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Documenting Support for Ongoing and Improved Efforts in Sexuality Education

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ABSTRACT

As debate regarding sexuality education continues, STD, HIV, and teen pregnancy rates remain high. Garnering support is critical to ensure quality programs addressing these public health concerns. As part of a funded project to reduce adolescent sexual health issues in a large Florida county, this study assessed voter support for specific sexuality education topics. A survey was developed after reviewing existing instruments. The university's Public Opinion Research Laboratory used random-digit-dialing to administer the survey (N=311). Most participants supported topics taught in middle school: dealing with pressure to have sex (85%), talking to parents about sex (90%), human anatomy/reproduction (91%), HIV/STDs (92%), abstinence (93%), birth control (83%), and condom use (81%). Support was even greater in high school (88%-97%) for these topics. Most participants (86%) supported teaching both abstinence and birth control/safer sex practices. Chi-square results showed significant differences in support of topics by several demographics. Results add substantial support for age-appropriate, school-based sexuality education and policy to support evidence-based abstinence-plus or comprehensive sexuality education. Documented support is important in establishing, changing, and ensuring ongoing policy. Such findings can both encourage and support administrators and teachers in offering evidence-based sexuality education programs.

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BACKGROUND

Nationally, and particularly in Florida, sexuality education in schools has been considered a controversial topic when determining which type of program to offer (Eisenberg, Bernat, Bearinger, & Resnick, 2008; Jones, 2011; Wiley, 2012; Zipperer, 2017). Three overall categories of sexuality education programs exist: (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 abstinence-plus); 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; Constantine, 2008; Sexuality Information and Education Council of the United States [SIECUS], 2004). As the debates continue, so does the need for quality sexuality education to address risky sexual

behaviors of youth and associated negative health outcomes.

Risky sexual behaviors among youth remain high. According to the 2015 national Youth Risk Behavior Survey (YRBS) data, (41.2% of high school students in grades 9-12 reported ever having had sex (ranging from 39.9% for white students to 48.5% for black students) (Centers for Disease Control and Prevention [CDC], 2016a). Similarly in Florida, overall 40.3% report ever having had sex (35.7% of females, 44.9% of males). Among high school seniors in the United States (U.S.), 58.1% reported ever having had sex (57.3% of Florida seniors), and 19.2% reported having had four or more partners (17.3% of Florida seniors) (CDC, 2016a). Data for high school freshman, generally 14 to 15 years old, showed that 24.1% reported having had sex (same 24.1% in Florida) and 4.9% reported having had four or more partners (6.7% of Florida freshman) (CDC, 2016a). In a review of available 2015 middle school YRBS results (17 areas/states), data documented that as many as 7.6% of 6th graders and 19.5% of 8th graders reported having engaged in sexual intercourse (CDC, 2016a). In another study,

Lindberg, Jones and Santelli (2008) found that 50% of teens surveyed had engaged in vaginal intercourse, 55% in oral sex, and 11% in anal sex. As concerning is the lack of condom and contraceptive use, also documented by 2015 YRBS data. Only 18.2% of U.S. teens reported using the birth control pill at last intercourse, (13.6% of Florida teens), and 56.9% of U.S. teens used a condom at last intercourse (61% of Florida teens) (CDC, 2016a). These risky sexual behaviors have numerous negative health and social outcomes.

Adolescents are faced with epidemic rates of STDs/HIV and unintended pregnancy. In the U.S., nearly half of the 20 million new STD infections each year occur in individuals under age 25, and one in four teens has an STD (CDC, 2011a). Of the new HIV infections in 2015, young people ages 13-29 made up 41% of the total U.S. rates (CDC, 2016b). Additionally, young people, ages 13-24, were the most likely to be unaware of their infection, comprising an estimated 51% of those living with HIV who didn't know (CDC, 2016b). Florida had the second highest rate of newly diagnosed HIV infections in 2014, and the highest rates of newly diagnosed AIDS cases (Florida Department of Health [FDOH], 2017a). (FDOH, 2017b).

The U.S. teen pregnancy rates for 2011 represented the lowest observed in the past four decades (Kost & Maddow-Zimet, 2012). However, in spite of the progress, the U.S. continues to lead other developed countries in teen pregnancy, birth and abortion rates (Kost & Maddow-Zimet, 2012; Guttmacher Institute, 2007). The National Campaign to Prevent Teen and Unplanned Pregnancy [TNC] (2016) estimates that 1 in 4 female teens are pregnant by age 20 (approximately 750,000 teens become pregnant each year), and 1 in 7 teen girls give birth before age 20. In 2011, Florida ranked 32nd of 50 states in teen pregnancy rates (1st is the best, 50th is the worst) and 23rd in teen birth rates (TNC, 2016). Finally, with one-in-ten new mothers in the U.S. being a teen, more than 400,000 babies are born to teen girls each year, almost 1,100 every day (CDC, 2011b).

Fortunately, numerous studies have documented the effectiveness of various sexuality education programs in preventing adolescent STDs, HIV and pregnancy (Kirby, 2001; Alford, 2008; Kohler, Manhart, & Lafferty, 2008; Sullentrop, 2011). 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, 2001). In Florida, 2015 YRBS state data documents that students who had been taught or talked to about HIV/AIDS were more likely to use a

condom at last intercourse than those who had not been taught (62.6% vs. 57.1%) (CDC, 2016a).

Unfortunately, implementation of evidence-based sexuality programs including both abstinence and contraception in U.S. schools is lacking. Of the mere 24 states and the District of Columbia (DC) that require schools to teach sexuality education, only 18 and DC require that programs provide information on contraception (Guttmacher Institute, 2017). Florida requires “Family Life” instruction, a component of “Comprehensive Health Education” under Florida State Statute 1003.42(2n) (Florida Legislature, 2017). Required, related topics listed as part of this statute include sexual abstinence, teen pregnancy, prevention and control of disease, and teen dating violence and abuse. Some people may misinterpret this statute to believe Florida is an “abstinence-only state.” However, this is not true. Florida has not adopted a certain type of required program (abstinence-only, abstinence-based, or comprehensive). This decision is left to the local districts. Although abstinence must be included, specific content and curriculum, such as condoms and birth control, is determined by local school district policy (Zipperer, 2017). As of 2013, according to a Florida Department of Education Health Education Survey assessing the 67 school districts in the state, 25 districts reported being abstinence-only (teaching only abstinence and not condoms/contraception other than potentially including failure rates), 34 abstinence-based (teaching both abstinence and condoms/contraception), and 8 comprehensive (teaching a broad set of topics related to sexuality and sexual health) (Zipperer, 2017).

Purpose

One obstacle in schools teaching abstinence-based sexuality education is the perceived lack of support for doing so (Darroch, Forst, & Singh, 2001; Landry et al., 2003). However, a growing body of literature documents strong government, community, educator, and parental support for such sexuality education. Years of national and state level research has repeatedly shown the majority of the public overwhelmingly support teaching both abstinence and contraception, which is typical of an abstinence-based or comprehensive program (Millner, Mulekar & Turmes, 2015; Barr, Moore, Johnson, Forrest & Jordan, 2014b; Eisenberg et al., 2008; Kirby, 2001; Bleakley et al., 2006; Constantine, Jerman, & Huang, 2007; Eisenberg, Bernat, Bearinger, & Resnick, 2009; Howard-Barr & Moore, 2007; Howard-Barr, Moore, Weiss, & Jobli, 2011; Ito, Gizlice, Owen-O'Dowd, Foust, Leone, & Miller, 2006; National Public Radio [NPR], 2004; Yarber, Milhausen, Crosby, & Torabi, 2005). Documentation of support at the local level has been to shown to be more effective in helping to create policy and practice

changes (Howard-Barr et al., 2011). As part of a funded project to reduce adolescent sexual health issues in a large Florida county, this study assessed voter support for specific sexuality education topics in both middle school and high school. Discussion of these findings and how they are / have been used to support ongoing efforts and initiatives to help ensure the continuation of quality sexuality education programs and policy is included.

METHODS

Instrumentation

The survey was developed after a review of several state and national surveys assessing voter/parent support for sexuality education in the schools (Eisenberg et al., 2009; Howard-Barr & Moore, 2007; Howard-Barr et al., 2011; Ito et al., 2006; NPR, 2004; Yarber, Milhausen, Crosby, & Torabi, 2005; The Future of Sex Education, 2012). An expert panel consisting of researchers and personnel from the school district (teachers, grant staff), health department and local health agencies reviewed the survey for readability, content and face validity. Feedback resulted in removing some questions, and revisions to the wording of other questions. The final survey consisted of 21 questions for parents/caregivers and 19 questions for non-parents/caregivers. Questions used in this analysis are described below.

Two questions assessed support for eight sexuality education topics being taught at the MS and HS levels: 1. How to deal with pressure to have sex, 2. How to talk with parents about sex and relationships, 3. Human anatomy and reproduction, 4. HIV and sexually transmitted diseases, 5. Abstinence from sexual activity, 6. Birth control methods, 7. Condom use, and 8. Gender and sexual orientation. Participants were first asked, "Please tell me if you support children learning about each of the following topics in HIGH school." The question was then repeated to ask about topics in MIDDLE school (two separate questions; 1=Strongly support to 4=Strongly oppose). Four additional questions assessed opinions about sexuality education in general. (Non-caregivers) "If you had a child in school, would you"... OR (caregivers) "Would you allow your child/children to participate in grade level appropriate sexuality education at his or her school?" (1=Yes, 2=No, 3=Don't know/Not sure). "How important do you think it is to have sexuality education as part of the middle/high school curriculum?" (2 separate questions; 1=Very important to 4=Not at all important). "Which of the following statements comes closest to the way you feel about sexuality education in public schools?" (Students should NOT be taught sexuality education in school; Schools should ONLY promote abstinence and NOT teach young people about birth control and safer sex

practices; Schools should promote abstinence AND teach young people about birth control and safer sex practices).

Two additional questions assessed perceived percent of adolescents that have had sexual intercourse. "What percent of middle school (6-8th grade)/high school (9-12th grade) students do you think have had sexual intercourse?" (two separate questions; open ended). Another question inquired whether or not participants knew whether sexuality education was taught in their county schools. "Do you know if sexuality education is taught in Duval County Public Schools?" Finally, seven questions assessed demographics. They included sex, race, age, education level, marital status, parental status, and political affiliation. All response options are listed in Table 1.

Procedures

Computer Assisted Telephone Interviewing (CATI) was used to perform the data collection at the University's Public Opinion Research Laboratory. This software package allows the polling center to maintain quality data collection by automatic data tabulation. Approximately 40 students conducted the interviews in the 27-station polling laboratory in January 2014. A polling sample was selected through the use of Random-Digit-Dialing methodology. An additional cell phone sample was used to increase representation. For working residential and cell phone numbers, up to five attempts were made. To ensure a representative sample, calls were made from 5:00 p.m. - 9:00 p.m. during the weekdays. Respondent eligibility included being a county resident over the age of 18. Of those contacted to complete the survey, 408 refused to participate and an additional 275 hung up during the introduction. Those that were not county residents (N = 124) or under the age 18 (N = 130) were excluded from participation, as were those who only partially completed survey (N = 69). Age, sex and race were weighted to the U.S. Census data.

A total of 311 surveys were completed averaging 9.6 minutes each. The margin of error of 5.56% for the survey suggests that a representative sample was selected. Specifically, the margin of error indicates that there is a 95% chance that the results collected fall within the margin of error (plus or minus 5.6%) of the "true" measure that would have been obtained had everyone in the county been surveyed. Prior to implementing the survey, it was approved by the University's Institutional Review Board.

Data Analysis

SPSS 22 was used to run frequencies for all variables. Chi-square tests were used to examine whether there were differences in support for sexuality education topics across demographic

variables and opinions on sexuality education in general. Weighted data was used for tests of significance and may result in differences in the numbers between the frequency table and analyses tables.

Table 1
Sample Characteristics (N=311)

Variable	N (%)
Sex	
Female	167(53.7)
Male	144(47.3)
Race	
White	179(59.7)
Black	99(33.0)
Am Indian/Alaskan Nat	2(0.7)
Asian	7(2.3)
Hispanic	6(2.0)
Other/Mixed	7(2.3)
Age	
18-29	51(16.5)
30-39	42(13.6)
40-49	52(16.8)
50-59	66(21.4)
60-69	61(19.7)
70 and above	37(12.0)
Education Level	
Grade School	2(0.6)
Some high school	12(3.9)
High school graduate	60(19.5)
Some college	115(37.3)
College graduate	84(27.3)
Postgraduate degree	35(11.4)
Marital status	
Married	152(49.2)
Living with a partner	18(5.8)
Widowed	30(9.7)
Divorced	36(11.7)
Separated	7(2.3)
Never been married	63(20.4)
Other	3(1.0)
Children \leq 18 years	
Yes	94(30.4)
No	215(69.1)
Political affiliation	
Democrat	99(34.6)
Republican	82(28.7)
Independent	66(23.1)
Other	17(5.9)
None	22(7.7)

RESULTS

Participants and General Support for Sexuality Education

The sample was 54% female and 60% white. Thirty percent were parents of children under age 18,

76% had at least some college, and approximately half were married (49%).

Overall, participants expressed very supportive views about including sexuality education in school instruction. The majority supported teaching both abstinence and birth control (86%), while 6% supported teaching abstinence-only, and 5% did not support teaching sexuality education in the schools at all. The majority reported that sexuality education was important to teach in middle school (79%) and in high school (87%). When asked, "Do you know if sexuality education is taught in Duval County public schools," 75.8% replied, "Yes, it is taught," and 24.2% replied, "No, it is not taught." Finally, when asked the percent of middle and high school students participants believed to have had sex, the mean estimate was 61% for high school and 33% for middle school, with much variation.

Support for Sexuality Topics in Middle School

Respondents were very supportive of the eight topics listed as potential topics to include when teaching sexuality education in middle schools, grades 6-8. When asked whether or not they would be in favor of their child learning about the specific topics in middle school, 85% were in favor of dealing with pressure to have sex, 90% in favor of talking to parents about sex, 91% in favor of anatomy and reproduction, 92% in favor of HIV/STIs, 93% in favor of abstinence, 83% in favor of birth control, 81% in favor of condom use, and 72% in favor of gender and sexual orientation. More than 70% of the participants supported teaching all eight topics in middle school.

Significant differences in support for sexuality education topics by demographic characteristics exist at the middle school level, most notably by marital status and age. Married respondents were least supportive of teaching about HIV/STDs ($\chi^2 = 7.18$, $p < .05$), birth control ($\chi^2 = 14.40$, $p < .05$), and condom use ($\chi^2 = 16.33$, $p < .05$). Younger respondents were more supportive of topics related to anatomy and reproduction ($\chi^2 = 6.41$, $p < .05$), birth control ($\chi^2 = 7.12$, $p < .05$), and condom use ($\chi^2 = 11.90$, $p < .05$). In addition, females were more supportive of teaching abstinence ($\chi^2 = 4.64$, $p < .05$) and those with lower education levels (high school graduate or less) were least supportive of topics related to dealing with pressure ($\chi^2 = 7.38$, $p < .05$) and abstinence ($\chi^2 = 7.81$, $p < .05$). White and black respondents were more supportive of teaching topics related to dealing with pressure ($\chi^2 = 18.68$, $p < .05$) and how to talk to parents ($\chi^2 = 11.35$, $p < .05$) than respondents who identified as a member of some other racial group. There were no differences by parental status.

Support for Sexuality Topics in High School

The majority of respondents were also supportive of the eight topics listed as potential topics to include when teaching sexuality education in high schools, grades 9-12. When asked whether or not they would be in favor of their child learning about the specific topics in high school, 88% were in favor of dealing with pressure, 94% in favor of talking to parents, 96% in favor of anatomy and reproduction, 97% in favor of HIV/STIs, 94% in favor of abstinence, 89% in favor of birth control, 90% in favor of condom use, and 80% in favor of gender and sexual orientation. Of the participants, 80% or more supported teaching all eight topics in high school.

Support for teaching sexuality education topics varied as a function of demographic characteristics at the high school level. Specifically, respondents with lower education levels (high school graduate or less)

were least supportive of teaching sexuality topics related to dealing with pressure to have sex ($\chi^2 = 15.22, p < .05$), talking with partners ($\chi^2 = 8.10, p < .05$), anatomy and reproduction ($\chi^2 = 22.64, p < .05$), and HIV/STDs ($\chi^2 = 9.85, p < .05$). Democrats were more supportive of teaching about dealing with pressure to have sex ($\chi^2 = 8.14, p < .05$), birth control ($\chi^2 = 10.00, p < .05$), condom use ($\chi^2 = 10.04, p < .05$), and gender/sexual orientation ($\chi^2 = 7.96, p < .05$). In addition, males were more supportive of teaching about how to deal with pressure to have sex ($\chi^2 = 7.63, p < .05$), and younger respondents were more supportive of teaching about HIV/STDs ($\chi^2 = 6.70, p < .05$) and gender/sexual orientation ($\chi^2 = .03, p < .05$). Finally, Blacks were more supportive of teaching about how to deal with pressure to have sex ($\chi^2 = 10.34, p < .05$). There were no differences by marital status or parental status.

Table 2
Support for Sexuality Education and Sex Education Types

Variable	Total N (%)
Total	
Allow child to participate in sex ed?	
Yes	237 (76)
No	47 (15)
How important is sex ed in MS?	
Very/Somewhat	246 (79)
Not too/at all	57 (18)
How important is sex ed in HS?	
Very/Somewhat	269 (87)
Not too/at all	31 (10)
How feel about sex ed in schools?	
Should not be taught	16 (5)
Only abstinence	20 (6)
Abstinence+birth control/safer sex	267 (86)

Note.

MS = middle school, 6-8th; HS = high school, 9-12th

DISCUSSION

This study contributes to the research documenting public support for sexuality education, and specific sexuality topics in middle school and high school separately. In general, the respondents were very supportive of age-appropriate sexuality education with 79% agreeing sexuality education was important for middle school students and 87% for high school students. The majority supported all seven topics listed being taught starting in middle school. These results demonstrate substantial support for age-appropriate school-based sexuality education. This high level of support reinforces support in general for abstinence-based programs teaching both abstinence and condoms/contraception, consistent with previous research (Barr et al., 2014b; Eisenberg et al., 2008;

Kirby, 2007; Bleakley et al., 2006; Constantine et al., 2007; Eisenberg et al., 2009; Howard-Barr & Moore, 2007; Howard-Barr et al., 2011; Ito et al, 2006; NPR, 2004; Yarber et al., 2005). Additionally, these findings are in agreement with the newly established National Sexuality Education Standards that recommend age-appropriate sexuality education at all grade levels (The Future of Sex Ed, 2012). Finally, such findings clearly address two of Kirby's (2007) characteristics of implementing effective sexuality education programs: (1) secure at least minimal support to share with appropriate authorities and (2) employ behavioral messages appropriate to teen's sexual experience (Kirby, 2007). The findings in this study add support to the importance of future funding for evidence-based abstinence-plus or comprehensive

sexuality education. Such programs meet the needs of all youth, whether currently sexually active or not.

This survey was implemented as part of larger funded project. The goals of the project are to: 1. acquire and use Youth Risk Behavior (YRBS) and School Health Profile (SHP) data to increase community-wide awareness in an effort to target interventions, establish funding priorities, and support development of state and local policies and practices that will reduce priority health risk behaviors among youth; 2. implement Exemplary Sexual Health Education (ESHE) in middle and high schools in the County; 3. increase the number of schools that provide and link secondary school students to Key Sexual Health Services (KSHS); 4. implement Safe and Supportive Environment (SSE) initiatives focused on supporting LGBTQ middle and high school students in the county; and 5. educate decision-makers on policies supporting ESHE, KSHS, and SSE. The strong community support documented in this study has been utilized to help achieve some of these goals. For example, a fact sheet showing the need for sexuality education (local YRBS data on sexual risk behaviors; STD/HIV, and pregnancy rates), the effectiveness of sexuality education, and the local support for sexuality education (results of this survey) were developed and distributed to all health teachers and school administrators. Results have helped teachers feel more comfortable implementing the selected evidence-based sexuality education curriculum in their classrooms and have reinforced administrators' decision to support requiring sexuality education through local policy.

An interesting finding of the study was the perception of the percent of sexually active youth. Although variation existed, the participants' perceptions were actually much higher than local statistics document. The mean estimate of the percent of students who had ever had sexual intercourse for MS was 33%, and the estimate for HS was 61%. In actuality, results of the county 2013 YRBS Survey showed that only 15% of MS students had ever had sex, while only 46% of HS students had ever had sex. Teen sexual behavior is lower than what participants in this study believe, with 75% of participants overestimating the percent of MS students who had had sex, and 80% overestimating the percent of HS students.

Limitations

This study had several limitations. First, although the sample was representative of the county in which it was conducted, results cannot be generalized to the rest of the state or country. Second, respondents were asked about their support for sexuality education in middle schools and high schools. Only a third of respondents had children under age 18, and even

fewer in the age range being asked about (MS and HS). Participants may have answered differently if they had a child in the age range being asked about. Third, the survey 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 is not known. Additionally, the study included only quantitative methods. The use of qualitative methods may have added to the results by addressing why participants did or did not support sexuality education in general as well as the specific topics included. Finally, one question during the middle school survey implementation, support for gender and sexual orientation, was unavoidably left out due to a technical error with the computer system. It did not appear in the list of questions to be read aloud as the data collectors were administering the questions over the phone. This is an unfortunate example of how technical difficulties can impact findings. However, the researchers decided to still report the findings for this particular middle school question. Although participation was extremely low (n=35), the high support for this question mirrors previous studies (Barr et al., 2014b; Howard-Barr et al., 2011; NPR, 2004; Yarber et al., 2005).

IMPLICATIONS FOR PUBLIC HEALTH PRACTICE:

Documented support can be useful in establishing, changing, and ensuring ongoing, quality public health related policy. Other communities might consider replicating a similar assessment to document support for sexuality education in their own state or community. As school districts look to improve sexuality education, more data to document what residents are truly in favor of may help decision makers consider the preferences of the "quiet majority" when changing existing policy or creating new policy. District and school personnel can also counter potential minority opposition with the evidence found in this study. Even in communities with quality public health policies already in place, it may be just as useful to document that the ongoing policy is consistent with the majority of residents' views, especially when such policies are challenged. Educating decision makers, including school board members, about real support for sexuality education, coupled with information on effective programs, is an important strategy in successfully adopting and ensuring the delivery of evidence-based programs (Howard-Barr et al., 2011). This in turn may broaden support and delivery of programs that provide medically accurate information and have been shown to reduce risky sexual behaviors among youth.

To conduct a similar study at the local level, a critical, initial step is to identify key people who are interested to participate in the process. This group, similar to a planning committee, could include a

Table 3
Support for Sexuality Topics in Middle School by Demographic Characteristics

	Deal with Pressure N (%)	Talk to Parents N (%)	Anatomy & Reproduction N (%)	HIV & STDs N (%)	Abstinence N (%)	Birth Control N (%)	Condom Use N (%)	Gender/Sexual Orientation N (%)
Total	251 (85)	270 (90)	269 (91)	275 (92)	272 (93)	244 (83)	242 (81)	35 (72)
Gender								
Female	134 (86)	142 (91)	142 (93)	144 (92)	144 (96)	127 (84)	128 (83)	17 (71)
Male	117 (83)	128 (89)	128 (90)	131 (91)	128 (90)	117 (82)	114 (80)	18 (72)
Race								
White	143 (88)	152 (93)	152 (94)	153 (94)	155 (95)	138 (86)	135 (84)	18 (69)
Black	75 (87)	77 (91)	76 (89)	78 (91)	78 (93)	68 (80)	70 (81)	10 (71)
Other	23 (61)	31 (76)	32 (84)	35 (85)	30 (86)	31 (82)	31 (76)	4 (80)
Marital Status								
Married	119 (84)	126 (89)	123 (88)	123 (88)	125 (91)	101 (74)	100 (72)	13 (59)
Never married	63 (83)	69 (91)	70 (95)	74 (97)	71 (96)	70 (92)	69 (91)	12 (80)
Other	66 (85)	70 (91)	72 (94)	73 (95)	71 (92)	70 (90)	70 (90)	8 (89)
Age								
18-39	107 (88)	115 (93)	115 (96)	119 (96)	116 (95)	111 (90)	112 (90)	17 (81)
40-59	92 (84)	97 (88)	95 (86)	97 (88)	97 (92)	81 (76)	79 (73)	5 (45)
60 and above	50 (80)	56 (88)	57 (90)	57 (89)	57 (90)	50 (81)	49 (78)	11 (73)
Education Level								
HS grad/less	53 (75)	58 (83)	58 (85)	62 (87)	57 (85)	55 (79)	57 (80)	8 (73)
Some college	101 (89)	106 (92)	105 (93)	106 (93)	108 (96)	97 (89)	97 (85)	12 (75)
College grad/post	95 (86)	104 (92)	104 (93)	104 (92)	105 (93)	89 (79)	87 (78)	13 (72)
Political Affiliation								
Democrat	79 (91)	85 (97)	83 (95)	83 (94)	82 (95)	79 (91)	79 (90)	13 (100)
Independent	52 (87)	54 (89)	57 (93)	55 (90)	55 (90)	44 (75)	43 (73)	7 (70)
Republican	68 (81)	75 (89)	73 (87)	76 (90)	76 (94)	67 (83)	69 (82)	6 (46)
Other	31 (78)	37 (88)	34 (89)	39 (93)	37 (93)	34 (81)	32 (78)	6 (75)
Children ≤18								
Yes	90 (85)	94 (89)	91 (88)	94 (88)	94 (92)	83 (81)	86 (81)	7 (58)
No	159 (85)	175 (91)	177 (94)	180 (94)	177 (94)	160 (84)	156 (82)	28 (36)

Note.

N (%) = those that strongly support/support the service; Bold = Chi-square significant at $p < .05$

Table 4
Support for Sexuality Topics in High School by Demographic Characteristics

	Deal with Pressure N (%)	Talk to Parents N (%)	Anatomy & Reproduction N (%)	HIV & STDs N (%)	Abstinence N (%)	Birth Control N (%)	Condom Use N (%)	Gender/Sexual Orientation N (%)
Total	255 (88)	278 (94)	286 (96)	292 (97)	279 (94)	265 (89)	267 (90)	228 (80)
Gender								
Female	126 (83)	144 (94)	149 (96)	153 (97)	146 (95)	126 (89)	129 (90)	109 (81)
Male	129 (93)	134 (94)	138 (96)	139 (97)	133 (94)	138 (90)	139 (90)	119 (80)
Race								
White	142 (89)	154 (95)	158 (98)	160 (98)	152 (93)	145 (90)	147 (91)	126 (79)
Black	78 (93)	80 (94)	82 (96)	84 (98)	83 (98)	77 (90)	77 (91)	63 (78)
Other	26 (72)	33 (92)	37 (93)	38 (93)	34 (92)	34 (92)	33 (87)	32 (89)
Marital Status								
Married	122 (90)	131 (95)	133 (96)	136 (97)	130 (92)	116 (86)	119 (89)	99 (76)
Never married	64 (83)	72 (94)	74 (97)	74 (97)	72 (96)	72 (94)	71 (92)	64 (88)
Other	67 (88)	72 (94)	73 (95)	77 (99)	73 (95)	73 (94)	73 (94)	61 (80)
Age								
18-39	106 (90)	118 (97)	122 (99)	124 (100)	117 (98)	115 (93)	118 (95)	104 (90)
40-59	96 (91)	100 (93)	102 (94)	104 (95)	100 (91)	92 (87)	92 (87)	76 (72)
60 and above	51 (80)	57 (90)	60 (95)	62 (97)	59 (92)	56 (87)	56 (88)	46 (77)
Education Level								
HS grad/less	51 (75)	62 (87)	59 (87)	65 (93)	61 (89)	59 (86)	62 (87)	48 (74)
Some college	104 (95)	107 (97)	114 (100)	114 (100)	109 (95)	105 (95)	106 (95)	87 (81)
College grad/post grad	97 (89)	107 (97)	110 (98)	110 (98)	106 (95)	98 (88)	97 (87)	91 (83)
Political Affiliation								
Democrat	82 (94)	85 (98)	86 (98)	87 (99)	83 (95)	86 (97)	86 (98)	76 (88)
Independent	56 (91)	58 (95)	58 (97)	58 (97)	58 (95)	50 (85)	50 (85)	49 (83)
Republican	65 (82)	78 (96)	82 (98)	85 (100)	82 (96)	71 (89)	74 (90)	60 (77)
Other	31 (82)	36 (90)	38 (93)	41 (98)	33 (87)	34 (83)	35 (83)	23 (68)
Children ≤18								
Yes	93 (93)	97 (93)	100 (96)	103 (96)	103 (96)	90 (89)	92 (89)	79 (79)
No	162 (86)	179 (95)	184 (96)	188 (98)	175 (93)	175 (91)	174 (91)	148 (81)

Note.

N (%) = those that strongly support/support the service; Bold = Chi-square significant at $p < .05$

health teacher, a school nurse, a school counselor, a representative from the local School Health Advisory Council (SHAC), a parent, a student, etc. This team might consider partnering with a public health community organization and/or the county health department. A second important step is to collect local data and information to document the need for sexuality education and related policy. Such information may include STD/HIV rates, teen pregnancy and birth data, and the current sexuality education policy if one exists. Finally, identifying and partnering with a local University or College may be beneficial. Such institutions could provide assistance in developing and conducting the research. Departments of public health, health education, and health promotion are a good place to start to identify faculty potential members interested in this area of public health.

Once local information is gathered, both sexual health data and public support, it should be shared with teachers and administrators. Developing and distributing fact sheets that summarize the findings is essential. Such fact sheets could be distributed at teacher trainings, emailed to both teachers and administrators, and possibly shared with parents. Such findings can encourage and support administrators and teachers in offering evidence-based sexuality education programs that are supported by the public and reflect the needs of adolescents. More specifically, sharing this information with teachers can help support and empower them if they question whether or not they should be covering these topics. Many teachers may fear scrutiny from parents or administrators. Knowing both that the majority supports them and that their students need this information, teachers may feel more secure and supported when presenting this topic.

Human Subjects Approval Statement

This study was approved by the University of North Florida's Institutional Review Board (IRB#540836-2).

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