics as family planning and teen pregnancy prevention; responsible use of contraception, including protecting oneself against STDs and HIV; the impact of substance use during pregnancy and effective strategies to prevent and treat substance abuse among pregnant women.

D. Violence Against Women

D.1. Take integrated measures to prevent and eliminate violence against women

The Advisory Council on Violence Against Women, created in 1995, co-chaired by Attorney General Janet Reno and Secretary of Health and Human Services Donna Shalala consists of 46 domestic violence and sexual assault experts, including researchers, practitioners, survivors, and representatives from a wide range of other fields including law enforcement, media, health and social services, education, and

victim advocacy working together to prevent violence against women. The Office on Women's Health serves as Secretariat. The Council provides the Attorney General Janet Reno, and Health and Human Services Secretary Donna Shalala, with practical and general policy advice concerning the implementation of the Violence Against Women Act. The Council focuses on three main areas through Task Forces: Changing Social Norms and Attitudes, Prevention and Early Intervention, and Service Provision. Currently, the committee is working on establishing an agenda for the nation. A draft of this Agenda was presented at The Millennium Conference on Domestic Violence in September 1999 and at the National Sexual Assault Resource Sharing Project in October 1999, as well as disseminated electronically for comment. The Agenda for the Nation on Violence Against Women will be presented at White House millennium observances in early 2000.

DHHS Violence Against Women (VAW) Steering Committee. This Committee has the responsibility of coordinating the DHHS response to issues related to violence against women and their children and also coordinates DHHS violence related activities with those of other Federal agencies (i.e. Department of Justice).

DHHS Employee Domestic Violence Policy. Released in October 1998, this Action Guide is written as an addendum to the Workplace Violence Training Guidelines that were issued in May 1997. This document informs Department of Health and Human Services employees of the measures that can be taken if they suspect a domestic violence situation exists. The guide also includes examples of possible physical security precautions and policies and procedures others have found helpful in preventing domestic violence.

Office on Women's Health (OWH) Nursing Task Force on VAW - represents 30 national nursing organizations and is working with all participating organizations to develop and implement a unified national nursing response to domestic violence. This task force is divided into four working groups: 1) Education, 2) Prevention and Intervention, 3) Universal screening and 4) Workplace Violence.

Collaboration between OWH and Institute on Domestic Violence in the African American Community – to develop a focus group research instrument on violence against women in the African American community. The focus group research instrument shall address 1) African American women's experience and perception of shelter services, as well as the health care system's services and responsiveness to their needs; 2) African American women who work in the domestic violence system's perception and experience with victims of trauma who turn to them for assistance (such respondents should include shelter/crisis advocates); 3) the impact of poverty and access to services for these women.

Social Workers Initiative - The Office on Women's Health (OWH) is collaborating with national social worker organizations to coordinate a national effort to address Violence Against Women issues, as done with the National nursing organizations. The OWH plans to support a national conference on this issue is also preparing to collaborate with the Howard University School of Social Work on the role of minority social service professionals in Violence Against Women prevention and intervention. The OWH is also

working with the social workers to plan a summit for the year 2000 to develop a national action plan for continuing and strengthening their collaboration.

Health Resources and Services Administration (HRSA): Domestic Violence.

In July 1998, as part of an Agency-wide initiative to combat domestic violence, HRSA released its "Action Plan to Prevent Family and Intimate Partner Violence". The Plan includes five components: policy, training, service delivery, family education and prevention promotion, and research and evaluation. The top priority areas for FY98 and FY99 under HRSA's Action Plan have been the training of health care providers and the incorporation of domestic violence screening and intervention strategies into service delivery at HRSA-funded sites. Copies of the Action Plan are available through the HRSA Office of Minority Health, 301-443-2964, or on their website at www.hrsa.gov/hrsa/omh/omh.htm.

HRSA is currently developing a three-part Distance-Based Learning Domestic Violence Project that will primarily target HRSA's service delivery grantees (i.e. community and migrant health centers, area health education centers, HIV/AIDS service delivery sites, maternal and child health care sites, and rural health centers). The primary purpose of this training effort is to increase the skills of providers at HRSA's service delivery sites to identify and intervene in cases of domestic violence and participate effectively as members of a coordinated community response team.

Seventeen states receiving maternal and child health block grants have incorporated domestic violence performance measures into their programs to collect data from maternal and child health service sites within their states. The measures will yield information on types of abuse, numbers of abused women, abuse during pregnancy, and other related information.

HRSA provided the Better Homes Fund with approximately $48,000 one-time funding in FY98 to develop a diagnostic screening tool to identify homeless women who have suffered abuse or are in current abusive situations. The Fund will complete a manual in FY99 to accompany the screening tool that instructs providers on violence and homeless women.

Domestic Violence in the Rural Community. HRSA is continuing to look at the impact of domestic violence on rural health communities, and to address the prevention, identification, and treatment of domestic violence in remote areas across the country.

Domestic Violence Training Programs. HRSA's Maternal and Child Health Bureau (Maternal and Child Health Bureau), in collaboration with the American College of Nurse Midwives, developed basic professional training and continuing education curricula for nurse midwives to recognize and intervene appropriately in domestic violence cases. Train-the-trainers workshops were offered to nurse midwifery faculty and a training video and home study module were produced. The video was broadly disseminated to state agencies, rural health clinics, advocacy groups, and midwifery education programs.

HRSA's Maternal and Child Health Bureau, in collaboration with the State of Alaska, Department of Health and Social Services, developed a model for training health care professionals in rural areas to recognize and intervene appropriately in domestic violence cases.

The HHS Office of Minority Health administers the Family and Community Violence Prevention Program, under which 19 historically Black and Minority Colleges and Universities established Family Life Centers to address the problem of family and community violence. Additional Family Life Centers were supported in FY 1999.

The Administration for Children and Families (ACF) administers the Family Violence Prevention and Services program. In fiscal year 1999 ACF made $70 million available to States and tribes for the provision of shelters and services to victims of family violence and their dependents. ACF also funds the State Domestic Violence Coalitions (membership organizations in each State consisting of a majority of shelter operators and domestic violence service providers) and the domestic violence resource center network. The resource center network consists of the National Resource Center on Domestic Violence, the Battered Women's Justice Project, the Resource Center on Child Custody and Protection, the Health Resource Center on Domestic Violence, and the Resource Center for Native American Women (The Sacred Circle). The National Domestic Violence Hotline is also an entity in the resource center network and is supported through grant funds to the Texas Council on Family Violence. The National Hotline is a toll-free number (1-800-799-SAFE) available 24 hours a day, 7 days a week and everyday of the year. Issues for youth were highlighted in a Report to Congress, "Youth Education and Domestic Violence Model Programs" in which ACF recommended 5 programs as potential models for the nation.

SERVICES

National Domestic Violence Hotline. In February 1996, President Bill Clinton announced the opening of the 24-hour, toll-free National Domestic Violence Hotline to provide crisis assistance and local shelter referrals to victims of domestic violence throughout the country. The Hotline was funded through a Department of Health and Human Services grant to the Texas Council on Family Violence. The hotline number is 1-800-799-SAFE; the TDD number for the hearing impaired is 1-800-787-3224.

HHS Grants under the Violence Against Women Act. Department of Health and Human Services programs under VAWA include grants for:

- **Battered Women's Shelters.** Through the Family Violence Prevention and Services Act (FVPSA) authorized within the VAWA legislation, State agencies, Territories, and Native American Tribes and Alaskan Native Villages receive grants for the provision of emergency shelter services to domestic violence victims and their family members. In addition, funds may be used for related services such as counseling relating to family violence, legal assistance through civil and criminal courts, childcare services who are victims of family violence, and other prevention-focused activities. In 1999, HHS awarded $71 million to

States, Territories, and Native American Tribes and Alaskan Native Villages for shelters and related assistance.

- **State Domestic Violence Coalitions.** In 1999, HHS awarded $8.8 million in statewide grants to private nonprofit domestic violence coalitions to conduct activities that promote domestic violence intervention and prevention, and increase public awareness of domestic violence issues. State coalitions reaffirm a Federal commitment to reducing family and intimate violence and urge States, localities, cities, and the private sector to become more involved in State and local family violence prevention planning efforts. Specific areas of focus for State coalitions are systems advocacy, statewide planning, administration, direct services, and public awareness and community education.

- **Discretionary Programs and Activities.** Discretionary funding supports public agencies and nonprofit organizations in establishing, maintaining, and expanding programs and projects to prevent incidences of family violence and provide immediate shelter and related assistance for victims of violence and their family members. Furthermore, the collective efforts of these entities contribute to the overall improved systems response to domestic violence at the State and local levels.

Female Genital Mutilation (FGM). HHS is conducting outreach within the U.S. to affected communities to educate the public about health issues associated with Female Genital Circumcision (FGC) and Female Genital Mutilation (FGM).

The Department of Health and Human Services is carrying out activities in three areas related to FGC/FGM:

1) Data Estimates. The Centers for Disease Control and Prevention (CDC) has developed estimates based on U.S. Census data and FGC/FGM rates for African countries to derive an estimate for the U.S. population at risk of this procedure. CDC found that 168,000 women and girls either had or were at risk of FGC/FGM. Of these, 48,000 were girls under the age of 18. These estimates were published in Public Health Reports in September/October 1997.

2) Outreach. Community meetings were held in seven U.S. cities where major concentrations of ethnic groups that traditionally practice FGC/FGM reside to identify critical elements of outreach to these communities. Reports and recommendations have been synthesized.

3) Training materials. The Department supported publication of a new technical manual for health care providers entitled "Caring for Women with Circumcision" by the Research, Action and Information Network for Bodily Integrity of Women (RAINBO), an organization recognized as one of the technical experts on this issue. The manual, published in January 1999, fulfills part of a recent Congressional directive to the Department, to develop recommendations for the education of medical and osteopathic students regarding female genital mutilation and complications arising from such practices, and the dissemination of this information to such schools. The training

manual serves as a clinical guide for health practitioners on how to manage physical complications of female circumcision/female genital mutilation. It also includes discussion on culturally sensitive counseling, education, and outreach information, legal issues of concern, and special concerns of adolescent young women. To date, the guide has been disseminated to schools of medicine, nursing, and public health, as well as a number of allied health professional organizations. Requests for the training manual can be made to the Office on Women's Health, (202) 690-7650.

Families at Risk. HHS administers the program "Promoting Safe and Stable Families," and assists State child welfare agencies and tribes to fund family preservation services, family support services, time-limited family reunification services, and adoption promotion and support services. It was created in 1993 (funding began FY1994) and current funding for FY1999 is $275 million.

Treatment Improvement Protocol on Substance Abuse Treatment and Domestic Violence. In January, 1998, the Substance Abuse and Mental Health Services Administration released a Treatment Improvement Protocol, or TIP, on Substance Abuse Treatment and Domestic Violence (TIP 25). The TIP series is a compendium of best practice guides produced for substance abuse service and treatment providers. The report recommends that providers of treatment services for alcohol and drug abusers and for victims of domestic violence move toward more linked systems of delivering services to provide more effective care. The volume provides diagnostic tools to help drug addiction counselors recognize when clients are victims or perpetrators of domestic violence, and also to aid those who counsel abused women in need of protection to recognize drug and alcohol addiction. The TIP also includes a chapter on legal issues, and the sometimes conflicting federal rules of confidentiality for patients, and state laws requiring professionals to report abuse, particularly suspected child abuse. TIPs are available on the SAMHSA web site at http://www.samhsa.gov or they can be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686; TDD (for hearing impaired), 1-800-487-4889.

PUBLIC EDUCATION

HHS Grants. Department of Health and Human Services (HHS) programs under VAWA include:

- education and prevention grants to reduce sexual assault against women; and
- grants to develop educational model curricula.

Community Checklist. The Advisory Council on Violence Against Women was created in July 1995, and is co-chaired by the Attorney General and HHS Secretary and made up of 47 experts--representatives from law enforcement, media, business, health and social services, victim advocacy, and survivors. Seven subgroups then made recommendations focusing on heightening public awareness about violence against women and encouraging education for those who interact with victims and perpetrators of violence against women. The Council published *A Community Checklist: Important Steps Communities Can Take to End Violence Against Women* in October 1996.

E. Women and Armed Conflict

E.1. Increase the participation of women in conflict resolution at decision-making levels and protect women living in situations of armed and other conflicts or under foreign occupation.

E.2. Reduce excessive military expenditures and control the availability of armaments.

E.3. Promote non-violent forms of conflict resolution and reduce the incidence of human rights abuse in conflict situations.

E.4. Promote women's contribution to fostering a culture of peace.

E.5. Provide protection, assistance and training to refugee women, other displaced women in need of international protection and internally displaced women.

E.6. Provide assistance to women of the colonies and non-self-governing territories.

F. Women and the Economy

F.1. Promote women's economic rights and independence, including access to employment, appropriate working conditions and control over economic resources.

F.2. Facilitate women's equal access to resources, employment, markets and trade.

F.3. Provide business services, training and access to markets, information and technology, particularly to low-income women.

F.4. Strengthen women's economic capacity and commercial networks.

F.5. Eliminate occupational segregation and all forms of employment discrimination

NIOSH Research. The National Institute for Occupational Safety and Health (NIOSH) is currently studying job and organizational factors associated with workplace discrimination and sexual harassment against women in order to develop effective prevention strategies (i.e., targeting problematic job characteristics or organizational practices for change).

F.6. Promote harmonization of work and family responsibilities for women and men.

G. Women in Power and Decision-making

G.1. Take measures to ensure women's equal access to and full participation in power structures and decision-making.

G.2. Increase women's capacity to participate in decision-making and leadership.

H. Institutional Mechanisms for Women

H.1. Create or strengthen national mechanisms and other governmental bodies.

Offices of Women's Health. For the first time, nearly all Health and Human Services (HHS) agencies and regions have established offices or coordinators for women's health. These offices work collaboratively with the Office on Women's Health, which coordinates research, service delivery, and education programs across HHS agencies. The office is headed by the HHS Deputy Assistant Secretary for Women's Health.

Deputy Assistant Secretary for Women's Health. This new senior-level position was created in 1994 to coordinate and stimulate research, service delivery and education activities across HHS and to work with other government agencies, consumer and health care professional groups to advance women's health.

The Public Health Service's Coordinating Committee on Women's Health. The Public Health Service's Coordinating Committee on Women's Health was established to advise the Assistant Secretary for Health and the Deputy Assistant Secretary for Health (Women's Health) on current and planned activities across the Public Health Service (PHS) to safeguard and improve the physical and mental health of all women in the United States.

The Coordinating Committee serves as a forum for the Department to (1) share ongoing and proposed initiatives in women's health, identifying opportunities for collaborative activities; (2) provide advice and consultation to Office on Women's Health on its initiatives; (3) identify programs that can be shared with HHS Regions to foster local activity on similar priorities; (4) receive information about priority issues identified by women's health coordinators at the Regional level to discern the need for National initiatives; (5) identify and evaluate women's health issues likely to become policy-critical issues; and (6) receive and disseminate information about women's health issues internationally and participate in the development of U.S. positions on policies on women in international fora. The PHS Coordinating Committee is co-chaired by the Assistant Secretary of Health and the Deputy Assistant Secretary for Health (Women's Health). Its membership includes senior-level representatives of the agencies and offices of the Department.

HHS Offices of Women's Health. The Office of Research on Women's Health at the National Institutes of Health and the Team on Women's Services at the Substance Abuse and Mental Health Services Administration are codified in statute. Offices of Women's Health have also been established at the Food and Drug Administration and the Centers for Disease Control and Prevention, but are not mandated by statute.

HHS Internal Task Force. In early 1996, HHS, at the Secretary's direction, established a task force to further implementation of the Platform for Action adopted at the 1995 World Conference on Women:

- Analyze HHS's current and projected policies and programs in terms of the Platform.
- Identify new initiatives HHS could take to advance the overall agenda of improving the lives of women and girls.
- Think towards long-range institutionalized changes to complete this process.

H.2. Integrate gender perspectives in legislation, public policies, programs, and projects.

Secretary's Conference to Establish a National Action Plan on Breast Cancer. (1993). The National Action Plan on Breast Cancer (NAPBC) was established in 1993 in response to a National Breast Cancer Coalition petition signed by 2.6 million and presented to President Clinton. Under President Clinton's direction, Secretary Donna E. Shalala convened the *Secretary's Conference to Establish a National Action Plan on Breast Cancer.* The conference brought together more than 300 individuals, including breast cancer advocates, consumers, clinicians, scientists, government officials, educators, members of Congress, and the media to craft a series of recommendations for action in education, research, public policy and service delivery. From this conference, a Steering Committee of government and non-government representatives was formed to build necessary public/private partnerships and to guide a comprehensive national plan to eradicate breast cancer. Six Working Groups have been established to identify and implement specific initiatives: National Biological Resource Banks, Clinical Trials Accessability, Consumer Involvement, Breast Cancer Etiology, Hereditary Susceptibility, and Information Action Council. The DHHS Office on Women's Health coordinates the implementation of activities and oversees day-to-day operations of the Plan. More information on the NAPBC and Working Group products can be found on the NAPBC's web site (www.4woman.gov/napbc).

Canada-U.S. Forum on Women's Health. The Secretary of Health and Human Services and the Minister of Health (Canada) convened a forum in August 1996 in Ottawa to develop binational initiatives in women's health. Four joint initiatives in the areas of breast cancer, research, information clearinghouses and smoking were announced.

The U.S. -Mexico Binational Commission's Health Working Group's Core Group on Women's Health. The group was established in 1996 to facilitate exchange of information and to develop joint projects on women's health.

Binational Israel-USA Conference: Promoting Women's Health Across Generations. The U.S. Secretary of Health & Human Services, Donna Shalala, and the Israeli Minister of Health, Yehoshua Matza, convened a conference in December 1998

in Jerusalem, Israel. This conference promoted a dialogue between the two countries on women's health issues and identified priority areas to be addressed in the future.

The Office of Minority Health and the Office of Research on Women's Health, National Institutes of Health, have provided support to the **National Latina Institute for Reproductive Health** for its proceedings from two regional agenda setting conferences in 1998.

National Minority Women's Health Conference. (January 1997.) [See C.1. for description.]

First National Leadership Conference on Physical Activity and Women's Health. The Office on Women's Health, in collaboration with the President's Council on Physical Fitness and Sports (PCPFS), the Centers for Disease Control and Prevention, and the American College of Sports Medicine, convened this conference in February 1997 in Washington, D.C. which provided state-of-the-art information about the role of fitness plays in women's health. It resulted in recommendations for action relevant to women of all ages and physical abilities.

Physical Activity and Sport in the Lives of Girls: Physical and Mental Health Dimensions from an Interdisciplinary Approach. This ground breaking report was created by the President's Council on Physical Fitness and Sports (PCPFS) in 1997, under the direction of the Center for Research on Girls and Women in Sport. It highlights the multiplicity of ways in which physical activity and sport have become an integral part of girls' lives. The report was also created to develop future research paths and policy recommendations as a guide for planning and programming.

H.3. Generate and disseminate gender-disaggregated data and information for planning and evaluation.

I. Human Rights of Women

I.1. Promote and protect the human rights of women, through the full implementation of all human rights instruments, especially the Convention on the Elimination of All Forms of Discrimination Against Women

I.2. Ensure equality and non-discrimination under the law and in practice.

I.3. Achieve legal literacy.

J. Women and the Media

J.1. Increase the participation and access of women to expression and decision-making in and through the media and new technologies of communication.

J.2. Promote a balanced and non-stereotyped portrayal of women in the media.

K. Women and the Environment

K.1. Involve women actively in environmental decision making at all levels.

K.2. Integrate gender concerns and perspectives in policies and programs for sustainable development.

K.3. Strengthen or establish mechanisms at the national, regional and international levels to assess the impact of development and environmental policies on women.

POLICY, RESEARCH, TESTING, AND ASSESSMENT

The Federal Interagency Working Group on the Environment and Women's Health. Many major causes of death and disability in women are environmentally mediated, including breast and ovarian cancers, osteoporosis, endometriosis, and uterine fibroids. To bring coherence and organization to existing diverse efforts on women's health and the environment, and to provide a focal point for action in this area, the Office of Women's Health in the Department of Health and Human Services established the Federal Interagency Working Group on the Environment and Women's Health in 1994. The Working Group includes more than 40 representatives from HHS agencies, the Environmental Protection Agency, the Department of Labor, and the Department of Defense. The Working Group shares information, develops joint initiatives, and mobilizes multiple agencies to address women's health and the environment. It focuses on how environmental factors at home and work, such as pollutants and exogenous hormones, and other environmental factors may contribute to the risk for diseases in women.

Four subcommittees carry out the Working Group's initiatives: Environmental Hormones, Occupational Health, Environmental Exposures, and Initiatives. The last subcommittee has developed an inventory of federal activities that address women's health and the environment. The committee will develop strategies to protect women from environmental hazards.

Gender Differences in Susceptibility to Environmental Factors: A Priority Assessment. On May 21, 1997 the Institute of Medicine convened a panel of experts in a workshop and deliberated on the state of knowledge on gender differences in susceptibility to environmental factors, appropriate research and policy strategies to ensure adequate protection of both women and men from environmental factors throughout their life cycles. The workshop was co-sponsored by the Environmental Protection Agency, the Office on Women's Health, the Office of Research on Women's Health of the National Institutes of Health, the National Institute of Environmental Health Sciences of the National Institutes of Health, the National Institute of Child Health and Human Development of the National Institutes of Health, and the Centers for Disease Control and Prevention.

In April 1998 the Institute of Medicine (IOM) released the workshop report "Gender Differences in Susceptibility to Environmental Factors: A Priority Assessment." Recommendations from the IOM Committee focused on three main areas - research on

exposure, basic biological research, and policy. The report is available at http://www.nap.edu.

The Office of Women's Health of the Department of Health and Human Services and the Society for the Advancement of Women's Health Research included a panel deliberating on the IOM report at their Women's Health and the Environment: Innovation in Science and Policy Conference on September 10, 1998.

ENVIRONMENTAL HAZARDS

The National Action Plan on Breast Cancer. The Etiology Working Group of the National Action Plan on Breast Cancer (NAPBC) is working to expand the scope of biomedical research activities related to the causes of breast cancer, including environmental exposures. The Working Group has sponsored ground-breaking workshops, bringing together scientists and breast cancer activists, on topics such as hormones and the environment, ionizing radiation exposure, and electromagnetic fields and light-at-night. As a result of the Workshop on Hormones, Hormone Metabolism, and the Environment, a supplement was published in Environmental Health Perspectives (105 [Suppl 3], 1997). Summaries of these workshops are also available on the NAPBC web site (www.4woman.gov/napbc). Additionally, the Working Group has developed the Breast Cancer Comprehensive Questionnaire, designed to provide researchers with standardized questions on environmental factors linked to breast cancer. The complete questionnaire and interviewer's manual is available on the NAPBC web site.

L. The Girl-Child

L.1. Eliminate all forms of discrimination against the girl-child.

L.2. Eliminate negative cultural attitudes and practices against girls.

L.3. Promote and protect the rights of the girl-child and increase awareness of her needs and potential.

EDUCATION CAMPAIGNS

GIRL POWER! Girl Power! is a multiphase, national public education campaign sponsored by the Department of Health and Human Services to help encourage and empower 9- to 14-year-old girls to make the most of their lives. Studies show that girls tend to lose self-confidence and self-worth during this pivotal stage, becoming less physically active, performing less well in school, and neglecting their own interests and aspirations. It is during these years that girls become more vulnerable to negative outside influences and mixed messages about risky behaviors.

First phase. During its first phase, Girl Power! combines strong "no-use" messages about tobacco, alcohol, and illicit drugs with an emphasis on providing opportunities for girls to build skills and self-confidence in academics, arts, sports, and other endeavors. Subsequent phases will address related issues such as physical activity, nutrition, and mental health.

Campaign Materials. To provide positive messages, accurate health information, and support for girls and those who care about them, the Girl Power! campaign products include a diary for girls containing writings and drawings by girls ages 9 through 14. Also available is a Girl Power! Community Education Kit which contains resources that adults can use to set up a Girl Power! Program in their community. For more information, check out the Girl Power! Web site on the National Clearinghouse for Alcohol and Drug Information home page at http://www.health.org and national toll-free number 1-800-729-6686.

Since its launch in 1996, the Girl Power! campaign is becoming more visible and more entrenched into the local communities. As of November 1998, Girl Power! reached over 8.7 million people through messages, Web site visits, and media circulation. The campaign empowers girls while promoting good health. There is clear evidence of its impact on developing community public/private linkages.

BodyWise Eating Disorders Educational Campaign The Office on Women's Health is sponsoring the BodyWise Eating Disorders Educational Campaign for middle school educators. The goal of the program is to increase awareness and knowledge of eating disorders, including their signs and symptoms, steps to take when concerned about students, and ways to promote healthy eating and reduce preoccupation with body weight and size. Information packets, distributed in Fall 1999, include materials emphasizing the links among health eating, positive body image, and favorable learning outcomes. It will also be available on the NWHIC and Girl Power! web sites.

Improving upon Previous Government Efforts. Three aspects of the Girl Power! campaign set it apart from past federal government efforts:

The Girl Power! campaign recognizes that while some messages work equally well for boys and girls, girls also need to hear health messages targeted to their unique needs, interests, and challenges.

The Girl Power! campaign takes a comprehensive approach, addressing not only a range of health issues but also the erosion of self-confidence, motivation, and opportunity that is too typical for many girls 9 through 14 years of age.

The Girl Power! campaign is based on research indicating that girls at 8 or 9 typically have very strong attitudes about their health. According to the Partnership for a Drug-Free America's 1995 Partnership Attitude Tracking Study, for example, the overwhelming majority of girls and boys in grades 4 through 6 believe that "using drugs is dangerous." Younger girls also tend to be more physically active than older girls. This campaign works to reinforce and sustain these positive values among girls 9-14.

Girl Neighborhood Power! Girl Neighborhood Power! Building Bright Futures for Success (GNP) is a five-year national demonstration program based on the principles of positive youth development. Initiated in 1997 as a component of Secretary Donna Shalala's National Strategy to Prevent Teen Pregnancy, GNP fits under the larger umbrella of the Department's Girl Power! Program. GNP objectives include promoting

health and well-being of girls and adolescents between the ages of nine and fourteen; encouraging connectedness between girls and the communities in which they live; developing leadership skills in girls and young female adolescents; and fostering community and neighborhood investments in youth. Community partners develop mechanisms to help girls and their families identify physical and mental health needs, to enroll in Medicaid and State Children's Health Insurance Programs, and to access appropriate health care services. Because school success can protect against engaging in health risk behaviors, community partners develop programming to help girls with schoolwork and to feel connected to school and develop creative service programs, including sports and field trips, and writing projects to help girls develop language skills and self-expression.

L.4. Eliminate discrimination against girls in education, skills development, and training.

Health Science Curriculum Online. The National Institutes of Health Office of Science and Education and the Office on Women's Health are collaborating to make available on the Girl Power! website access to an existing project, Health Science Curriculum Online. This curriculum is a unique learning experience that integrates science, health information, health resources, and career opportunities. The curriculum consists of scenarios based on topics such as diabetes, cardiovascular disease, and cancer. It emphasizes the importance of understanding one's personal health risk factors, the science behind the risk factors, and the interdisciplinary nature of science. Students explore their family and community risk factors to determine their own health risks to make appropriate lifestyle changes.

L.5. Eliminate discrimination against girls in health and nutrition.

The Office on Women's Health will be partnering with the Food and Drug Administration to develop a Girl Power! component to the current "Take Time to Care" project [See C.2 for more information]. This project is aimed at older women to raise awareness of using medications wisely and properly. A variation of this program will be developed which targets girls with chronic illnesses. Girl Power! will provide the message that taking charge of your body and your health is an important component to having Girl Power! An informational brochure for girls as well as a module for the Girl Power! website will be created.

WNBA: Be Active. The President's Council on Physical Fitness and Sports (PCPFS) is collaborating with the WNBA on their nationwide health and fitness initiative the WNBA Be Active Program. The grassroots program includes girls and boys ages 9-14, and encourages young people to exercise regularly and is designed to raise awareness on how to "Play Fit and Stay Fit". The program is being held in 19 cities across the country.

<u>SMOKING PREVENTION</u>

Public Education. HHS has initiated an anti-smoking educational partnership with the U.S. Women's Soccer Team, directly targeting adolescent girls. The PHS Office of Women's Health has developed a smoking prevention campaign with Girl Scouts USA.

L.6. Eliminate the economic exploitation of child labor and protect young girls at work.

L.7. Eradicate violence against the girl-child.

SERVICES

Child Welfare. The Department of Health and Human Services funds State child welfare agencies to provide a range of child welfare services to help keep families at risk or in crisis together when appropriate or to ensure that children achieve permanency in another family, including:

- Family preservation and support services;
- Child abuse and neglect services; and
- Foster care and adoption services.

Foster Care and Adoption Assistance Programs. HHS is also authorized by title IV-E of the Social Security Act to provide funds to States for foster care maintenance payments to certain eligible children who require placement outside of their homes, and adoption assistance to parents who adopt children with special needs. In December 1996, the President announced his goal of doubling the number of adoptions by 2002. In response, HHS recommended a strategy to accomplish this goal which included making tax credits available to adoptive families and financial incentives to States to increase the number of children adopted from the public foster care system. Congress subsequently authorized the tax credits and adoption incentives, and passed legislation that reformed the child welfare system by focusing on the timely permanency and safety of children.

The **Child Abuse and Neglect program** funds states and grantees in several different programs authorized by the Child Abuse and Neglect Prevention and Treatment Act (CAPTA). The programs seek to assist States to meet their responsibilities for the prevention and integration in cases of child abuse and neglect by providing funds and technical assistance; generate knowledge by funding research, service improvement programs, and demonstration projects; generate knowledge through the ongoing collection of data about the scope and nature of the problem, its consequences, and the effectiveness of prevention and treatment services; facilitate information dissemination and exchange; and support policy development and the education of professionals in the field.

L.8. Promote the girl-child's awareness of and participation in social, economic and political life.

REDUCING TEEN PREGNANCY

In 1997, HHS launched its **National Strategy to Prevent Teen Pregnancy** --a comprehensive plan to prevent teen pregnancies and to support and encourage adolescents to remain abstinent. The new strategy will strengthen the Department's ongoing efforts to assure that every community in the country is working to prevent out-of-wedlock teenage pregnancies. HHS-supported programs that include teen pregnancy prevention already reach an estimated 30% of communities in the United States. Two such programs are:

The Community Coalition Partnership Program for the Prevention of Teen Pregnancy. This is one of HHS' most comprehensive and innovative teen pregnancy prevention programs. In 1995, two-year grants were awarded to community-wide coalitions in communities with high rates of teenage pregnancy. Renewed funding since FY 1997 has helped the 13 community coalition partnerships implement their action plans for supporting effective and sustainable teen pregnancy prevention programs, evaluate the impact of these programs, and support related data collection, evaluation and dissemination activities.

The Adolescent Family Life Program. This program, administered under Title XX of the Public Health Service Act, supports demonstration projects to reduce adolescent pregnancy, largely through abstinence-based education, and to provide comprehensive social and medical services to pregnant and parenting adolescents and their infants. An independent evaluation is required of each demonstration project. In FY 1998, 83 projects were funded in 37 States and the District of Columbia. In addition, the program supported eight research projects examining causes and consequences of adolescent pregnancy.

Hermanita Summer Institute. The Office of Minority Health (OMH) supported MANA, a National Latina Organization, in conducting its First Annual Hermanita Summer Institute July 9-11, 1998. This event is a youth leadership development, mentoring, and stay-in-school effort geared to teen-age Latinas and their families.

The Second Annual Hermanita Summer Institute was held during the summer of 1999, in Washington DC. The Bureau of Health Professions and the Maternal and Child Health Bureau (HRSA) contributed a total of $15,000 in support of this event. The Office on Minority Health contributed an additional $5,000.

L.9. Strengthen the role of the family in improving the status of the girl-child.

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