



Aggressively Implement Colorado House Bill 07-1292

During the 2007 legislative session, Colorado's General Assembly passed House Bill 07-1292 to expand access to medically and scientifically accurate comprehensive sexuality education courses to reduce sexually transmitted infections, unintended pregnancy, and the need for abortion. Signed into law by Governor Bill Ritter that spring, the law requires school districts, where instruction about human sexuality is provided, to ensure their curricula adhere to science-based content standards. Specifically, courses must be abstinence-based, age-appropriate, comprehensive, scientifically and medically accurate, and discuss the health benefits provided by contraceptives. Prevention First Colorado recommends the aggressive implementation of House Bill 07-1292 to ensure Colorado's young people receive the information they need to make responsible, healthy decisions to protect themselves and their partners in their intimate relationships throughout their lives.

THE NEED FOR AGGRESSIVE IMPLEMENTATION OF HOUSE BILL 07-1292

For the 12 months ending September 30, 2007, Colorado received more than \$2.1 million in federal taxpayer dollars to support abstinence-only-until-marriage education programs, despite growing evidence that such programs have been shown to be ineffective.¹ In October 2007, state officials declined to reapply for federal Title V dollars, one of three federal funding streams established to support abstinence-only-until-marriage education programs. (See Table 1 on page 59, "At-a-Glance: Federal Abstinence-Only-Until-Marriage Funding Streams.")

Despite the multi-million dollar pool of funds earmarked for abstinence-only-until-marriage programs, a number of indicators demonstrate that Colorado's youth are not making responsible, healthy decisions in their intimate relationships. Data compiled by the Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention (COAPPP), for example, showed that nearly 42,000 babies were born to teens in Colorado between 2001 and 2006.² Moreover, 4,730 cases of chlamydia were diagnosed among 10- to 19-year-olds as of 2006, which represented nearly 30 percent of all reported cases.³ That same year, 870 cases of gonorrhea were diagnosed among 10- to 19-year-olds, representing nearly one-quarter of all diagnosed cases.⁴ Through September 2007, adolescents aged 13 to 19 accounted for approximately 2.3 percent of all HIV cases in Colorado with 146 cases.⁵

Prevention First Colorado found that among teens who participated in survey research assessing their knowledge of sexual and reproductive health, 95 percent of respondents indicated they had had sex and nearly one in three believed it was at least somewhat likely they would become pregnant within the next year.⁶ Survey respondents demonstrated a

general lack of knowledge about sexual and reproductive health. For example, 23 percent of respondents indicated withdrawal was an effective contraceptive method and 27 percent said pregnancy cannot occur if a girl is "on top" during intercourse.⁷

Research cited in House Bill 07-1292 (HB07-1292) shows that

"individuals who receive early, comprehensive, age-appropriate, and medically accurate education regarding the health benefits and other benefits derived from sexual abstinence, family planning, and birth control are more likely to delay sexual activity and engage in such activity with a higher degree of responsibility and safety."⁸

Although HB07-1292 tasked the Colorado Department of Education with issuing guidelines for compliance with or recommendations for implementation of the law, the Department does not have the authority to enforce compliance. Additional challenges to implementation and compliance are addressed later in this report in the "Barriers to Implementation" section.

OTHER STATES AND NATIONWIDE

Despite spending more than an estimated \$1.8 billion⁹ in federal taxpayer dollars on abstinence-only-until-marriage education programs since 1982, the United States recorded the second-highest rates of teenage pregnancy and births to teenage mothers among 46 countries in the developed world.¹⁰

Historically, sexuality education has been delivered through multiple avenues, including direct parent-child communication, community-based groups, faith-based organizations,

and public and private schools. However, the nature of the topic has precluded development of consistent content standards; that is particularly evident when it comes to sexuality education delivered through the public schools system. Because education is considered a state responsibility, sexual and reproductive health care education policies vary from state to state, and within some states, from school district to school district.

A growing body of research has demonstrated the ineffectiveness of abstinence-only-until-marriage programs in reducing sexual activity, pregnancy, births and the spread of sexually transmitted infections (STIs) among teens.¹¹ As a result, a number of states have opted to reject federal funding for abstinence-only-until-marriage programs and to establish education policies that call for the use of comprehensive sexuality education curricula that include medically and scientifically accurate information about the use and benefits of contraceptives. Currently, 23 states (including Colorado) require that abstinence be stressed when taught as part of sexuality education, according to an analysis of state-level sexuality education and STI-prevention policies.¹²

Rigorous research into and evaluation of existing programs aimed at reducing teen pregnancy and the spread of STIs among teens has produced a series of objective criteria that educators, parents, faith-based organizations, health care experts and policymakers can use to evaluate a prospective program’s likelihood of success in their specific community. It is critical to note that programs vary from those that focus

on sexual risk and protective factors, such as curriculum-based sex and STI/HIV prevention, education programs aimed at parents and teens, clinic-based programs, and school- or other community-based contraception-distribution programs; to those that focus on nonsexual factors, such as welfare reform, early childhood development, and youth development programs for adolescents; to those that focus on both sexual risk/protective and nonsexual factors, such as programs that focus on sexual risk-taking behaviors, violence and substance abuse.

Within that context, research showed that effective curriculum-based sex and STI/HIV prevention programs have 17 common characteristics, which can be broken into four categories: curriculum development, curriculum content, activities and teaching methodologies, and curriculum implementation. (See sidebar on page 60, “Characteristics of Effective Curriculum-Based Sexuality Education Programs.”) Moreover, most programs

“with these 17 characteristics were effective; most effective programs incorporated most of these characteristics; and programs with these characteristics were more effective than programs without these characteristics.”¹³

Nationwide, each state, and in some cases, each school district, uses a different approach to implement and evaluate compliance with established policies on sexuality education. One common strategy has been the use of broad, community-based coalitions that engage parents, youth, educators,

Table 1: At-a-Glance: Federal Abstinence-Only-Until-Marriage Funding Streams¹⁴

Funding Stream	Federal Law	History and Evolution	Requested for Fiscal Year 2009†
Adolescent Family Life Act (AFLA)	Title XX of the Public Health Service Act	Originally funded in 1981; components evolved from pregnancy-prevention by discouraging premarital sex to 1997 incorporation of strict eight-point conditions outlined in Title V to qualify grant applicants as “abstinence education” providers	\$13 million
Title V	Section 510(b) of the Social Security Act	Originally part of the 1996 Welfare Reform Act; provides eight strict conditions that “abstinence education” programs must meet to receive funds	\$50 million
Community-Based Abstinence Education	Originally administered by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services (HHS); now administered by HHS’ Administration for Children and Families	Created in 2000; provides federal grants directly to community-based organizations, bypassing state-level approval processes; requires grantees to teach all eight points of federally defined “abstinence education” concepts	\$141 million
Miscellaneous	Congressional earmarks and funds administered by HHS and the U.S. Centers for Disease Control and Prevention	No specific date of origin; individual members of Congress lobby for earmarks and funding to be allocated for HIV/AIDS and STI prevention, with receiving entities using funds to carry out abstinence-only programs	Not calculated

† Fiscal Year 2009 budget as submitted by President George Bush in 2008.

health care experts, policymakers and community leaders to specifically call for the provision of comprehensive sexuality education that provides information about abstinence and contraception.

The Chicago Public School District, for example, is implementing the Family Life and Comprehensive Sexual Health Education Policy adopted by the Chicago Board of Education in 2006. Steps for implementation have included a deliberate assessment of existing barriers to implementation; evaluation of strategies for implementation used by school districts of comparable size elsewhere in the country; and examination of both existing resources for implementation and expected gaps.¹⁵ The Illinois Caucus for Adolescent Health (ICAH) supported those efforts. In addition, ICAH, whose history dates to 1977, has established itself as an expert in implementation and evaluation of programs to ensure

Illinois youth have access to the information and health care services they need to make responsible, informed decisions about their reproductive and sexual health. According to the ICAH Web site, caucus participants include “advocates, community leaders, and organizations committed to supporting public policies that promote adolescent health.”¹⁶

In Washington state, where the state Legislature enacted the Healthy Youth Act in 2007, a coalition of individuals, organizations and agencies are working through the Healthy Youth Alliance (HYA) to educate the public about the law as part of the Alliance’s mission of “increasing the number of youth in Washington communities who are exposed to researched, proven and effective sexual health programs.”¹⁷ That state’s law calls on schools that teach sexuality education to ensure that curricula adhere to standards developed in 2005 by the state’s Department of Health and the

Characteristics of Effective Curriculum-Based Sexuality Education Programs¹⁸

“Curriculum Development Process

1. Involved multiple people with expertise in theory, research, and sex and STD/HIV education to develop the curriculum
2. Assessed relevant needs and assets of the target group
3. Used a logic model approach that specified the health goals, the types of behavior affecting those goals, the risk and protective factors affecting those types of behavior, and activities to change those risk and protective factors
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies)
5. Pilot-tested the program

Curriculum Goals and Objectives

6. Focused on clear health goals – the prevention of STD/HIV, pregnancy, or both
7. Focused narrowly on specific types of behavior leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these types of behavior, and addressed situations that might lead to them and how to avoid them
8. Addressed sexual psychosocial risk and protective factors that affect sexual behavior (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) and changed them

Activities and Teaching Methodologies

9. Created a safe social environment for young people to participate
10. Included multiple activities to change each of the targeted risk and protective factors
11. Employed instructionally sound teaching methods that actively involved participants, that helped them personalize the information, and that were designed to change the targeted risk and protective factors
12. Employed activities, instructional methods, and behavioral messages that were appropriate to the teens’ culture, developmental age, and sexual experience
13. Covered topics in a logical sequence

Implementation Process

14. Secured at least minimal support from appropriate authorities, such as departments of health, school districts, or community organizations
15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision, and support
16. If needed, implemented activities to recruit and retain teens and overcome barriers to their involvement (e.g., publicized the program, offered food or obtained consent)
17. Implemented virtually all activities with reasonable fidelity”

Washington State Office of Superintendent of Public Instruction. Those standards are consistent with characteristics of successful sexuality education programs subsequently summarized by Douglas Kirby in “Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases,” which is considered a seminal compilation of research evaluating the efficacy of such programs.

As part of the community education and outreach efforts aimed at implementing the law, HYA member organization NARAL Pro-Choice Washington developed and distributed an advocacy toolkit for parents that provides step-by-step instructions to ensure local school districts have developed sexuality education curricula that comply with the Healthy Youth Act. Staff at NARAL Pro-Choice Washington indicate that because of the Healthy Youth Act, the state has a formal definition of what sexuality education is to help guide schools in understanding whether they already are teaching material that qualifies as sexuality education and whether there is a need to make adjustments to comply with the Act.

CURRENTLY IN COLORADO

Under HB07-1292, the state Department of Education is tasked with incorporating the statutory standards set forth for comprehensive sexuality education into guidelines for implementation of comprehensive health education programs. However, neither financial nor personnel resources were allocated by the Legislature to carry out the collaborative, community-based process used to develop such guidelines. As a result, the Department has not been able to provide guidance to local school districts about ways to deliver effective sexuality education programs that adhere to the principles set forth in HB07-1292.

Moreover, there is a lack of publicly available information about sexuality education curricula used in each of Colorado’s 178 school districts or a method of delivery. Regarding the latter, anecdotal reports shared by COAPPP revealed that sexuality education content may be taught by school teachers, nurses or other staff, community health clinic staff, county health department personnel, or educators trained or employed by private, community-based organizations. (For a discussion of some private programs that provide sexuality education, see sidebar on page 62, “Snapshot of Programs that Provide Curriculum-Based Sex and STIs/HIV Prevention in Colorado.”) As a result, school boards, parents, community leaders and other interested parties face challenges in assessing the extent to which the sexuality education offered in their schools is consistent with the standards set forth in HB07-1292; how their programs compare to content delivered elsewhere in the state; and the extent of training that educators receive prior to teaching the courses in classrooms.

In 2008, a coalition of community-based advocacy groups established the Campaign for Healthy Colorado Youth

(CHCY) to coordinate efforts among organizations that share the common goal of ensuring that every adolescent in Colorado has access to comprehensive sexuality education that is science-based, culturally sensitive and relevant, and medically accurate. CHCY is working to identify opportunities to incorporate the standards established in HB07-1292 into efforts aimed at implementing comprehensive school health programs at the local level, reaching out to like-minded organizations throughout the state to build grassroots capacity, and developing comprehensive strategies to leverage community support for implementation of HB07-1292.

BARRIERS TO IMPLEMENTATION

Colorado’s Constitution vests locally elected school boards with the authority to determine content for instruction in public schools. Neither the state Legislature nor the state Department of Education, which is responsible for supporting school boards in carrying out their educational duties, have the authority to establish statewide requirements for educational outcomes. Likewise, the state Board of Education has limited authority regarding education policy.

To the extent that statewide educational policy objectives are desired – such as establishing minimum high school graduation requirements – the state Legislature, Board of Education, and Department of Education may establish standards, facilitate exchange of information based on best practices, and create criteria for evaluation. However, implementation is left to each of the 178 school districts to establish curricula, desired educational outcomes, and preferred methods of instruction. Consequently, curricula vary by school district and often reflect the preferences of the individuals elected to the respective school boards and any community-based organizations involved in education-related issues in their communities. Changes in curricula, therefore, require a bottom-up approach rather than a top-down implementation strategy.

One of the largest obstacles to delivery of comprehensive sexuality education in Colorado is a well-funded and highly public abstinence-only movement that has allies within local boards of education. As noted earlier, Colorado received more than \$2 million to support abstinence-only-until-marriage education programs; the large majority of those funds went to private entities.¹⁹ In addition to delivering abstinence-only education programs, the entities also partnered with and developed their own community-based advocacy organizations to promote abstinence-only principles.²⁰ As a result, there is a perceived debate over whether abstinence-only education or abstinence-based programs consistent with HB07-1292 should be delivered in Colorado’s schools. Despite this perceived debate, national research shows the majority of Americans support the latter approach: nearly nine out of 10 (88 percent) parents of junior high school students and 85 percent of parents of high school students believe information on how to use and where to get contraceptives

is an appropriate topic for sexuality education programs in schools.²¹

Evaluations of comprehensive sexuality education programs show that, “they do not increase rates of sexual initiation, do not lower the age at which youth initiate sex, and do not increase the frequency of sex or the number of sex partners among sexually active youth.”²²

In fact, as former Surgeon General David Satcher stated in 2001,

“evidence shows that comprehensive sex education programs that provide information about both abstinence and contraception can help delay the onset of sexual activity among teens, reduce their number of sexual partners and increase contraceptive use when they become sexually active.”²³

In addition, preferred academic outcomes in the area of health education have not been established for Colorado students, creating an environment in which students’ health education varies by school district. Currently, Colorado Model Content Standards exist for the academic areas of civics, dance, economics, geography, history, math, music, physical education, reading and writing, science, theatre, visual arts, and world language – all considered core competencies. Absent from this list are health education specifically, and sexuality education in particular. Under a

2008 law, those standards are under review, with revisions expected to be adopted by the state Board of Education in December 2009. It is unclear, however, to what extent comprehensive health education will be incorporated into those standards.

Additional barriers such as inadequate funding and personnel, lack of easily accessible information about effective curricula, and insufficient time in the school day for sexuality education, also affect the implementation of HB07-1292. Where restricted resources may be considered a barrier to implementation, some existing, semi-related programs may provide opportunities for provision of comprehensive sexuality education in schools. For example, 45 school-based health clinics throughout the state may provide a unique opportunity for schools to leverage the expertise of on-site medical professionals to deliver age-appropriate information to the more than 200,000 eligible students in host schools. (Refer to companion recommendation on page 65, “Provide Reproductive Health Care Services and Dispense Contraceptives On-Site through School-Based Health Centers that Deliver Health Care to Adolescents in Colorado.”)

Public grants and other funding opportunities may offset financial barriers to implementation. For example, counties can receive funds through the federal Temporary Assistance for Needy Families (TANF) program to support their efforts to prevent and reduce out-of-wedlock unintended preg-

Snapshot of Programs that Provide Curriculum-Based Sex and STIs/HIV Prevention in Colorado

The Denver Teen Pregnancy Prevention Partnership (DTPPP), initially convened by the City and County of Denver’s Office of Strategic Partnerships, is a group of organizations working together to provide sexuality education to high-risk teens. This multi-faceted collaborative model provides curricula that are science-based and intensive educational programs. The curricula include information about abstinence, condoms and other contraceptives. The work of the collaborative currently serves one middle and two high schools in the Denver Public Schools system and reached more than 1,000 parents and students during the 2007-2008 school year. DTPPP currently has courses and information designed for preventive services but has not created specialized curricula or services for pregnant or parenting teens. The program does offer leadership development classes for teens who are non-parenting or parenting. The courses help build knowledge about practicing healthy sexual behaviors, building relationship and communication skills that can be used with partners and parents, boundary setting, refusal skills, and self-efficacy in making informed decisions about reproductive and sexual health. DTPPP also works to link teens and parents to clinical and health care resources that offer family planning services and to increase students’ knowledge about ways to reduce teen pregnancy and transmission of STIs/ HIV.²⁶

An additional resource for Denver teens is Girls Incorporated of Metro Denver (GIMD). GIMD has extensive after-school programs for girls starting at a young age to keep them safe and engaged in positive activities. GIMD has served more than 2,000 girls in the Denver metropolitan area in the last year, with provision of services to high school-aged girls increasing by 178 percent in 2007.²⁷ Programs offered at GIMD range from arts and sports to financial literacy and health classes, including sexuality education. GIMD has integrated its program into the community and reached out to at-risk girls needing after-school support in an effort to postpone their first sexual encounter and to reduce the chances of their using drugs and alcohol.

In 2008, Planned Parenthood of the Rocky Mountains (PPRM) educators provided education to more than 19,000 individuals through its community education department. The organization’s programs aim to educate and empower individuals and communities to make responsible choices regarding their sexuality and sexual health. The programs target individuals of all ages, work in a variety of settings, and collaborate with public schools, faith-based organizations, after-school programs and detention centers. PPRM’s youth-development programs use best practice, evidence-based curricula and are vigorously evaluated to ensure they generate successful outcomes. The organization offers a variety of programs for the community, including both short-term education and youth-development education.²⁸

nancies, which is one of the four stated goals of the TANF program.²⁴ In addition, the TANF-authorizing legislation specifically references reduction and prevention of teen pregnancies.²⁵ As a result, public schools that use county health departments to provide sexuality education should work with the county to determine whether TANF funds are available to offset the costs of providing sexuality education that is consistent with standards set forth by HB07-1292. Similar funding streams may be available through grants offered by the U.S. Centers for Disease Control and Prevention (CDC), which has long-standing programs aimed at STI prevention. It should be noted that President Obama's fiscal year 2010 budget proposed in spring 2009 recommends eliminating funding for abstinence-only-until-marriage programs and instead calls for investing \$173 million in evidence-based sexuality education programs to prevent teen pregnancy.²⁹

FIRST STEPS

Providing education about sexual health and behavior through the public schools is a complex issue that can produce divisions within a community as families' differing attitudes and expectations around sexual activity collide within the shared space of a local school. Regardless of whether sexuality education is delivered through schools, community-based organizations, or in direct parent-to-child communications, it is generally agreed that young people deserve comprehensive information that will provide them with the tools they need to make safe and educated decisions in their intimate relationships. The state Legislature recognized this with its adoption of HB07-1292. To ensure aggressive implementation of that law, the following steps should be pursued.

1. Conduct a statewide assessment of sexuality education curricula used by each of Colorado's 178 school districts and demonstrate the need for curricula that adhere to the standards set forth in HB07-1292 by identifying:
 - a. adolescent STI and pregnancy rates in affected communities;
 - b. students' attitudes toward and knowledge about sexual health;
 - c. ages/grades in which sexuality education courses are taught;
 - d. general concepts taught at each age/grade level;
 - e. method of instruction (i.e., teacher, school nurse, third-party vendor); and
 - f. barriers to provision of sexuality education, if identified

Based on that information, create benchmarks for change and facilitate inter-district exchange of curricula, strategies for implementation, and best practices.

2. Maximize available funding streams, including TANF and CDC funds earmarked for the prevention and reduction of teen pregnancy, unintended pregnancy, and STIs.

3. Leverage health care expertise in existing school-based health centers in middle and high schools to deliver comprehensive sexuality education that meets the standards outlined in HB07-1292.
4. Amend Colorado's Model Content Standards to incorporate comprehensive health education objectives, including physical, behavioral, sexual/reproductive and other health care needs.
5. Secure funding and personnel resources for the Colorado state Board of Education's Prevention Initiatives Unit to provide guidance for compliance with HB07-1292. That unit already "assists Colorado school districts and youth-serving agencies in providing accurate and age-appropriate health programs for school and agency staff, students K-12, and parents."³⁰

Consequences of inconsistent and/or incorrect contraceptive use range from greater likelihood of unintended pregnancy and contraction of STIs to increases in dangerous sexual health practices that result in rapid transmission of STIs to unsuspecting partners. By aggressively implementing HB07-1292, local school districts can ensure Colorado's young people have access to accurate information to make responsible decisions in their intimate relationships. Moreover, teens will be equipped with the skills necessary to make healthy choices throughout their reproductive lives.

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