

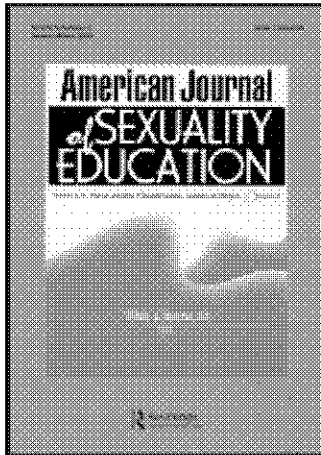
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### Public Opinion Toward Sexuality Education: Findings Among One South Florida County

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## RESEARCH

# Public Opinion Toward Sexuality Education: Findings Among One South Florida County

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*As part of a community plan to implement abstinence-based sexuality education, this study assessed opinions toward sexuality education among residents. Respondents ( $N = 1,090$ ) were selected by random digit dialing. The survey, adopted from previous national studies, assessed attitudes towards sexuality education. Chi-square tests of significance were used to determine relationships between demographic variables and participants' attitudes. Results demonstrated overwhelming support and were successfully used as part of a larger initiative to replace an abstinence-only curriculum with an abstinence-based one. This study details those findings and demonstrates the benefit of using local data to bring about community change.*

**KEYWORDS** *Sexuality education, adolescents, public support, abstinence-only sexuality education, abstinence-based sexuality education, comprehensive sexuality education, community change*

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## INTRODUCTION

Debate continues in the United States over the controversial topic of how to best implement sexuality education in the schools (Advocates for Youth, 2001; Eisenberg, Bernat, Bearinger, & Resnick, 2008; Kirby, 2007). Such programs typically fall within one of three categories: (1) abstinence-only, which emphasizes abstinence from all sexual behavior outside marriage and may only include contraception in terms of failure rates; (2) abstinence-based, which emphasizes the benefits of abstinence yet includes information about contraception as a disease prevention method (sometimes referred to as comprehensive); and (3) comprehensive, which is age-appropriate, sequenced K-12 sexuality education that includes information on a broad set of topics related to sexuality and sexual health including abstinence and contraception as disease prevention methods (Bleakley, Hennessy, & Fishbein, 2006; Sexuality Information and Education Council of the U.S. (SIECUS), 2004).

Despite the debate, implementing sexual risk reduction programs for youth is critical as adolescents are faced with epidemic rates of STDs/HIV and unintended pregnancy. In the United States, half of new STD and HIV infections occur in individuals under age 25, and one-fourth of sexually active teens have an STD (Kirby, 2007). Of the approximate 56,300 new HIV infections in the United States in 2006, young people ages 13–29 made up the largest group (34%, or 19,200) followed by those 30–39 (31%, or 17,400) (Centers for Disease Control and Prevention [CDC], 2008). In addition, the United States leads other developed countries in teen pregnancy, birth, and abortion rates (Alan Guttmacher Institute, 2006; Singh & Darroch, 2000). In 2006, the pregnancy rate for U.S. teens ages 15–19 was 71.5 per 1,000, while the birth rate was 41.9 per 1,000 (Guttmacher Institute, 2010–2012). The equates to one in three teenage girls becoming pregnant at least once before age 20, with more than 400,000 babies being born to teenagers each year (National Campaign to Prevent Teen Pregnancy (NCTPTP), 2006). Nationally, Florida ranks second in reported cases of adolescent HIV and AIDS, twelfth in teen pregnancy rates, ninth in teen abortion rates, and twenty-first in teen birth rates (CDC, 2004; Guttmacher Institute, 2010–2012).

Risky sexual behaviors among youth that lead to such elevated numbers of STDs/HIV and teen pregnancy remain high. Lindberg, Jones, and Santelli (2008) found that 50% of teens surveyed had engaged in vaginal intercourse, 55% had engaged in oral sex, and 11% in anal sex. Careful and consistent contraceptive use among many teens is lacking, with only 70% of teen girls who rely on oral contraceptives actually taking them every day (Kirby, 2007). Of further concern is that Florida rates are higher than national rates for the percent of high school teens who report ever having sex (50.6% vs. 46.0%), percent of seniors who report ever having had sex (62.5% vs. 62.3%), teens having had four or more partners (21.8% vs. 20.9%), and teens having had sex before age 13 (6.2% vs. 4.4%) (CDC, 2010).

Numerous studies have documented the effectiveness of sexuality education programs in preventing adolescent STDs, HIV, and pregnancy (Cohen, Nsuami, Martin, & Farley, 1999; Kirby, 2007; Kohler, Manhart, & Lafferty, 2008; Landry, Darroch, Singh, & Higgins, 2003; Tiezzi, Lipshutz, Wroblewski, Vaughan, & McCarthy, 1997; Zimmer-Gembeck, Doyle, & Daniels, 2001). These programs, often referred to as “evidence-based” programs, teach both abstinence and contraception and have been found to delay the initiation of sexual intercourse, decrease the frequency of sexual intercourse, decrease the number of sexual partners, and/or increase the use of condoms and contraception (Kirby, 2007). Furthermore, both the public and most professional organizations such as the American Medical Association and the American Academy of Pediatrics prefer this type of education (Boonstra, 2002). Years of national research and polling have shown that the majority of the public overwhelmingly support teaching both abstinence and contraception (Bleakley et al., 2006; Constantine, Jerman, & Huang, 2007; Eisenberg et al., 2008, 2009; Howard-Barr & Moore, 2007; Ito, Gizlice, Owen-O’Dowd, Foust, Leone, & Miller, 2006; Kirby, 2007; Lindley, Reininger, & Saunders, 2001; National Public Radio (NPR), 2004; Vincent, Berne, Lammers, & Strack, 1999; Yarber, Milhausen, Crosby, & Torabi, 2005). Also, more than 140 professional organizations are part of the National Coalition to Support Sexuality Education, which also promotes teaching both abstinence and contraception (SIECUS, 2005).

Since most adolescents under age 18 attend school, this avenue is a logical place to provide sexuality education (Lindley et al., 2001). School-community partnerships have been found to be particularly effective in addressing adolescent sexuality health issues (Kirby, 2007). Unfortunately, implementation of evidence-based sexuality programs including both abstinence and contraception in U.S. schools is lacking. Of the mere 21 states and the District of Columbia (DC) that require schools to teach sexuality education, only 15 and DC require that programs “cover” contraception, and no state requires that it be “stressed” (Guttmacher Institute, 2010–2011). Guidelines for teaching contraception and condom use as a disease prevention method are typically vague, with individual school districts determining the level of instruction (Guttmacher Institute, 2010–2011).

Although sexuality education to include abstinence is mandated in Florida schools, local school boards may determine whether to include contraception (Guttmacher Institute, 2010–2011). Currently, Florida public K–12 educational instruction is based on the “Sunshine State Standards” as part of the Florida Statutes. The Florida State Board of Education has adopted these Statutes, which require addressing the “awareness of the benefits of sexual abstinence as the expected standard and the consequences of teenage pregnancy” when sexuality education is taught, Statute 1003.42, and must include “the benefits of monogamous heterosexual marriage,” Statute 1003.46 (Florida Department of Education (FDOE), 2010). Local school boards have

the authority to decide which additional sexuality education topics, if any, are addressed by the schools (FDOE, 2010). A recent study found that the majority (87%) of Florida teachers agree that some form of sexuality education should take place in their schools. However, many Florida students receive no sexuality education since the majority of Florida schools do not require sexuality education for all students. When students do take sexuality education, most (85%) receive 20 hours or less in a year. There is little uniformity in what content is taught as sexuality education is often included as part of another course. Finally, sexuality education often occurs late in one's high school career with little uniformity among who teaches it. Certifications of those responsible for teaching sexuality education include "Family and Consumer Sciences," "Physical Education," "Science," and "Health" (Dodge et al., 2008).

Although there are several reasons both abstinence and contraception might not be included in state or district sexuality education guidelines or taught in the classroom, one common reason cited is the misperception that local residents do not support this type of education. It is often further assumed that this lack of support may lead to controversy for the schools if sexuality education is taught. In fact, lack of support by local residents has been reported as a major barrier to providing abstinence-plus sexuality education (Darroch, Frost, & Singh, 2001; Forrest & Silverman, 1989; Landry et al., 2003). However, it is ironic that the prevailing public opinion which supports teaching both abstinence and contraception does not match district, state, and federal policies that limit and sometimes prohibit teaching contraception (Eisenberg et al., 2008). This incompatibility is evident with the "vocal minority" often influencing school decisions regarding sexuality education (Eisenberg et al., 2008). School personnel can use such evidence of support to counter minority opposition who attempt to control the curricula offered (Howard-Barr & Moore, 2007; Vincent et al., 1999).

The purpose of this article is to describe the results of a survey to assess attitudes of St. Lucie County Florida residents toward sexuality education, including support for specific sexuality education topics and when such topics should be taught. Among Florida counties, St. Lucie has the highest HIV rate among Black residents, with 1 in 35 being HIV positive (Florida Department of Health (FDOH), 2006) and ranks fourth in teen pregnancy among the 67 Florida counties (FDOH, 2008). This county is unique in that it has a Shared Service Network Executive Roundtable (ERT), a group of 24 chief executive policymakers, elective officials, and leaders from funding agencies, state, and local government entities and nonprofit organizations. This group formed an HIV/AIDS Subcommittee and was determined to address the current HIV epidemic in their county. Their efforts included meetings with key members of the school system, the development of a community action group to address teen pregnancy, a review of evidence-based sexuality programs, an assessment of local support for sexuality education, and the development

and distribution of an educational DVD on HIV. The actual process of using this data as part of a larger effort to replace an existing curriculum with an evidence-based sexuality program is described elsewhere (Weiss, Dwonch-Schoen, Howard-Barr, & Panella, 2010). This article focuses specifically on the assessment component describing attitudes of St. Lucie County residents toward sexuality education.

## METHODS

### Participants & Procedures

Participants included 1,092 full time residents of St. Lucie County Florida 18 years of age and older. This number included an oversample 402 parents with children attending local schools in grades K–12. Data were collected over a three week period in September and October 2006 during interviews that lasted an average of 8.2 minutes (Sexuality Education Survey, 2006). The margin of error was  $\pm 3.1\%$  for the general population sample and  $\pm 4.9\%$  for the parent oversample, which reflects a 95% confidence level. Computer Assisted Telephone Interviewing (CATI) was employed at a supervised polling laboratory at the University of North Florida.

A sample of the population was selected through the use of Random-Digit-Dialing methodology. Phone calls were placed between 5:00 p.m. and 9:00 p.m. during the weekdays and between 10:30 a.m. and 2:30 p.m. Saturdays to ensure a representative sample. For noncompletes with a working residential phone line, at least six callbacks were attempted. Approximately 30 trained and supervised students at the University of North Florida performed data collection. The laboratory employs Spanish-speaking interviewers as well to ensure ethnic representation in the sample. The majority of respondents were female (68.4%), white (73.4%), and had at least some college education (70.5%), compared to the residents of the area where 51.2% were female, 79.1% white, and 44.9% with at least some college education. Just over one-third (36.8%) of participants had school-age children attending local schools. Additional details of the sample are shown in Table 1.

### Measures

Various state and national surveys previously developed and implemented to determine support for sexuality education were identified (NPR, 2004; Zogby, 2003). After extensive review and discussion, it was determined that the instrument for this study would be adapted from a national survey, the 2004 Kaiser Family Foundation Poll (NPR, 2004). This survey on sexuality education was developed as a joint project of NPR, the Henry J. Kaiser Family Foundation, and Harvard University's Kennedy School of Government (NPR,

**TABLE 1** Demographic Frequencies

Variable	N (%)
Gender	
Female	747 (68.4)
Race	
White	802 (73.4)
Black	130 (11.9)
Other	135 (12.4)
Hispanic or Latino	
Yes	141 (12.9)
Age	
18–24	101 (09.2)
25–34	177 (16.2)
35–44	260 (23.8)
45–54	220 (20.1)
55–64	150 (13.7)
65+	176 (16.1)
Education level	
Grade school	41 (3.8)
High school	272 (24.9)
Some college	364 (33.3)
College grad	296 (27.1)
Postgrad degree	110 (10.1)
Kids in school	
Yes	402 (36.8)

2004). The NPR survey contained 52 questions related to sexuality education with an additional 16 demographic questions.

Due to specific concerns as well as the cost involved, the HIV/AIDS Subcommittee of St. Lucie County decided to use one section of the NPR survey verbatim to assess the attitudes of St. Lucie County (SLC) residents. This section contained 22 questions. Of the 22 questions, 18 specifically addressed individuals' attitudes towards the appropriateness of sexuality education topics in public schools. Participants were asked if various sexuality topics were (1) appropriate for middle school students, (2) appropriate for high school students, (3) appropriate for both age groups, or (4) not appropriate for either age group. The four additional questions included one question about the importance of teaching sexuality education in general, one question about the type of sexuality education preferred (abstinence-only, abstinence-based, or responsible decision making), and two questions asking if birth control promotes sex or promotes "safer sex."

In addition to the 22 questions used from the NPR survey, two questions taken from a Zogby International 2004 survey addressing attitudes toward abstinence were also added. These two questions were included at the request of HIV/AIDS Subcommittee members who were abstinence-only supporters. The final 31 question instrument included seven demographic questions: gender, age, race (White, Black or African American, Asian, or

Other), Hispanic or Latino origin, child(ren) attending local school, grade of child(ren) (elementary K–6, middle 7–8, or high school 9–12), and respondent's education level (grade school, high school graduate, some college, college graduate, postgraduate degree). Content validity was established via a group of five experts in sexuality education, adolescent health, and survey development. Minor changes in question wording and order were made to maximize question clarity.

### Data Analysis

Data were analyzed using SPSS for Windows 17.0. Frequencies were run for all variables. Chi-squares tests of significance were used to analyze six demographic variables (age, race, education level, gender, Hispanic, kids in school) by four survey questions (importance of sexuality education in school, type of sexuality education preferred, birth control encourages sex, birth control encourages safer sex). Significance was set at  $p < .05$ .

## RESULTS

### Attitudes Toward Sexuality Education

Overall, participants expressed supportive views about including sexuality education in school instruction. The vast majority (91%) of respondents felt it was very (71%) or somewhat (20%) important to teach sexuality education. When asked which type of sexuality education program they preferred (Q1), half (48.7%) supported abstinence-based sexuality education, 33.6% supported responsible decision making, and few (13.6%) supported abstinence-only sexuality education. An additional 4.1% either did not know or refused to answer this question.

### Attitudes Toward Condoms and Contraception

Respondents also held supportive views about condoms and contraception. When asked if providing teens with information about how to obtain and use condoms and other contraception encourages them to have sexual intercourse earlier than they would have (Q21), the majority (63.1%) of respondents selected "no, will not encourage them." Only 32.3% selected "yes, it will encourage them," and the remaining 4.6% either did not know or refused to answer this question. When asked if giving teens information about how to obtain and use condoms and other contraception makes it more likely that they will practice safe sex now or in the future (Q22), the majority (76.2%) selected "yes, more likely to practice safe sex." Only 19.8% selected

“no, not more likely to practice safe sex,” and the remaining 4.1% either did not know or refused to answer this question.

### Attitudes Toward Abstinence

The majority of respondents also were supportive of abstinence, with 93.9% agreeing that the best choice for sexual intercourse was to be linked to love, intimacy, and commitment in a faithful marriage (Q23). Only 4.8% disagreed with this statement, and 1.3% either did not know or refused to answer this question. The majority of respondents (83.4%) also agreed that the more sexual partners a teen has, the greater the likelihood of physical and psychological harms (Q24). Of those remaining, 12.9% disagreed with this statement, and 3.7% either did not know or refused to answer this question.

### Attitudes Toward the Appropriateness of 18 Sexuality Education Topics

Results showed all 18 topics were supported by the majority of participants; that is, each topic was supported by 71.8% or more of respondents as being appropriate for either middle school students, high school students, or both. In addition, 12 of the 18 topics were supported by 90% or more of respondents as being appropriate for one or both levels. The four least supported topics included homosexuality and sexual orientation (Q18), masturbation (Q13), that teens can obtain birth control pills from family planning clinics and doctors without permission from a parent (Q17), and oral sex (Q19). Although oral sex (Q19) was the least supported topic overall with 28.2% of respondents selecting “neither,” 68% of respondents still believed it was an appropriate topic to teach to middle school, high school, or both. A summary of the findings is shown in Table 2.

### Demographic Differences in Attitudes Toward Sexuality Education

#### IMPORTANCE OF SEXUALITY EDUCATION

There were no significant differences by demographic variables on rated importance of teaching sexuality education. The majority of those in all categories within each of the six demographic variables thought it was very important to teach sexuality education.

#### APPROACH TO SEXUALITY EDUCATION

Although the majority of respondents in all categories within each demographic variable choose abstinence-based as their preferred approach to sexuality education, there were significant differences within four of the six

**TABLE 2** Sexuality Education Topic Appropriateness Frequencies

Question	MS N (%)	HS N (%)	Both N (%)	Neither N (%)
Q2. The basics of how babies are made, pregnancy and birth	173 (15.8)	176 (16.1)	692 (63.4)	45 (4.1)
Q3. HIV/AIDS	139 (12.7)	115 (10.5)	807 (73.9)	29 (2.7)
Q4. Sexually transmitted diseases including HIV/AIDS	125 (11.4)	141 (12.9)	800 (73.3)	22 (2.0)
Q5. Birth control and methods of preventing pregnancy	110 (10.1)	254 (23.3)	647 (59.2)	71 (6.5)
Q6. How to use and where to get birth control and other methods of preventing pregnancy	88 (8.1)	338 (31.0)	532 (48.7)	112 (10.3)
Q7. Waiting to have sexual intercourse until older	124 (11.4)	161 (14.7)	730 (66.8)	68 (6.2)
Q8. How to get tested for STDs including HIV/AIDS	93 (8.5)	287 (26.3)	644 (59.0)	56 (5.1)
Q9. How to deal with the emotional issues and consequences of being sexually active	101 (9.2)	220 (20.1)	684 (62.6)	74 (6.8)
Q10. Waiting to have sexual intercourse until married	111 (10.2)	130 (11.9)	734 (67.2)	99 (9.1)
Q11. How to talk with a girlfriend/boyfriend or partner about "how far to go" sexually	104 (9.5)	242 (22.2)	629 (57.6)	99 (9.1)
Q12. How to put on a condom	83 (7.6)	342 (31.3)	473 (43.3)	165 (15.5)
Q13. Masturbation	89 (8.2)	235 (21.5)	451 (41.3)	246 (22.5)
Q14. How to talk with parents about sex and relationship issues	155 (14.2)	96 (8.8)	789 (72.3)	42 (3.8)
Q15. Abortion	72 (6.6)	314 (28.8)	473 (43.3)	210 (19.2)
Q16. How to make responsible choices based on individual values	106 (9.7)	200 (18.3)	675 (61.8)	85 (7.8)
Q17. That teens can obtain birth control pills without permission from a parent	52 (4.8)	360 (33.0)	348 (31.9)	304 (27.8)
Q18. Homosexuality and sexual orientation—that is being gay, lesbian or bisexual	88 (8.1)	248 (22.7)	493 (45.1)	233 (21.3)
Q19. Oral sex	58 (5.3)	307 (28.1)	384 (35.2)	308 (28.2)

Note. Question stem = "Is (question) an appropriate topic for middle school (MS), high school (HS), both (both) or not appropriate for either age group (neither)?"

demographic variables. The percent that chose abstinence-only decreased with age group, from 18.9% for those 65 and older to 7.2% for those 18–24 years. African Americans were more likely to choose abstinence-only (22% vs. 12% of white and 14% of other) and less likely to choose responsible decision making than whites or other races (25% vs. 36%, 40%, respectively). Those who did not have children were more likely to choose responsible decision making than those who did have children (38% vs. 30%). Males were more likely than females to choose abstinence-only (18% vs. 12%) and responsible decision making (40% vs. 33%). There were no differences by ethnicity or education level.

## BIRTH CONTROL ENCOURAGES SEX

The majority of respondents within each demographic variable did not think birth control encouraged sexual intercourse. However, significantly more African Americans (48% vs. 30% of white, 41% of other), Hispanics (44% vs. 33%), and males (39% vs. 31%) answered yes to this question as compared to their counterparts. There were no significant differences by age group, kids in school, or education level.

## BIRTH CONTROL ENCOURAGES SAFER SEX

The majority of all respondents within each variable thought that birth control did encourage safer sexual behaviors. However, those ages 44 and younger were significantly more likely to agree with this statement as compared to those older than 44 (82–88% vs. 71–76%). Parents were also more likely to agree with this statement than nonparents (84% vs. 77%). See Table 3.

## DISCUSSION

The purpose of this study was to determine public opinion toward support for sexuality education in one south Florida county. Findings from this survey of St. Lucie County residents are consistent with similar studies at state and national levels (Eisenberg et al., 2008; Howard-Barr & Moore, 2007; Kirby, 2002; Lindley et al., 2001; NPR, 2004; Vincent et al., 1999). Contraceptive use along with abstinence is a critical component of evidence-based programs identified by both the Centers for Disease Control and Prevention and by Douglas Kirby and the National Campaign to Prevent Teen Pregnancy as being effective in reducing risky sexual behaviors (Kirby, 2007). It is interesting to note that at the time of this study an abstinence-only curriculum was being implemented in St. Lucie county schools, thus not matching the preference of county residents nor recommendations for effective sexuality education curriculum.

In addition to supporting teaching about contraception and abstinence, there was support for a wide variety of other important topics for both middle and high school students. In addition, some of the topics often considered to be more controversial and not typically included in sexuality curriculum were also supported by the majority of respondents. For example, approximately four out of five respondents supported teaching about both sexual orientation and abortion. Yet according to Dodge et al. (2008), only 29% of 479 Florida teachers surveyed reported teaching about sexual orientation, and 42% covered abortion. There was also much support for teaching about masturbation (77.5%) and oral sex (71.8%), but among those teaching sexuality education in Florida only 27% reported teaching about masturbation (Dodge

**TABLE 3** Attitudes Toward Sexuality Education by Demographic Variables

Questions Demographic variables	Important (Very) N (%)	Preferred approach to sexuality education		RDM (%)	Birth co: encourages sex		Birth co: encourages safer sex (Yes) N (%)
		Ab-only N (%)	Ab-based N (%)		(Yes) N (%)	(Yes) N (%)	
Total	779 (72)	148 (14)	532 (51)	367 (35)	353 (34)	832 (79)	
Age	<i>ns</i>		22.1(10), .02		<i>ns</i>	16.7(5), .01	
18-24	80 (79)	7 (7)	53 (55)	37 (38)	32 (34)	87 (88)	
25-34	135 (77)	20 (12)	103 (60)	49 (29)	55 (33)	145 (85)	
35-44	190 (74)	33 (13)	138 (55)	81 (32)	83 (33)	210 (82)	
45-54	156 (71)	32 (15)	102 (48)	80 (37)	63 (29)	165 (76)	
55-64	98 (66)	25 (18)	67 (48)	48 (34)	56 (39)	100 (71)	
65+	115 (67)	31 (19)	65 (40)	68 (42)	62 (38)	119 (75)	
Gender	<i>ns</i>		15.9(2), .00		6.1(1), .01	<i>ns</i>	
Female	534 (72)	90 (12)	397 (55)	237 (33)	224 (31)	577 (81)	
Male	245 (72)	58 (18)	135 (42)	130 (40)	129(39)	255 (77)	
Race	<i>ns</i>		13.5(4), .01		17.9(2), .00	<i>ns</i>	
White	566 (71)	96 (12)	397 (51)	281 (36)	233 (30)	619 (81)	
Black	96 (74)	28 (22)	67 (53)	31 (25)	60 (48)	94 (76)	
Other	98 (74)	17 (14)	57 (46)	50 (40)	51 (41)	100 (76)	
Hispanic	<i>ns</i>		<i>ns</i>		6.3(1), .01	<i>ns</i>	
Yes	108 (77)	13 (9)	65 (49)	55 (41)	58 (44)	108 (79)	
No	658 (71)	132 (15)	457 (51)	309 (44)	291 (33)	712 (80)	
Kids	<i>ns</i>		12.2(2), .00		<i>ns</i>	8.8(10), .00	
Yes	294 (74)	48 (12)	223 (58)	115 (30)	128 (33)	327 (84)	
No	484 (71)	100 (15)	307 (47)	252 (38)	224 (34)	504 (77)	
Education	<i>ns</i>		<i>ns</i>		<i>ns</i>	<i>ns</i>	
Grade school	32 (80)	7 (18)	17 (45)	14 (37)	18 (47)	31 (80)	
High school	199 (74)	37 (14)	122 (46)	104 (40)	96 (38)	216 (83)	
Some college	266 (74)	49 (14)	172 (49)	131 (37)	118 (34)	278 (80)	
College grad	207 (71)	40 (14)	161 (57)	82 (29)	85 (30)	222 (77)	
Postgrad	69 (63)	14 (14)	56 (54)	34 (33)	32 (29)	80 (76)	

Note. Survey questions: Rated importance of sexuality education, preferred approach to sexuality education (abstinence-only, abstinence-based, responsible decision-making), birth control encourages sexual intercourse, birth control encourages safer sex; ns = not significant; X<sup>2</sup>(df), p value for significant tests only.

et al., 2008). However, both oral sex and masturbation are commonly practiced by teens (Lindberg et al., 2008). This demonstrates that what is usually being taught is inconsistent with not only the attitudes among the majority but also inconsistent with the current sexual behaviors among youth.

Furthermore, there were supportive attitudes toward sexuality education across demographic variables. Respondents in all categories of the demographic variables analyzed in this study were most likely to say that it was very important to teach sexuality education and were most likely to support an abstinence-based or responsible decision-making approach to sexuality education rather than an abstinence-only approach. There were a few significant differences within demographic variables worth noting. African-Americans were more likely than whites and other races to choose an abstinence-only approach and more likely to say that teaching about birth control encouraged sexual activity. Males responded similarly to these two questions; they were more likely than females to choose an abstinence-only approach or a responsible decision-making approach and to say that providing birth control information encouraged sex. Interestingly, previous studies of Florida voters have shown no differences by gender or race in type of sexuality education supported (Healthy Teens Campaign, n.d.; Howard-Barr & Moore, 2007). Finally, while more parents than nonparents supported an abstinence message along with contraceptive information, they also were more likely to agree that providing contraceptive information increased the likelihood of young people practicing safer sex.

This study had several limitations. One concern was the restriction placed on data collection through a random-digit dial telephone survey. Although 95–98% of all owner-occupied and renter-occupied housing units in the United States have telephone service, telephone unavailability is a concern (U.S. Census, 2000). This concern is more prevalent among traditionally economically disadvantaged persons. Second, this study used a brief description to imply the content of sexuality education topics to be taught. Therefore, support for the nature and depth of each topic was not known. Finally, all participants resided in a single county. Although the views of this sample were consistent with other state and national findings, opinions of St. Lucie County residents may not have been fully generalizable to those in other areas.

In conclusion, the majority of people surveyed in this study supported evidence-based programs teaching both abstinence and contraception, and such programs were consistent with actual sexual behavior among teens. St. Lucie County was able to replace an existing program with an evidence-based program by clearly addressing two of Kirby's (2007) characteristics of implementing effective programs: (a) securing at least minimal support for appropriate authorities and (b) employing behavioral messages appropriate to teens sexual experience. The data presented in this article was instrumental in facilitating that change.

This study's findings have implications for future efforts to increase the implementation of evidence-based sexuality programs for youth. The widespread public support for sexuality education, and even of those topics perceived as controversial, can be used to assist others in efforts to implement such programs in the classroom or community. This study in particular shows the benefit of using local data to bring about change. Other communities may replicate a similar assessment to document support for sexuality education in their own counties. If cost is an issue, a smaller scale assessment of fewer participants or a Web-based survey may be more conceivable. Possibilities for various surveys participants include parents only, school personnel/teachers, or registered voters. Residents, and particularly parents, should be encouraged to share their views on sexuality education since this is a public health issue. Educating decision makers on real support for sexuality education coupled with information on programs that have been found to be effective may be an important strategy in successfully adopting evidence-based programs. This in turn may broaden support of programs that provide medically accurate information and can reduce risky sexual behaviors among youth. Future research should further investigate the relationship between demonstration of local support for sexuality education and the sexuality education being implemented in the schools. As other communities look to change current policy or curriculum, they can certainly learn from the efforts of St. Lucie County, Florida.

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