Parental Perceptions in Teen Health Education: Sexual Health, Healthy Relationships, and Communication

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Abstract

Objectives: This nursing practice project explores parental perspectives on teen health education taught within public high schools. The findings of this project informed the design of the teen health curriculum that aims to prevent unplanned pregnancy and sexually transmitted infections, with a long-term goal of reducing the rate of infant mortality in some of Ohio's most vulnerable communities. ***Design***: A descriptive qualitative design guided this research. Analysis of focus group narratives examined manifest and latent content including: coding, categorical separation, and thematic abstraction. ***Sample***: Parents and/or trusted adults of teens who attended the Upstream RISE curriculum course voluntarily consented to join a focus group to gather qualitative and demographic information. ***Results***: Focus group data suggests three themes present in parental perspectives regarding the teen health education curriculum: a.) Incentivized, collaborative parent/guardian involvement in teen health/sex education is needed b.) Teaching teen health/sex education requires special training c.) An education course, rooted in life-goals, that begins at an early age and progresses through teen years, will be most successful.
Conclusions: The results of this project informed the continued efforts of the Ohio Equity Institute (OEI) and guided the revisions made to the reproductive health curriculum taught within and urban high school in the Midwest.

Keywords: health education, health promotion, reproductive health, adolescent health, parent-child relations, communication, public health, infant mortality

Background

Infant mortality is defined as, "the death of a baby before his or her first birthday." The most current data reports the United States (U.S.) infant mortality rate at "5.96 per 1000 live births" (Centers for Disease Control and Prevention [CDC], 2016, para. 2; Matthews, MacDorman, & Thoma, 2015, p. 2). The *National Vital Statistics Reports* conclude that the "U.S. ranked 26th for infant mortality among 29 countries monitored by the Organization for Economic Co-operation and Development (OECD) in 2010" (U.S. Department of Health and Human Services [DHHS], 2014, p. 2). Therefore, a mere three countries included in this data were ranked higher than the U.S., some of them lacking the economic, medical, and infrastructure resources available in the United States. More recent data shows a decline in the U.S. ranking to 32nd highest out of the 44 countries included in the OECD (Organization for Economic Co-operation and Development [OECD], 2013). While at first glance, this seems favorable, in recent years the U.S. rate was "comparable to Croatia, despite an almost three-fold difference in GDP per capita" (Chen, Oster, & Williams, 2015, p. 1).

Decreasing the Rate of Infant Mortality

Decreasing the rate of fetal and infant deaths is identified by the Office of Disease Prevention and Health Promotion (ODPHP) as one of the *Healthy People 2020* objectives (2016). Ohio has the seventh highest number of infant deaths compared to all 50 states in the U.S., the District of Columbia, Guam, and Puerto Rico according to the *National Vital Statistics Report* (Matthews et al., 2015), with the study county among the top nine in rates of infant mortality when compared with all other counties within Ohio. Annual trends in 2015 and 2016

revealed the study county held a steady rate of 9.0 infant deaths per 1,000 live births (Remy & Boeshart, 2016). Non-Hispanic black infant deaths are more than twice the rate of non-Hispanic white infant deaths and even higher when compared to other races and ethnic origins (Ohio Institute for Equity in Birth Outcomes [OEI], 2014; Matthews et al., 2015). Not only is the study county among the highest counties in Ohio, but the study city as a whole holds an IMR of 8.4 per 1,000 live births which is above the Health People 2020 goal of less than or equal to 6.0 (CHD, 2016b).

A national multi-faceted approach is necessary to decrease infant mortality and includes changes in knowledge, attitudes and behaviors of both males and females, empowered communities, health equity, and a commitment to prevention (Johnson et al., 2007). To have the greatest impact on the health of our nation, the CDC recommends programs that are two-fold and collaborative in nature; programs that target the leading causes of infant mortality while simultaneously recognizing and decreasing health disparities among populations (2016). The leading causes of infant deaths in Ohio are: low birthweight (LBW) and very low birthweight (VLBW) babies being born, preterm births, sudden infant death syndrome (SIDS), babies born with a serious defect, maternal complications before and during birth, and injuries (Ohio Department of Health [ODH], 2013). Risk factors associated with these leading causes include smoking, “poverty, lack of education, under-resourced neighborhoods, poor nutrition and race” (ODH, 2013, p. 1).

The Ohio counties with the highest rates of infant mortality all participate in the Ohio Institute for Equity in Birth Outcomes (OEI), an initiative to strengthen the evidence-based focus for reducing the rate of infant mortality. Within each participating county, multitudes of projects exist. This paper will discuss a portion of the Upstream RISE (Reach, Involve, Support,

Empower) project; a project taking place within one of nine urban communities in Ohio. The Upstream RISE project was implemented based upon the premise that, "Until we see equity in housing, education, economics, and transportation, health disparities will continue to exist," (OEI, 2014, p. 4). The long-term goals of this project include 'Movement toward financial equity thereby reducing poverty, improved birth outcomes, and decreased infant mortality,' (Cincinnati Health Department [CHD], 2016a, para. 2). The Upstream RISE project addresses key principles of infant mortality through the collaboration of multidisciplinary stakeholders within the study city and county.

The project targets 9th-12th graders in public high schools serving students who live in areas where infant mortality rates are the highest within the study county. The three main objectives of the Upstream RISE project, as defined by OEI (2016, slide 9) are to: a) Support each student to create a Life Plan: long-term career/health/relationship goals b) Educate on healthy choices, healthy communication and relationships, and reproductive life planning. The Health Department in the study city and the Ohio Department of Health (ODH) gained Institutional Review Board (IRB) approval for the Upstream RISE project, specifically the implementation of the health education curriculum, known as the *Know Your Choices* curriculum (formerly the Upstream RISE curriculum). The *Know Your Choices* curriculum consists of multiple health education sessions taught during regular school hours in the students' health and wellness course.

Currently, there is not a standard curriculum model in place for sexual education/reproductive health, only the requirements provided by the Ohio Department of Education (ODE). The absence of a standard curriculum model allows for inconsistencies and variation between school districts-and even the schools within them (ODE, 2016). Mandating

state-wide changes in health curriculum is vital to population health, specifically infant mortality, but cannot occur until approved by both houses of the general assembly (Standards and Curricula for Computer Literacy, Fine Arts, Foreign Language - Health or Physical Education Provisions, 2001/2009).

Survey results from the first implementation of the health education sessions revealed a correlation between individuals with low levels of perceived social support and low self-esteem with having high levels of stress (Cincinnati Health Department [CHD], 2016b). The Wilcoxen Signed Rank Test indicated statistical significance between the pre-test and post-test scores regarding sexually transmitted infections (STIs), banking, budgeting, health/wealth, and credit/debt (CHD, 2016b). After review of the data from the initial implementation of the *Know Your Choices* curriculum and personal communication with curriculum facilitators, the OEI study county home team determined an area in need of improvement was the lack of parental input into the curriculum.

Review of Literature

Parental Involvement

The involvement of parents in their child's sexual health education has proven to be beneficial to achieving optimal outcomes and healthy relationships in life. A high degree of parent-child "connectedness" is associated with postponement of sexual behavior, use of contraception, and fewer unplanned pregnancies (Wright & Fullerton, 2013, p. 5). Also relevant, is after systematically reviewing the literature spanning nearly 20 years, sexual education programs involving children, but excluding parents, have produced only minimal success (Wright & Fullerton, 2013). Drawing from the strongest literature for teen health, education programs will guide the best evidence-based practice.

Successful Sexual Health Programs

Various strategies exist for the involvement of parents in teen health education programs. Programs that incorporate the facilitation of healthy communication between parents and children support the most positive outcomes in teen health. Among the most successful sexual health programs that incorporated this parent-teen communication were those that encouraged parents to monitor and regulate their teens' behavior (Wright & Fullerton, 2013).

Encouraging parents to monitor and regulate their teens' behavior. Baptiste et al. completed a randomized control trial in which parents and their adolescents attended 12 three-hour workshops in a community based setting (2009). Content, discussion, and exercises within this study included the following: sexual education, which included the topics of sexually transmitted diseases and prevention of, parent-child conflicts, daily parenting hassles, controlling youths' behavior, positive parenting techniques, expanding family support networks, parent-child communication breakout sessions to discuss content learned, and workbook activities. This study shows positive differences between control and treatment groups about increased knowledge, attitudes, communication, and monitoring of youth behavior.

O'Donnell et al. (2005) completed a randomized trial using a parent-only intervention. This program included three 25-minute audio recordings of educational material mailed directly to parents of 5th to 6th grade students to listen and practice on their own. The content focused on role modeling effective communication about values, communicating to children expectations related to making healthy choices, and using effective parenting techniques. O'Donnell et al. (2005) also points out that given the large sample size within this study (*n*=846 families) and positive impact on communication between parent and child, the intervention was effective

among a well-known difficult-to-reach group. The participants were parents of 5th and 6th graders within inner city New York schools with known vulnerable demographics.

Studies with strongest scientific evidence of impact on sexual behavior. Few studies provide evidence of behavior-change or intention-to-change future behavior among teens, and even fewer report success in locations with the highest rates of unplanned pregnancies (Wright & Fullerton, 2013). A myriad of approaches to sexual health programs exist, but only those that incorporate the establishment of healthy parent-child relationships and communication show promise for changing sexual behavior among teens (Wright & Fullerton, 2013). Programs including "intensive" training with parents and those taking place outside of the clinical setting have provided the strongest scientific evidence to change adolescent risk behavior (Burrus et al., 2012; Wright & Fullerton, 2013, p. 24).

Keepin' it R.E.A.L. (Responsible Empowered, Aware, Living), a study named after its sexual health program, provides some of the strongest scientific evidence for influencing sexual behavior among adolescents according to systematic reviews completed by Burrus et al. (2012) and Wright & Fullerton (2013). Dilorio et al., (2006) developed the *Keepin' it R.E.A.L.* program by comparing two community-based programs, one with mothers and adolescents together and the other with them separate at times. The program included 14 sessions of educational content and practice using parenting skills. The study revealed an increase in adolescent use of condoms and in the amount of discussions mothers and daughters were engaging in regarding sex (2006).

The Community Preventative Services Task Force (CPSTF), complementing the work of the Unites States Preventative Services Task Force (USPSTF), completed a meta-analysis based on programs targeting a reduction in risk behavior among adolescents (Burrus et al., 2012). The meta- analysis and found that the inclusion of parents or responsible adults in teen risk-reduction

programs should be embraced, clearly articulated, and measured for programs intending to see meaningful impact in population health (Burrus et al., 2012). Programs in which parents are encouraged to communicate their values to their children about sexual relationships and life goals and role model those values are among the most successful in the literature (Wright & Fullerton, 2013).

There are gaps in the literature to support which type of person-to-parent/caregiver delivery is best: face-to-face, electronic, reading, one-on-one, group discussion, etc. (Burrus et al., 2012). Therefore, the delivery method of the adolescent risk-reduction program should be tailored to the population being targeted until more robust literature is published. What is known is that programs that understand the demographics, values, and perspectives of the children and families of whom they are educating, are better able to provide a culturally competent approach and be representative of the population at hand (Wilson, Dalberth, Koo, & Gard, 2010).

Support for Parent Focus Groups and Use of Theoretical Framework

Communication about sexual health between parents and their children varies in degree, timing, and content (Wilson et al., 2010). Not only is gender a factor in parent-teen communication, but differences exists between races and ethnicities (Wilson et al., 2010). Without understanding the values and experiences parents have communicating with their teens about sex, program approach may not be appropriate or effective. Focus groups are an effective research method to gain meaningful qualitative data and would be helpful to understand the perspectives of the parents of teens receiving the *Know Your Choices* curriculum. Participants may provide needed information in a focus group setting more readily than in an individual interview (Mateo & Foreman, 2014).

The theoretical framework guiding this project is the Theory of Planned Behavior as described by Ajzen (1991). This theory claims that human behavior is explained by analyzing the following aspects: "attitudes toward the behavior, subjective norms, and perceived behavioral control; and these intentions, together with perceptions of behavioral control, account for considerable variance in actual behavior" (Ajzen, 1991, p. 179). The subjective norms mentioned here are comprised of what all friends, family, and others influencing the teen view as socially accepted behavior. During the *Know Your Choices* health education sessions, the facilitators are able to explore socially acceptable behavior as defined by teens, but the parents and/or other adult figures in these teens' lives are not included. It is the aim of this project to determine how to successfully include parents and/or trusted adults into the *Know Your Choices* sessions.

Purpose

The following clinical practice questions guided this practice project: What are parental experiences and perspectives regarding teen health including: general health education, sexual health education, healthy relationships, and communication? What information about these experiences and/or perspectives should be integrated into the *Know Your Choices* curriculum?

Methods

Design and Sample

This project utilizes an emergent framework, following a descriptive qualitative design. In an emergent framework, the researcher begins with pre-determined open-ended questions and modifies subsequent questions based on the focus group discussion (Polit & Beck, 2017; Guba & Lincoln, 1994). The student's University IRB approved all pre-determined open-ended questions and the project. Table 5 in Appendix A depicts samples of approved focus group questions. The primary investigator personally recruited parents of teens who attended the *Know*

Your Choices curriculum at pre-planned Parent Partner (similar to parent-teacher organizations) meetings. Five participants voluntarily consented to join the focus group to provide qualitative and demographic information (Table 1). Each participant received a number assignment for use during the focus group discussion, rather than verbalizing his or her name.

Table 1

Participant Demographic Information

Participant Total	5
Participant Age	20% 26-35 years old 60% 36-45 years old 20% 56 years or older
Participant Gender	80% Female 20% Male
Participant Race	80% Black, non-Hispanic 20% Native American
Annual Household Income	60% $25,000-$49,999 20% $100,000-$199,999 20% no answer
Highest Level of Education Completed	100% college graduate

Analytic Strategy

The primary investigator led the interview during the focus group while a trained research assistant transcribed participant quotes, and began each quote with the participant's assigned number. Emergent designs allow the researcher to begin analysis of content during the focus group, framing questions, and summarizing participant responses aloud, to ensure representativeness of the group's collective voice. At the conclusion of the focus group, a directed content analysis was completed using a color coding schematic. Appendix B presents samples of color coding schematics. Multiple disciplines support a directed content analysis when conducting qualitative research (Graneheim & Lundman, 2004). This approach includes systematically analyzing manifest and latent content including: coding, categorical separation, and thematic abstraction.

Results

Three major themes evolved as presented in Tables 2-4. The primary investigator ensured trustworthiness, by the following: a) thorough selection of diverse participants, b) a directed process for data analysis, and c) the validation of the results with the participants (Graneheim & Lundman, 2004). Focus group participants validated results after data analysis was complete.

Table 2

Category: Parental Involvement

Category: Parental Involvement **Codes**	**Theme A: Incentivized, collaborative parent/guardian involvement in teen health/sex education**
Poor/no role models at home	"Kids might not want to discuss these types of things with a parent"
Increase parent involvement	"Education just in schools isn't going to break that cycle, parents need to be involved"
Multi-tiered approach needed	"We have to reach the kids that are at the bottom and this is not. The bottom seed is what has to be dealt with…we need to reach them!"
Incentivizing parental involvement	"An incentive to get parents more involved could be allowing volunteer work in the school to count towards the Ohio Works Program for cash assistance"

Table 3

Category: Course Facilitator

Category: Course Facilitator **Codes**	**Theme B: Teen health/sex educator specially trained, relatable language**
Trained facilitator	"They [facilitators] Must be able to relate content to teens' interests, need to use slang terms, language matters"
Use developmentally appropriate language	"I think offering this course in middle school is necessary, just maybe not raw and uncut, keep it on their level"

Table 4

Category: Course Philosophy

Category: Course Philosophy	**Theme C: Teen health/sex education course rooted in life goals that begins at an early age and progresses through teen years**
Subcategory: Course foundation: life goals	

Codes	
Comprehensive health course	"Some kids may not have a parent or trusted adult, there needs to be a backup plan, like a counselor or mentor in the community that can meet with these kids "
Don't insinuate condoning sex	"When you hand out condoms doesn't it encourage them to have sex? You have to offer a course that ties it all together, make good choices all around in life"
Course foundation: life goals	"I think this course takes a good spin on health and life goals, it's not just a sex ed class, in my mind I don't want my kids to make choices that make it harder for them, not just sex, but everything"
Subcategory: Introduction and Pacing of Instruction	
Codes	
Early intervention	"I've been talking to them [my kids] since 5th grade it's an uncomfortable conversation that must happen as early as possible"
Repeated intervention	"This information is needed over and over again, kids have total misunderstandings of who can get what STDs and when and who can get pregnant and when"

Discussion

Relationship of Results to Framework, Aims and Objectives

The results of this research support the guiding theoretical framework, the Theory of Planned Behavior as described by Ajzen (1991). Ajzen suggested human behavior is a result of accepted norms, personal attitudes toward the behavior, and behavior control, all influenced by nature, nurture, and self-efficacy. The parental perspectives expressed in this focus group suggest that a comprehensive health education course for children should include parental participation and should include a value-based, goal-driven foundation. Participant feedback also suggested that primary prevention, such as the *Know Your Choices* curriculum, is not enough to change behavior when children live in home environments where trusted adults/parents are not role modeling the values discussed in the course curriculum. Therefore, the participants are suggesting that the lack of positive role modeling occurring in the home environment is resulting in "accepted norms" as explained by Ajzen (1991).

The major themes discovered in this project are consistent with published literature. The work by Karofsky, Zeng, and Kosorok (2000) supports Theme A, an incentivized, collaborative parent/guardian involvement in teen health/sex education and Theme C, a teen health/sex education course rooted in life goals, with the course begging at an early age and progresses through teen years. The 10-year longitudinal study by Karofsky and colleagues concluded that linking sexual education concepts to family values, results in delayed adolescent initiation of sex. Research conducted by Layzer, Rosapep and Barr supports Theme B, teen health/sex educator should be specially trained and uses relatable language Layzer and colleagues found that teens in their sample described their communication with adults about sex as "awkward" and lacking the relatability needed for teens to perceive the education seriously (2017).

The broad aim of this project under the OEI was to address the aforementioned risk factors associated with infant mortality within the study county, specifically "lack of education" in regards to teen/reproductive health (ODH, 2013, p. 1). The specific parental involvement project aim was to determine parental perspectives regarding teen health education and how to successfully include parents and/or trusted adults in the education, which was achieved. The manifest and latent content results of this project informed the continued efforts of the OEI. This project guided revisions made to the *Know Your Choices* curriculum, specifically, how parents and/or trusted adults are involved in the course. Changes included: 1) Facilitator orientation: Sharing focus group results and a brainstorming activity for upcoming course facilitators to consider how to best include parents/trusted adults within their home school(s), 2) Family Homework: Opportunities for teen and parent to engage in prompted discussions following school-based sessions. The focus group participants were invited to voluntarily serve as "parent advocates", supporting the implementation of the *Know Your Choices* curriculum, citywide. The

city school board then approved the implementation of the *Know Your Choices* curriculum in all study city public high schools.

Strengths and Limitations

There are limitations to this practice project. First, five participants took part in the focus group discussion. More participants with varying demographics representing other schools within the district may have resulted in a more robust focus group discussion. However, previous research suggests parent participant demographics match those of the teens participating in the teen health course, which was the case in this project, and thus a strength. The second limitation was that the focus group took place on a date and time the parent participants were already accustomed to attending a "Parent Partners" meeting at the high school. Therefore, it is possible the feedback received contains some bias and does not reflect the thoughts and opinions of all parents of teens in this high school.

This project included continuous collaboration between the primary investigator, the OEI study county home team, county and city epidemiologists, health educators and school nurses within the city high schools, the Resource Coordinator within the study high school, school board officials within the study city, and non-profit organizations. The study city Health Department was invaluable to the success of this project. This multidisciplinary approach is essential to achieving improvements in maternal and infant health. The study city Health Department continues to be committed to the project's sustainability.

Recommendations and Implications for Future Practice

The *Know Your Choices* curriculum project is one component of a national effort to improve birth outcomes and reduce racial disparities in infant deaths. Currently presented during the Health and Wellness course in ten public high schools, permanent integration of the *Know*

Your Choices curriculum in all high schools within the study city is a long-term goal of the project. Another ongoing project goal is engagement with policymakers This engagement includes advocating for policymakers to broaden the ODE policy governing health education within public schools.

Funding for this project cannot go without notice. CityMatCH, a national membership organization that supports urban maternal and child health efforts at the local level, subsidizes the OEI grant that provides financial sustainability for the *Know Your Choices* curriculum project. OEI grant eligibility is a formalized reapplication process every five years.

Ongoing evaluation of the *Know Your Choices* curriculum is crucial to measuring the influence the course has on teen knowledge, attitudes and behaviors, thus decreasing social inequalities and disparities, resulting in a decreased infant mortality rate. Curriculum evaluation includes: 1) pre and post-surveys completed by teen participants focusing on knowledge, skills, and behaviors, 2) content updates and revisions as new information is available, and 3) trending of city and county data, including sexually transmitted diseases, unplanned pregnancy and infant mortality rates. Curriculum evaluation and quality improvement will include an evaluation of the parental involvement for each city school as well. In addition, evaluation will include a review of parental buy-in, collaboration, and effectiveness based on the extent and nature of parent involvement for each individual school. Each school may adopt different strategies to evaluate the effectiveness of the parental involvement, but all strategies are tied to the overall *Know Your Choices* curriculum evaluation.

The information obtained in this project can guide other entities throughout the United States wishing to provide a comprehensive teen health education course or improve upon current adolescent health programs that lack parental involvement. Parental perspectives in teen health

education may vary depending on the geographic location, cultural norms, faith beliefs, and race (Wilson, Dalberth, Koo, & Gard, 2010). However, these factors are essential for consideration when implementing any teen health education program. Confidential focus group discussions allow for a low-pressure environment where thoughts, expressed openly, lack the threat to confidentiality.

Conclusion

This project serves as a springboard for action and aims at directly addressing the risk factors associated with the leading causes of infant mortality (ODH, 2013). By considering the individual perspectives of parents/trusted adults within our target area and coupling these perspectives with an evidence-based curriculum, this comprehensive teen health education course will directly influence the health of our population. Future plans include continuous program evaluation to address the strengths and areas that needs improvement. Success is dependent on the strong relationship between the city and county health departments and the public high schools in which they reside.

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Appendix A

Table 5

Focus Group Question Samples

1) The purpose of the curriculum is to:
    a. Educate teens
    b. Help them to focus on their life goals and plan for achieving their goals
    c. Empower them with tools to support their goals, decisions, and conversations with others including their parents/guardians.

    After reviewing curriculum examples, what did you think about the materials (content, activities, and family homework)?
    -Prompters if need:
        i. What do you think about the content on the slides?
        ii. What do you think about the activities being done in class?
        iii. What do you think about the family homework exercises?

2) What can we do to make the program better?
    a. Prompters if need:
        i. At what age should children be taught this material?
        ii. Is parent/guardian involvement necessary?
        iii. What is the best way to involve parents?

3) What are your opinions about teaching children health education including sexual education in schools?
    a. Prompters if needed:
        i. Can you explain that a little further?

4) What have your experiences been when talking to your children about sex?
    a. Prompters if needed:
        i. Can you tell me more about what you said (or your child said)?

5) Which of the following would you find the most helpful (you can choose more than 1):
    a. Parent support group that meets on a regular basis at the school or in the community to talk about parenting issues, raising teens, talking with teens.
    b. Family homework your child brings home that requires him or her to talk with you about certain topics such as family values, life goals, making healthy decisions, and sex.
    c. Classes for parents to learn and practice strategies for talking to their teens about values, goals, decisions, and sex.
    d. Tips sent electronically (text, email, Facebook, etc.) to parents about: monitoring and regulating your child's behavior, strategies for talking to their teens about values, goals, decisions, and sex.

Appendix B

Samples of Color Coding Schematics

Meaning Unit (Text being Analyzed)	Condensed Meaning Unit (shortening, while still preserving the core)	Code (Abstraction)
“how effective is this stuff going to be for children that that have parents selling drugs, doing drugs, having sex in front of kids”? -5	Poor role model parents/guardians/trusted adults	Poor/no role models at home--
“we need to teach earlier”-5	Early(ier) intervention	Early intervention--
“bring parent in to facilitate the class[as opposed to just the teacher teaching], helps kids to relate [they know kids the best]”-5	Parent involvement helps kids relate content	Increase parent involvement--
“We have to reach the kids that are at the bottom and this is not. The bottom seed is what has to be dealt with…we need to reach them!”-5	Education alone won’t fix the generational/system issues	Multi-tiered approach needed--
“Has to be raw and uncut”-5	Facilitator/course ability to relate course content to real-world is needed	Trained facilitator-- Developmentally appropriate language--
“Need it every year, a reminder! Pointless to offer this course just once”-5	Repeated intervention	Repeated intervention--
“All this is fine and dandy but what is this really going to help, the progress with this is too small.”-5	Education alone won’t fix the generational/system issues	Multi-tiered approach needed--
“You all need to be talking to students, which teachers have that personality that can teach this course.”-5	Facilitator/course ability to relate course content to real-world is needed	Trained facilitator-- Developmentally appropriate language--
“Government has created barriers; kids can’t go to nurse to get condoms, that’s a problem.”-2	Education alone won’t fix the generational/system issues	Multi-tiered approach needed--
“We cannot assume that every parent is teaching their children about sex”-2	Not all parents teach kids about sex	Increase parent involvement--
“We need to teach at an earlier age”-2	Early(ier) intervention	Early intervention--