STATEMENT BY

CHARLES KECKLER

ACTING DEPUTY ASSISTANT SECRETARY

FOR POLICY AND EXTERNAL AFFAIRS

ADMINISTRATION FOR CHILDREN AND FAMILIES

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Mr. Chairman and Members of the Committee, thank you for providing me with the opportunity to discuss the abstinence education programs administered by the Department of Health and Human Services. The Administration continues to support abstinence education programs, as one among several methods used by educators to address the continuing problems created by adolescent sexual activity, the result of which includes unacceptably high rates of non-marital childbearing and sexually transmitted diseases among America's youth. Remarkable progress has occurred in this area over the last 15-20 years. Teenage pregnancy among 15-17 year-old girls declined over 20% since the early 1990s, although it remains substantially above the rates recorded for other industrialized nations. Teenage sexual activity and non-marital childbearing have serious consequences for teens, their families, their communities and our society. The two greatest risk factors for teen pregnancy and transmission of STDs are the age at first onset, and the number of partners. In other words, if a teen delays the onset of sexual activity and reduces the number of partners, they are much less likely to become pregnant or get someone pregnant compared to those who don't.

By definition, abstinence education programs aim to do just that. Abstinence is the only 100 percent effective method to prevent pregnancy and sexually transmitted diseases. Through education, mentoring, counseling and peer support, abstinence education services help teens delay the onset of sexual activity and reduce the number of sexual partners they have. The ideal of abstinence programs is to encourage individuals to wait to experience sexual relations within the context of a healthy marriage. Abstaining until you get married also has another beneficiary. There is a wide body of social science literature showing more positive outcomes across a variety of measures for

children raised in 2-parent married households when compared to their peers in unmarried households.

In addition to the serious risks of disease, early childbearing very often limits later opportunities for both the parents and the children involved, creating greatly enhanced risks of a fragile family structure, poverty and welfare dependence. The State Abstinence Education Program and the Community-Based Abstinence Education (CBAE) Program of the Administration for Children and Families, together with the Adolescent and Family Life Program from the Office of Population Affairs, provide useful tools to help parents, schools, communities and States guide our Nation's youth away from these devastating outcomes. As requested by the Committee, my testimony will provide background on these programs and discuss what we know and what we are seeking to learn about their effectiveness. I also would like to take this opportunity to discuss recent steps we have taken to improve administration of the programs and increase our knowledge of their operation. However, before I describe the abstinence education programs, evaluation efforts, and efforts to improve program administration, I will first provide some background on HHS' comprehensive strategy to combat teen pregnancy and sexually-transmitted diseases.

Background: HHS' Comprehensive Strategy

HHS' abstinence education programs are part of a broader strategy to combat teen pregnancy and STDs. Over the last five years, the Department estimates that it has expended billions of dollars towards this effort. HHS funds a variety of interventions, both primary models which include a risk-avoidance message provided through

abstinence education programs, as well as secondary models, which include a risk-reduction message. These interventions provide information about the risks of sexual activity and the ways to eliminate or reduce these risks, with the goal of altering adolescent attitudes and behaviors in ways that lead to healthier outcomes. Other interventions can provide direct health services to adolescents, including administering contraception and providing information about its proper use. Beyond abstinence education, the Department provides at least $300 million annually to administer a variety of pregnancy prevention or STD/HIV prevention and awareness programs. Some of these programs may include information about abstinence or encouraging delayed sexual activity, but are not subject to the Title V, Section 510 A-H definition of abstinence education in the Social Security Act. Curriculum often called "abstinence-plus" or "comprehensive sex education" could be supported under these funding streams. Additionally, the Department provides hundreds of millions annually in family planning services to adolescents through a variety of programs. Of the total federal resources devoted to combating teen pregnancy and STD prevention, abstinence education accounts for a fraction. The majority of departmental funding devoted to this effort includes family planning services, pregnancy prevention activities, and other STD or HIV prevention and awareness activities for adolescents.

Abstinence education, unlike a comprehensive sex education message, has been given a detailed statutory definition by Congress in Title V of the Social Security Act, as part of the Personal Responsibility and Work Opportunity Reconciliation Act enacted in 1996 during the Administration of President Clinton. However, because comprehensive sex education curricula may include information about abstinence, although to varying

degrees, these approaches in practice exist along a continuum of approaches rather than as two completely distinct approaches. The main difference is that comprehensive sex education programs, in addition to abstinence education, also provide instruction about the use of various forms of contraceptive devices. In other words, abstinence education programs do not provide detailed instructions on how to use contraceptive devices, although some provide information about the relative effectiveness of contraceptive devices in preventing pregnancy and disease. This is because the statute requires using federal funds for the "exclusive purpose" of teaching abstinence. In epidemiological terms, both interventions are oriented toward risk prevention; abstinence education is fully focused on risk prevention using a primary public health intervention. Comprehensive sex education mixes the risk-prevention message with a risk-reduction component, using a secondary public health model. By contrast, a pure risk-reduction program could, for example, involve simply distributing contraceptives to adolescents and demonstrating their proper use.

Background: Abstinence Education Programs

HHS' Administration for Children and Families is responsible for administering the State Abstinence Education program. This program was first authorized in 1998 to provide up to $50 million per year in grants to States by Title V of the Social Security Act. Funds are allocated to States and territories according to a pro-rata method based on the ratio of the number of low-income children in each State to the total number of low-income children in all States. States must match every four dollars they receive in federal abstinence education funds with three non-federal dollars. In FY 2007, approximately

$39 million dollars was awarded to 40 States, the District of Columbia, and three territories.

The Administration for Children and Families also administers the Community-Based Abstinence Education (CBAE) program. This program was first funded in FY 2001 to support public and private entities for implementation of abstinence education programs for adolescents ages 12 through 18. Annual appropriations language also references the statutory definition of abstinence education program in Title V, Section 510 of the Social Security Act for administering CBAE. These programs are focused on educating young people and creating an environment within communities that supports adolescent decisions to postpone sexual activity until marriage. Grantees include public and private entities such as community-based and faith-based organizations, hospitals, health centers, school systems and other youth services agencies. In FY 2008, Congress appropriated $113 million for the CBAE program. These funds will be used to support approximately 188 new start and continuation grants, as well as fund technical assistance, evaluation, research, and public education campaign. The FY 2009 Budget requests an increase of $28 million for CBAE.

The final abstinence education program administered by HHS is the Adolescent Family Life (AFL) program. This program is administered by the Office of Population Affairs within the Office of Public Health and Science and supports two types of demonstration grants: (1) Prevention (abstinence education) that promotes and evaluates abstinence from sexual activity among adolescents; and (2) care demonstration grants that provide and evaluate comprehensive health and social services for pregnant and parenting adolescents. The prevention demonstrations are abstinence education projects

that have been tied by legislative language in the annual appropriation bill to the statutory definition of abstinence education program in Title V, Section 510 of the Social Security Act. These demonstrations aim to find effective means of reaching preadolescents and adolescents before they become sexually active and to encourage them to abstain from sexual activity and other risky behaviors. The care demonstrations attempt to identify ways to minimize the consequences of this sexual activity by supporting projects for pregnant and parenting teens, their infants, their partners and their families. The abstinence education component of AFL is funded in FY 2008 at $13 million and supports 37 competitively awarded grants to public or private organizations. The FY 2009 Budget continues to request $13 million for this program.

Together, the three abstinence education programs reach more than two million youth every year. Countless other youth and families are reached through a national media campaign. The Parents Speak Up National Media Campaign, developed through a partnership with the Office of Public Health and Science, provides public service announcements encouraging parents to talk to their preteens and teens about waiting to have sex, and to share their values and expectations for their children's future. The campaign has developed and distributed media messages, established a website, and developed strategies for targeting Hispanic, African American and Native American communities.

Abstinence education is an important preventive component of an overarching federal strategy designed to protect youth from the physical, psychological and economic consequences associated with teenage sexual activity and non-marital childbearing. Teenage pregnancy among 15-17 year-old girls declined over 20% since the early 1990s,

although it remains substantially above the rates recorded for other industrialized nations. This decline in teenage pregnancy has been driven by both declines in early sexual activity and by more consistent use of contraception among teens, although there is an on-going debate in the research community about the relative contribution of these trends.

Evaluation of Abstinence Education Programs

Increasing abstinence among early adolescents cannot be wholly or directly attributed to health education interventions, including abstinence education. The current research questions surrounding the effectiveness of abstinence education programs are largely focused on the following: Are abstinence education programs equally or more effective in promoting abstinence than comprehensive sex education programs and does the absence of an explicit risk-reduction element in abstinence education cause participants to be less likely to use contraception if they engage in intercourse?

As a general matter, health education interventions have a record of mixed success. While the majority of studies have shown a limited impact on sexual behavior, some programs have shown evidence for effectiveness. Increasingly evident during the 1990s, studies showed certain programs had some effect on delaying the age at first intercourse, and in reducing the frequency of sexual activity or the number of partners involved. The use of abstinence education curricula, as such, has a shorter history of evaluation, but the results have been similar. Some peer-reviewed research has shown a significant effect in delaying intercourse among program participants. Other studies have shown some effect on partner number even if intercourse is not delayed. We are using

the results of these studies to identify the characteristics that distinguish effective from ineffective implementations. There is no strong evidence for a decline in the use of contraception as a consequence of these programs.

Recently, the Department reported the final results of a years-long longitudinal study by Mathematica Policy Research of five projects among the first group of abstinence education programs created by Title V and overseen by the State grantees. Some of these projects were effective in increasing participants' knowledge of sexually-transmitted diseases, and in the short-term, increasing pro-abstinence attitudes and the support of an individual's peers for abstinence. Both of these psychosocial traits were predictive of later abstinence; but the positive effects created by the intervention eroded rapidly in the intervening teen years. By the time of the last data collection four to six years later, behavioral and biological outcomes such as rates of sexual activity and pregnancy were not statistically distinct from a control population that had received the usual services available in that area. An important additional result of the study was that there was no additional risk of unprotected sex among abstinence education participants, contrary to the concern that lack of a contraception instruction component could create additional risk in this regard.

From a policy perspective, a key question is whether the relevant biological and behavioral outcomes differ systematically between abstinence education and comprehensive sex education programs, where both are available. Put simply, when we have the option to provide either type of curricula, is it possible to show that one is better than another in preventing disease transmission and teen pregnancy? This question was not addressed in the recent Mathematica research, nor has such a comparison ever been

made in any other major abstinence or comprehensive sex education evaluation to date. Currently, the Department is funding a long-term study in collaboration with the University of Texas Health Sciences Center that has randomly assigned students to the two different types of treatments, or to a control group. This type of experimental study design should provide us important new evidence that allows direct comparison between the two types of treatments. Data collection from this study, funded primarily by the Centers for Disease Control and Prevention and also ACF, is expected to be complete in May, 2010. At the current time, there is no reason to believe that programs involving abstinence education cannot be designed to be more effective with the available curricular alternatives in encouraging delays or reductions in adolescent sexual activity, and such programs do not appear to cause any decrease in the use of contraception by participants who choose not to abstain.

The Administration believes that the abstinence education program sends the healthiest message as it is the only certain way to avoid out-of-wedlock pregnancy, and sexually transmitted diseases. The great majority of American parents agree: a 2007 poll conducted by the National Campaign to Prevent Teen Pregnancy found that 90 percent of teens aged 12-19 and 93 percent of adults agree that it is important for teens to be given a strong message that they should not have sex until they are at least out of high school.

Also, the Health Education Guidelines used by many States and local school districts require use of abstinence education curricula. Likewise, many current grantee organizations would likely no longer apply to participate in providing health education programs if they were required to give instruction in contraceptive techniques. These jurisdictions and grantees have such constraints for a variety of reasons. For instance,

some have concerns that comprehensive sex education curricula do not fulfill their stated goal of making abstinence the primary message. Because abstinence education curricula must comply with Congress's statutory criteria, they represent a safe harbor for those agencies and entities seeking assurance that the curricula they choose comports with their requirements. Consequently, the abstinence education service option expands the range of possible providers, as well as the populations they can serve.

Progress in Administration of Abstinence Education Programs

In October 2006, the Government Accountability Office released a report on assessing the accuracy and effectiveness of federally funded abstinence education programs. Since this report was released, HHS has taken steps to improve the administration of abstinence education programs. Specifically, HHS' efforts have focused on heightened program oversight and strengthened expectations of our grantees.

HHS requires abstinence education grantees to comply fully with Section 317P of the Public Health Service Act. Section 317P requires mass-produced educational materials that are specifically designed to address sexually transmitted diseases to contain medically accurate information about condom effectiveness. Although abstinence education grantees do not always use materials that are subject to Section 317P's requirements, when they do, they are required to adhere to Section 317P by discussing condom effectiveness or ineffectiveness in the disease transmission context in a medically accurate way.

Compliance with 317P is part of HHS's broader commitment to scientific accuracy in abstinence education, a concern that has been expressed by the GAO and the

Committee, and which the Department fully shares. First, in FY 2007 ACF implemented GAO's recommendation to require Community-Based Abstinence Education and State Abstinence Education grantees to sign a written assurance in their grant applications stating that education materials are factually accurate. Additionally, ACF attached a special condition requiring that each grantee correct any medical inaccuracies identified by ACF in the proposed curriculum. Failure to provide satisfactory resolution to all medical accuracy issues raised by ACF will result in the withholding of funds and/or termination of the project, or both.

Also as recommended by GAO, curricula used by grantees in the Community-Based Abstinence Education program are now reviewed by an independent panel of medical professionals. When considering CBAE grantee plans, the proposed curriculum is reviewed by a research analyst who notes any statements of fact that are not referenced and obtains source documents, when available, of all references that are given. The curriculum is then reviewed by a medical professional (a doctor or nurse in the field of obstetrics and gynecology) to compare the information in the curriculum to the information in the sources, which are themselves assessed for scientific validity. In tandem with these efforts, ACF also requires States to provide their strategies for ensuring accuracy of medical and scientific information in the State Abstinence Education program.

In addition to increasing assurance of accuracy, the Department is also committed to making the changes necessary to increase program effectiveness. CBAE grantees are required to spend a minimum of 15 percent of funds on evaluation of their programs, and there is now an increased emphasis on standardized evaluations that will allow us to

aggregate data from multiple grantees to conduct program-wide analyses with large sample sizes. This will also greatly increase our ability to compare grantees with one another by identifying best practices in efficiency and effectiveness as well as those grantees that are underperforming. For example, grantees are required to report quantitative data on the number of youth served, the hours of service per youth, and the proportion of youth that complete the program. We are also requiring a new standardized survey that will be administered by CBAE grantees to all youth served both before and after service delivery, and a follow-up survey 6-12 months upon the completion of the intervention. The questions will measure initiation and discontinuation of sexual intercourse as well as evidence-based predictors of age at first intercourse, such as sexual attitudes and behavioral intentions. Combined, these data sources will help us to track how grantees are using their funds, and which ones are efficiently achieving meaningful change in adolescent sexual behavior.

In its report, GAO also expressed the expectation that certain ongoing research projects such as the Mathematica evaluation, when completed, should provide direction to our efforts in abstinence education. I am pleased to report that the final results of the Mathematica research study, released in April and August 2007, have already begun to be incorporated into programmatic changes as part of the Department's emphasis on evidence-based policy development. The results of the Mathematica study indicate that targeting abstinence education to youth only in their early adolescent years may not be sufficient, and the programs may be more effective if interventions occur more closely in time to heightened risks of sexual activity in the high school years or are at least sustained up until that time. Based on these findings, preferences will be given to grant

applications that show their programs include high school aged youth. The Mathematica study also indicated that the programs heighten pro-abstinence attitudes and friends' support for abstinence and are significant predictors of future abstinence, but that both frequently erode over the years following the intervention. We now have specific criteria that encourage grantees to focus on developing and sustaining peer networks among adolescent participants, which is expected to create mutual support for abstinence education and to increase the probability of favorable biological and behavioral outcomes in the long-term.

The Administration appreciates the opportunity to update the Committee on the progress we are making in this important area of adolescent health and remains committed to providing accurate information that effectively assists young people to make healthy and responsible choices as they mature towards adulthood.

I would be pleased to answer any questions that you have.