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School Administrator and Staff Member Perceptions of a Teenage Pregnancy Prevention Program

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COLLEGE OF EDUCATION

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2015

Abstract

School Administrator and Staff Member Perceptions of

a Teenage Pregnancy Prevention Program

by

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MBA, William Carey University, 2005

B.S.B.A, University of Southern Mississippi, 1998

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Mississippi is among the states with the highest teenage pregnancy rates, and the study site is among the high schools with the highest teenage pregnancy rates in the state. The purpose of this qualitative case study was to identify successful practices and areas for improvement in the implementation of a teenage pregnancy prevention program (TPPP) at the study site based on the perspectives of school administrators and staff members. Bandura's social cognitive theory provided a conceptual framework for considering behaviors and the social contexts in which they occur. Twelve participants were interviewed, including 3 administrators and 9 staff members. Data were analyzed using open coding to identify themes. Findings indicated that, according to the perspectives of the 12 participants, the evidence-based TPPP positively influenced the students by providing a structured curriculum for classroom teaching; promoting small-group discussions; and implementing an abstinence approach to prevent teenage pregnancy, HIV, and STDs. Strengths identified included the use of various instructional techniques and a general support for communication. Areas for improvement included scheduling, school staff and parent buy-in, and knowledge about specific problems related to risk-taking behaviors. Social change implications of this study include increased awareness among adult stakeholders of practices that support successful implementation of a TPPP and enhanced ability to make positive decisions about sexual behaviors among students. School officials could apply the findings to strengthening the effectiveness of the school's TPPP. Students may benefit from improved TPPP instruction by being better prepared to prevent teenage pregnancy, HIV, and STDs.

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Dedication

This research study is dedicated my mom, Rosemary McConnell. On June 8, 2010, the Lord decided to bring His child home. May her soul rest in peace. It is also dedicated to my sweet daughter, Bianca, and my husband, Terrence. They both had much patience and understanding from the beginning of this journey.

Acknowledgments

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Section 1: Introduction to the Study

Background of Study

Teenage pregnancy is a critical global problem, with the highest rates in the developed world among southern states in the United States (Ventura & Hamilton, 2011). This problem affects not only pregnant teenagers and their families, but also communities, states, and the nation (Ganderton, 2006; Santelli & Melnikas, 2010). According to the National Campaign to Prevent Teen Pregnancy and Unplanned Pregnancy (NCPTUP), teenage pregnancy and childbearing cost taxpayers in America approximately $9.4 billion a year (Hoffman, 2006; National Campaign to Prevent Teen Unplanned Pregnancy, 2013). Children born of teenage parents are more likely to experience health and societal hardships, as well as academic and behavioral problems in school (Holcombe, Peterson, & Manlove, 2009). Female children born to teenage mothers are more likely to become teenage mothers themselves, and male children born to teenage mothers are more likely to end up in prison (Holcombe, Peterson, & Manlove, 2009).

According to the NCPTUP (2013), babies born to teenage mothers have higher risk for very low birth weight, prematurity, and neonatal death compared with babies born to adult women. Teenage mothers are more likely to experience ectopic pregnancy, miscarriage, abortion, pregnancy-induced hypertension, and anaemia than older women who became pregnant (NCPTUP, 2013). The public financial costs of teenage pregnancy in the United States are high; the government pays for most births to teenage mothers,

and 20.7% of teenage mothers had repeated pregnancies and births outside of marriage (NCPTUP, 2013).

Federal funding for formal sex education programs has disproportionately favored those programs that promote an abstinence-only policy, despite a growing body of evidence suggesting that abstinence-only teenage pregnancy prevention programs (TPPPs) have had a minimal effect on the sexual behavior of teenagers (Boonstra, 2009; NCPTUP, 2012). More than $33 billion in federal funding were provided to 29 states and Puerto Rico for TPPPs, counseling, and mentoring programs under Title V. Organizations that received Title V funding through these states were encouraged to use evidence-based programs that included theoretical constructs to guide the implementation and sustainability of the selected programs (NCPTUP, 2012).

Research indicates that an assessment of needs, resources, and current knowledge of sexual risk and protective factors is necessary to effectively put into practice and sustain successful TPPPs (Kirby & Lepore, 2007). Evaluation studies that have focused on the effectiveness of TPPPs have indicated that many programs were ineffective, did not meet the societal needs of teenagers, and did not encourage positive behavioral changes that prevent teenage pregnancy. Research indicates that teenage pregnancy prevention practitioners should follow a systematic process to identify, modify, and adopt evidence-based or science-based TPPPs that meet the needs of the target population (Lesesne et al., 2008). The United States has the highest rate of teenage pregnancy among industrialized countries, and the abortion rate for teenagers is also high in the United States compared to other countries around the world (Ventura & Hamilton, 2011). Recent

statistics indicate that 410,000 teenage girls between the ages of 15 and 19 years give birth in the United States each year (Centers for Disease Control and Prevention [CDC], 2013). Despite the decline in teenage pregnancy rates between 1991 and 2004, a slight increase in 2006, and a decline in 2009, teenage pregnancy rates in the United States were 2 to 6 times higher than those of other industrialized countries (Ventura & Hamilton, 2011). Teenage pregnancy causes long-term issues for teenage mothers, their children, and society. Teenage pregnancy and birth rates are substantial factors that contribute to female students dropping out of high schools (CDC, 2013). Research studies have revealed that an estimated 50% of teenage mothers receive a high school diploma, compared to the 90% graduation rate for women who did not give birth during adolescence (CDC, 2013). Nationally, the annual cost of teenage pregnancy is more than $9.4 billion (Ventura & Hamilton, 2011).

The highest rates of teenage pregnancy are found in Alabama, Arizona, Georgia, Mississippi, New Mexico, and Texas (National Vital Statistics Service [NVSS], 2009); states with the lowest teenage pregnancy rates include Vermont, New Hampshire, Minnesota, North Dakota, Maine, and Massachusetts (NVSS, 2009). The states with the highest teenage pregnancy rates have about twice as many births to teenage mothers as the states with the lowest teenage pregnancy rates, and they have high teenage pregnancy rates on a continuing basis (NVSS, 2009). State-specific rates for teenage pregnancy range from 16.4 to 64.2 births per 1,000 females between the ages of 15 and 19 years. The southern state chosen for this doctoral study, Mississippi, had the highest rate of teenage pregnancy, at 64.2 per 1,000 teenagers (CDC, 2011; National Center for Chronic

Disease Prevention and Health Promotion, 2008). Provisional data from the state's Department of Health (MSDH) revealed teenage birth rates at 55.0 births per 1,000 females ages 15 to 19 years of age (Mississippi Vital Statistics [MVS], 2009). Other state statistics included the following:

- 71.4% of high school teenagers graduated (lowest in nation);
- 23% of 18-24 year olds did not work, did not attend school, and had no degree beyond high school diploma (second highest in the nation);
- 33% of children 18 years or younger in the southern state lived in poverty (highest in nation);
- 39% of children lived in households in the southern state where no adults had full-time employment (yearly employment, highest in nation); and
- 57.9% of high school teenagers and 28.4% of middle school students reported engaging in sexual activity (MVS, 2009).

Approximately 2,242 babies were born to teenage mothers between the ages of 15 and 17 (MVS, 2009). The presence of so many babies born to teenage mothers in the southern state has put a financial burden on families, communities, and the state (McKee, Southward, Dunaway, Blanchard, & Walker, 2011).

After 2007, Mississippi's teenage pregnancy rate increased for 2 consecutive years, with the highest rates concentrated in the state's metropolitan cities (National Vital Statistics Report, 2009). The national average for having four or more sexual partners in life was 13.8%, yet 23.7% of Mississippi's teenagers fit in this category (CDC, Youth Risk Behavior Surveillance System [YRBSS], 2009). Furthermore, nine out of 10

teenagers (85.7%) in the state did not use birth control pills to prevent pregnancy (CDC, YRBSS, 2009). Of Mississippi's teenagers who reported being sexually active, 92.8% indicated that they failed to use birth control the last time they had sex (CDC, YRBSS, 2009).

Teenage pregnancy rates varied within regions of Mississippi (McKee et al., 2011). One-third of all babies born in the state were born to teenage mothers. Additionally, Mississippi has the second highest rate of teenage mothers with repeat pregnancies (21%) and the nation's highest percentage of low-birth-weight babies (11.8%; NVSS, 2009). Mississippi's capital has 427 births to mothers younger than 20 years old out of a population of 173,707 (McKee et al., 2011; National Center for Health Statistics, 2008).

Southern states with the highest rates of teenage pregnancy, including Mississippi, have been slow to react to their teenage pregnancy epidemic. The lack of advocacy, supportive public policy, and funding continues to hamper efforts to reduce teenage pregnancy in the southern state (McKee et al., 2011). As of 2009, Mississippi had been ranked as one of 10 states without a statewide TPPP initiative to address reproductive and sexual health outcomes for adolescents (CDC, 2011; Hoffman, 2006). In the past, the lack of state funding and legislation mandated to implement evidence-based sex education and support evidence-based TPPP was identified as exacerbating teenage pregnancy in the state (Women's Fund of Mississippi, 2011). The main teaching advocated by abstinence-only TPPPs is that teenagers should abstain from sex until marriage, and abstaining from sex until marriage is most often regarded as the ideal

method to prevent teenage pregnancy. On the other hand, and in a nod to realism, abstinence-plus TPPPs take sex education further by teaching about condoms and birth control as contraceptive methods (McKee et al., 2011). Previously, in Mississippi, state legislation prohibited school districts from teaching sex education in a comprehensive manner or providing students abstinence-plus programs (Mississippi Legislative House Bill 999). School districts were allowed to teach abstinence-only TPPPs, but local school board approval was needed if school administrators wanted to offer more (McLaughlin, 2011). The lack of a statewide protocol and focus on teenage pregnancy in the southern state cost the state more than $155 million in 2009 (CDC, 2011; Women's Fund of Mississippi, 2011). Research and statistical data indicate that teenagers from Mississippi are more likely to become pregnant due to their lack of knowledge about health education, lack of access to sex education information, and lack of access to health services that would allow them to make informed decisions about their sexual behavior (NCPTUP, 2013; Women's Fund of Mississippi, 2011). Mississippi girls are 3 times more than likely to get pregnant compared to girls in other states (Kearney & Levine, 2011).

Policymakers in Mississippi passed Legislative House Bill 999 into law in 2011, which required every public school authority to adopt and implement a TPPP. Districts had the choice of adopting an abstinence-only or abstinence-plus program. Schools that chose to implement the abstinence-plus TPPP could go beyond the limits of the abstinence-only program, including information about topics such as safe sex. Most importantly, the southern state mandate provided neither financial support to schools to

fund teaching staff nor curriculum for abstinence-only and abstinence-plus education (Mississippi Legislative House Bill 999, 2011). McKee et al. (2011) stated that Americans support schools in teaching sex education as revealed in the Mississippi state survey cosponsored by Harvard University's Kennedy School, The Kaiser Foundation, and National Public Radio. Abstinence-plus TPPPs will more likely be supported as long as the teachings in the abstinence-only TPPP are not undermined (McKee et al., 2011). In general, southern state residents agreed that a sex education curriculum should be taught in schools, but there was much debate as to whether the approach should include abstinence-only or abstinence-plus TPPPs (McKee et al., 2011).

Both abstinence-only and abstinence-plus TPPPs are intensely debated in society. The Mississippi legislation promoted an abstinence-plus selection of topics such as safe sex and teenage pregnancy prevention that must be age appropriate. The decision to implement either an abstinence-only or abstinence-plus TPPP into Mississippi public schools was linked to constituents' overall social and personal beliefs, rather than to analysis of statistics about teenage birth (McKee et al., 2011). Social and demographic factors that include how often individuals participate in religious organizations and their political preferences demonstrate a connection between what individuals believe and the policy they support (McKee et al., 2011).

In the United States, 46% of respondents support abstinence-plus TPPPs compared to 15% of respondents who support abstinence-only TPPPs (McKee et al., 2011). In addition to teenage pregnancy prevention programs that promote abstinence, proper use of contraceptives, and a delay in sexual activity, the American Academy of

Paediatrics, the American Foundation for AIDS Research, the American Medical Association, the American Psychological Association, and the American Public Health Association recommend abstinence-plus TPPPs that are age-appropriate for children and teenagers (McKee et al., 2011). According to the sex-education proponent Sexuality Information and Education Council of the United States (SIECUS, 2010), abstinence-only curricula are ineffective. Despite more than 25 years of Congressional support of abstinence-only programs, there is an absence of literature in peer-reviewed journals that indicates the effectiveness of abstinence-only TPPPs in helping to prevent teenage pregnancy (McKee et al., 2011).

Every public school authority in Mississippi has a unique opportunity to serve as a grassroots advocate fighting teenage pregnancy. The new law demonstrated the state's supportive stance in the effort to tackle teenage pregnancy; however, it lacked guidance for local advocates and school administrators on how to identify and implement effective TPPPs that meet the environmental and cultural needs of students. Potential problems may arise that could cost Mississippi taxpayers time and funding if more guidance is not provided to implement evidence-based TPPPs that could decrease teenage pregnancy rates.

Child and adolescent advocates support evidence-based TPPPs in school and community settings as one of the most cost-efficient solutions to the teenage pregnancy epidemic (National Campaign to Prevent Teenage Pregnancy, 2009; Women's Fund of Mississippi, 2011). Twenty-eight science-based TPPPs have been rigorously evaluated and have demonstrated change in sexual risk and protective behaviors that directly relate

to preventing teenage pregnancy (Kirby, 2007). Research has also shown that science-based programs are effective in changing sexual risk and protective behavior when implemented as designed (Wilson & Schalet, 2011). The CDC, other federal agencies, and advocates are committed to improving the nation's health and promoting teenage pregnancy prevention in an effort to help teenage pregnancy practitioners use a science-based approach, set goals, and identify and modify TPPPs to meet the needs of targeted students (CDC, 2008).

Problem Statement

In response to the growing body of research and federal initiatives, a nonprofit organization in Mississippi was awarded funding to implement the Making a Difference! An Abstinence Based Approach to Prevention of STDs, HIV, and Teen Pregnancy (MAD) curriculum to teenagers in two rural counties. This evidence-based TPPP was one of the 28 TPPPs recommended to decrease teenage pregnancy rates. The nonprofit organization initiated the program as part of a 5-year, federally funded program using the evidence-based curriculum to assist teenagers in the delay of sexual activity and to reduce sexually transmitted disease (STD) risk at the high school. The MAD program uses multimedia materials and hands-on activities to facilitate bonding among the participants and supports learning (Select Media, 2010).

T County (pseudonym) is located in Mississippi and has a population of approximately 75,000 people. The population has the following racial/ethnic demographics: 36% Black, 60% White, 4% Hispanic, and 0.7% Asian. According to the

CDC (2009), T County has been identified as one of several counties in the state with the highest rates of teenage pregnancy.

Among T County's three public school districts is B Public School District (pseudonym), which was recognized in the metropolitan area as having one of the largest high schools in the state. The public school district has a free and reduced-price lunch program participation rate of 93% and receives Title I funds to support the academic success of students. The school district has one high school that serves 1,200 ninth through 12th grade students. At this school, 93% of the students live in families or households with an annual income of $14,000 or less. The student population consists of 95% African Americans, 3% Whites, 1% Hispanics, and 0.2% Asians. T County had 203 babies born to teenage females aged 15-19 years in 2009 (CDC, 2009). According to a 2009 CDC report, the Youth Risk Behavioral Surveillance System (YRBSS) reported that the national average for sexually active teens is 46%, yet 61% of teenagers in ninth through 12th grade in Mississippi are sexually active (CDC, YRBSS, 2009).

The state law passed by the legislature in 2011 required school districts to choose between abstinence-only or abstinence-plus education by July 2012. B Public School District strongly debated both sex education curricula. B Public School District distributed a survey inquiring whether the district should institute an abstinence-only or abstinence-plus TPPP. B Public School District mailed thousands of surveys out to parents of sixth through 12th graders. Additionally, surveys were handed out at schools, posted on the district's website, and distributed at two public forums held by B Public School District in March 2012. B Public School District received 410 responses. Of

those, 305 were in favor of an abstinence-plus curriculum. Seventy-four percent showed overwhelming support for an abstinence-plus policy, 20% of responses were in favor of an abstinence-only curriculum, and 6% of responses were in favor of neither. Because research supports abstinence-plus sex education programs, B Public School District was showing a strong initiative to increase teenagers' sex-related knowledge. T County's research revealed that abstinence-plus sex education curricula were one step toward empowering teenagers to make smarter and healthier decisions. Also, abstinence-plus TPPPs encourage teenagers to communicate with parents and teenagers and educators.

Nature of the Study

This qualitative study used a case study approach to illuminate adult stakeholders' perspectives regarding the implementation of a TPPP at a metropolitan high school. The study included open-ended, individual interviews of adult stakeholders. The qualitative nature of this study and its results add to the growing body of knowledge regarding adult stakeholders' perceptions of the implementation of a TPPP and serve as a basis for future project planning and implementation.

Research Questions

The research questions for this study were the following:

1. How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?
2. What aspects of the program for the TPPP do the participants perceive as having been implemented well?

3. What aspects of the program for the TPPP do the participants perceive as needing to be improved?
4. What are best practices that can be identified from this case?

Research Objectives

Current approaches to teenage pregnancy prevention were used to shape the context of interviews to collect data regarding adult stakeholders' perceptions of the implementation of a TPPP at T High School. Allowing adult stakeholders to provide their individual assessment of the TPPP implementation provided them with an opportunity to identify what went well with the implementation and what could have been improved. Categorizing participants' comments helped in identifying best practices for implementing the TPPP and served to improve subsequent use of the program in the school setting.

Purpose of the Study

The purpose of this case study was to identify successful practices and areas for improvement in the implementation of a TPPP at T High School based on the perspectives of adult stakeholders. The research study shed light on adult stakeholders' perceptions of the implementation of a TPPP in a school district in a southern state. The research and its results contribute to the vast body of literature related to teenage pregnancy by examining adult stakeholders' perceptions of factors that promote and impede implementation of a TPPP in the research setting. Many studies about teenage pregnancy address perceptions of parents, medical professionals, and adolescents. Because there appears to be no literature that relates to educators' perceptions, this study

served to address that knowledge gap. Conducting a case study helped to identify, map, and contrast the themes that characterize the perception of the population of educators in the target high school regarding implementation of TPPPs. The conceptual framework upon which this research study was formulated was Bandura's reciprocal determinism of social cognitive theory (SCT) derived from social learning theory (SLT).

Conceptual Framework

Many sexual-risk reduction programs or health behavior programs have documented success improving behavioral outcomes attributed to the program's foundation based upon behavioral theoretical frameworks (Robin et al., 2004). Research on sexual risk reduction programs' efficacy has also used theoretical constructs to explain or clarify characteristics of programs' effectiveness (Robin et al., 2004). Social cognitive theory (SCT) has been one of the most prominently used behavioral theories documenting cognitive change for health behaviors (Robin et al., 2004). Bandura, a Canadian psychologist, was credited for creating SCT in 1962 by expanding social learning theory. Bandura proposed that individuals' cognition to act or behave is influenced by others' previously observed actions and behaviors. In deciding whether to engage in particular behaviors, individuals use their learned behavior concerning how others behave or do not behave (Bandura, 1997). An individual's decision concerning engagement depends on the relationship among three primary factors (social, cognitive, and environmental), the relationship between an observer and the person whose behavior is being observed, and self-efficacy. This relationship is known as *triadic reciprocal causation* (Bandura, 1989). Self-efficacy, a construct of SCT, is an individual's belief

that he or she may or may not be able to perform an action or behavior (Bandura, 1988, 1997). According Robin et al. (2004), the effectiveness of sexual risk-reduction programs is reliant not only upon students' increased knowledge and attainment of skills to prevent teenage pregnancy, but also on individuals' perceived self-confidence or self-efficacy in their abilities and skills in maintaining self-control in various situations to accomplish goals.

Successful sexual-risk reduction programs, which include TPPPs, rely on appropriate training and motivation, as well as encouragement from program administrators and educators. A primary barrier to successful implementation of TPPPs and sexual risk reduction programs involves educators' abilities in implementing and sustaining research-based programs. Researchers' systematic reviews of theoretically based sexual-risk reduction programs have indicated a need for additional research studies to identify characteristics that drive positive effects in sexual-risk reduction such as preventing teenage pregnancy (Aarons, Hurlburt, & Horwitz, 2011; Robin et al., 2004).

Educators face many challenges that affect the wellbeing of students far beyond their academic attainment. Modeling positive behaviors (Bandura, 1988) as well as developing, implementing, and evaluating educational and social programs designed to enhance students' learning and application of knowledge and skills pose unique challenges for educators (Robin et al., 2004). The regulatory implementation of TPPPs poses an additional trial for educators. In Mississippi, new legislation (2011) was passed requiring every school district to identify and implement an evidence-based, effective

TPPP that would meet the environmental and cultural needs of all students (Mississippi Legislative House Bill 999, 2011). Educators' lack of knowledge about TPPPs and the lack of guidance in the law for the selection and implementation of evidence-based TPPPs could pose problems that could be costly and slow or impede the decrease in teenage pregnancy rates.

Operational Definitions

Abstinence: Abstinence includes refraining from any type of sexual intercourse including anal, oral, or vaginal sex (CDC, 2013).

Abstinence-only: Abstinence-only TPPPs include discussions of values and character (CDC, 2013). This type of education does not include safer sex education and only includes the promotion of abstaining from sex (CDC, 2013).

Abstinence-plus: Abstinence-plus TPPPs include safer sex education concepts, address the context for sex, and define contraceptives (CDC, 2013).

Adaption: Adaption is the process of making changes to a science-based program in order to make it appropriate for a target population without removing any core components (CDC, 2013).

Assessment: A needs and resource assessment is a systematic gathering of information about the target population and resources (CDC, 2013). Conducting an assessment helps providers develop greater focus and direction by identifying prevalent sexual risk-taking behaviors and protective factors affecting those behaviors by leveraging existing resources (CDC, 2013). An assessment provides the baseline data that can later help with evaluation (CDC, 2013). By surveying the field, providers can then

find more strategic uses of resources (e.g., staff, funding, materials, etc.) and design or select programs more purposefully (CDC, 2013).

Desired outcomes: Desired outcomes are the exact changes expected as a result of a program, also known as *objectives* (CDC, 2013).

Evidence-based approach: The use of evidence-based approaches helps ensure that a program that is implemented will have a greater chance of succeeding (CDC, 2013).

Fidelity: Fidelity refers to the process of implementing a science-based program without removing any of the program's core components (CDC, 2013).

Fit: The compatibility between a TPPP and the target population is referred to as the fit. A TPPP must fit with the target population's beliefs, behaviors, values, language, and customs (CDC, 2013).

Making a Difference (MAD): MAD is a TPPP curriculum that focuses on abstinence from sexual activity (CDC, 2013).

Promising program: A promising program is one that has not been formally evaluated but that includes most of the characteristics of programs shown to be effective (CDC, 2008). Promising programs use the 17 characteristics of effective sex and HIV education programs in the processes of selection, adaptation, and development (CDC, 2013).

Protective factors: Protective factors discourage behavior that could lead to teenage pregnancy or encourage behavior that could help prevent teenage pregnancy (Kirby, 2007).

Risk factors: Risk factors encourage behavior that could result in pregnancy or STDs (Kirby, 2007).

Safer sex: This behavior involves eliminating or minimizing risks associated with sexual practices that involve exchanging semen (CDC, 2013).

Science-based programs (also called *evidence-based, research-proven,* or *best practice programs*): These scientifically evaluated programs show measurable change related to students' risk-taking behaviors that are factors in preventing teenage pregnancy (CDC, 2013).

Assumptions, Limitations, Scope, Delimitations

The high school used in this research study had not gathered information from adult stakeholders regarding their perceptions about the implementation of a TPPP prior to the study. Research study participants were adults who held a faculty or staff position at the high school. The research study was limited to a purposeful sampling of adult stakeholders from a Mississippi high school. Because this research study included the examination of data on the perceptions of the factors related to implementation of a TPPP at one high school, the conclusions of the study could not be generalized to other settings. The data will be difficult to generalize due to the small sample size.

Significance of the Study

This research study can serve as a guide to school administrators and community advocates for project planning and the use of a science-based approach to identify, select, modify, and implement a TPPP that will effectively assist students in making informed decisions that will prevent teenage pregnancy. I will provide a brief executive summary

to the school district superintendent, the principal, and grantees who served on the taskforce to support the implementation and sustainability of an evidence-based teenage pregnancy prevention program. Additionally, I plan to provide a video-recorded presentation for the staff at the school in which I will offer a more detailed summary of the findings. These items will be provided within 3 months of the completion of the study. The research may help guide school officials in choosing a TPPP that meets the societal, cultural, and educational needs of students at T High School, which may ultimately save time and school funds while preventing school dropout and teenage pregnancy (CDC, 2008, 2013). The research study results could also be shared with the state department of education and other state school district officials to assist them with meeting the state mandate for identifying, selecting, modifying, and implementing an evidence-based TPPP.

Transition Statement

This chapter has included the purpose of the current study, which was to investigate adult stakeholders' perceptions of the implementation of a teenage pregnancy program in a metropolitan high school in a southern state. It has also included the research questions, as well as the conceptual framework. Additionally, this section has included discussion of teenage pregnancy, the need for more research related to minority settings, and adult stakeholders' perceptions of teenage pregnancy. The next section provides a review of the literature related to teenage pregnancy.

Section 2: Review of the Literature

Introduction

This review of literature includes nine areas: (a) Overview of Teenage Pregnancy, (b) Conceptual Framework, (c) Consequences of Teenage Pregnancy, (d) Dropout Rates, (e) Graduation Rates, (f) Postsecondary Achievement, (g) Perceptions of Teenage Pregnancy, (h) Recent History of Teenage Pregnancy Prevention, and (i) Ineffective and Effective Teenage Pregnancy Prevention Programs. The review opens with an overview of teenage pregnancy. Overall, the literature provides a framework that supports an examination of adult stakeholders' perceptions of teenage pregnancy in a southern state high school. The local problem is substantiated through an analysis of teenage pregnancy statistics on the local and state level for that particular area of the research study.

Overview of Teenage Pregnancy

Although the national teenage pregnancy rate has dropped from 61.8 births to 39.1 births per 1,000 women, the U.S. teenage pregnancy rate exceeds that of other developed countries by 4 times (CDC, 2013). This difference among nations in teenage pregnancy rates underscores the urgency of addressing current and ongoing economic and healthcare concerns and adopting public policy support of programs focusing on this issue (CDC, 2011, 2013). More research and examination of the issues that affect teenage pregnancy and teenage sexual behaviors are needed to understand what factors affect teenage pregnancy rates.

A decrease in the teenage pregnancy rate was noted among females 15-19 years of age, and among all racial and ethnic groups from 1990 to 2004. Birth and abortion

rates dropped during this period for all American racial and ethnic groups. Experts specializing in adolescent health speculated that this decline was due to several factors, including increased choice to practice abstinence and to use effective methods of birth control among sexually active teenagers (CDC, 2008; National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health, Youth Risk Behavioral Surveillance System, 2008; NCHS, 2008). Experts also speculated that a decrease in second pregnancies and a steady economy that provided teenagers with opportunities and resources to express their choice and responsibilities related to sexual behavior contributed to the decrease (Jayson, 2008).

Teenage pregnancy rates did not decline equally across all ethnic groups. Hispanic teenagers experienced the most modest decline (21%) in pregnancy rates from 1991–2005, compared with Blacks (50%) and Whites (34%). The different rates of teenage pregnancy across subpopulations in the United States highlight the complex interplay between sociocultural factors and sexual behavior. For instance, non-Hispanic teenagers initiated sex at an earlier age than Hispanic teenagers did but were more likely to use condoms. Hispanic teenagers were more likely than other teenagers to forgo condom use and to become pregnant during the teenage years. Foreign-born teenagers were less likely to begin having sex as teenagers than those who were born in the United States. Among Hispanic teenagers, those who spoke English as their primary language were at greater risk for early sexual activity and teenage pregnancy than those who spoke Spanish as their dominant language (CDC, 2011).

Teenage pregnancy rates have increased consecutively since 2006. From 2005 to 2006, the number of females ages 15 to 19 who became pregnant and gave birth increased 3%, from 40.5 births per 1,000 to 41.7 births per 1,000. The birth rate for women ages 18 to 19 was 73 births per 1,000, which was 3 times higher than the birth rate for women ages 15 to 17, which was 22 per 1,000. Among females in this group, the birth rate increased 4% during that same year (CDC, 2008; NCHS, 2008).

Child and adolescent advocates have suggested that changes have occurred in cultural acceptance of premarital sex and single parenting at a younger age (Jayson, 2008, 2009). This acceptance of teenage sexuality is becoming a growing trend that is highlighted in the media by teenage idols (Jayson, 2008, 2009). Particularly high growth rates were seen in the southern and southwestern regions of the country and among racial and ethnic minorities, including Black and Hispanic populations. The pregnancy rate for Black teenagers increased the most, rising 5%. There was a 4% increase for American Indian teenagers, a 3% increase for White teenagers, and a 2% increase for Hispanic teenagers (CDC, 2008; NCHS, 2008).

Despite some variation across sociocultural groups, sexual activity remains common among all subgroups of teenagers in the United States. Nearly half of teenagers ages 15–19 have engaged in vaginal sex, more than half have engaged in oral sex, and up to 11% have engaged in anal sex. Forty percent of teenagers have had multiple sex partners (Bleakley, Hennessy, & Rishbein, 2010; Klein & Adelman, 2008). Risk factors for increased likelihood of unprotected sexual activity and teenage pregnancy in the United States include the following:

- lower socioeconomic status (Hamilton, Martin, & Ventura, 2010);
- illicit drug use (especially methamphetamine, which is associated with hyper sexuality and decreased sexual inhibition; (Hamilton et al., 2010);
- being raised in a single-parent household (Hamilton et al., 2010);
- lower parental education levels (Hamilton et al., 2010);
- having a mother who herself became pregnant as a teenager (Hamilton et al., 2010);
- having an older teenage or adult sex partner (Hamilton et al., 2010);
- being in a romantic relationship for 3 years or longer (Hamilton et al., 2010);
- being incarcerated (Hamilton et al., 2010);
- exposure to sex, passionate kissing, or sexual talk on television or the Internet (Hamilton et al., 2010);
- community violence, including childhood physical and sexual abuse (Hamilton et al., 2010).

Manlove, Ryan, and Franzetta (2003) conducted a study that focused on contraceptive use among teenagers who experienced sexual encounters for the first time. The results of this study showed that teenagers who talked about contraception prior to engaging in any sexual activity were those for whom there was substantial time between the beginning of their relationship and their first sexual encounter. Teens who did not talk about contraception did not use it consistently, if at all. Although some teenagers used contraceptives at some point in their relationship, the likelihood of doing so declined as the longevity of the relationship increased.

Martinez-Prather and Vandiver (2014) conducted a study aimed at determining the effect of sexting among teenagers in the United States, the perceptions of parents regarding sexting, and parents' roles in preventing its associated undesired outcomes. The results indicated that a large number of females engaged in sexting. Also, a majority of them received sexting images while they were still in school. Apart from that, female adults engaged in sexting more frequently as compared to their male counterparts. Girls who participate in sexting are more sexually active than girls who do not (Martinez-Prather & Vandiver, 2014).

Other findings associated risk factors with teenagers who suffered from sexual abuse. Saewyc, Magee, and Pettingell (2003) established this correlation in a study that took place between 1992 and 1998 among sexually promiscuous high school students in Minnesota. This study showed that those who had been sexually abused reported teenage pregnancy involvement more significantly compared to their nonabused peers (Saewyc et al., 2003). A plethora of other studies have identified commonly observed social risk factors in developing the predisposition toward teenage pregnancy.

Conceptual Framework

The conceptual basis for this study was social learning theory. Self-efficacy and modeling are the two variables upon which social learning theory focuses (Bandura, 2001). *Self-efficacy* refers to an individual's ability to successfully undertake a specific action. Bandura (the father of the theory) considered self-efficacy to be the most crucial feature that determines an individual's effort to change behavior. *Modeling* refers to the

ability of an individual to learn from the actions of others (vicarious learning), meaning that people do not learn only from their personal experiences.

The modeling notion of social learning is the most crucial aspect when examining teenage pregnancy prevention (Calise, Howland, Bliss, Flaherty, & Gordon, 2012). Teenagers imitate behavior from other members of society through observational learning. Thus, health educators, counselors, elders, and school authorities have the duty of helping teenagers to notice that different and conflicting social norms might exist in the environment. This means that teenagers are likely to receive different messages from parents, the media, religious authorities, and peers, among others.

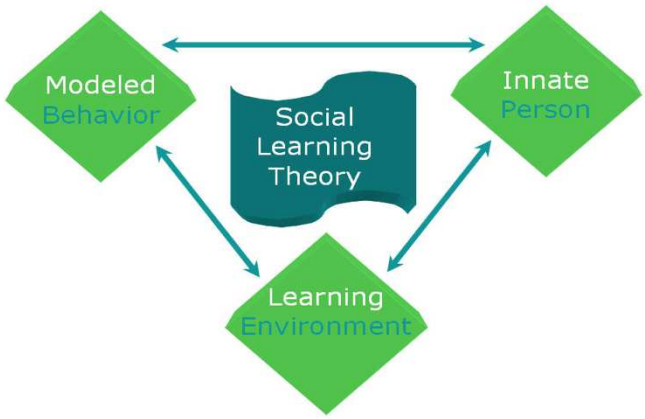

Figure 1. Connections in social learning theory. From "Social Cognitive Theory: An Agentic Perspective," by A. Bandura, 2001, *Annual Review of Psychology*, *52*, p. 23. Reprinted with permission.

Social cognitive theory indicates that one's knowledge is acquired in relationship to what one observes and experiences in social interactions, as well as through outside media influences (Bandura, 2001). This means that individuals acquire new behaviors not only by trying them, but also by the imitation of other people's actions. Modeling might

occur depending on whether such behavior and its outcome are rewarded or punished. The media presents models for different people in varied environmental settings. Bandura (2001) studied the adolescent period and the entrance into adulthood, focusing on behavior modeling. According to the theorist, youth do not inherit behaviors but learn and imitate other people's behavior. Thus, people acquire knowledge by learning through observation, making connections between their environment and personal behavior, comprehending the complexity of learned behavior, and using self-efficacy (Finer, 2010).

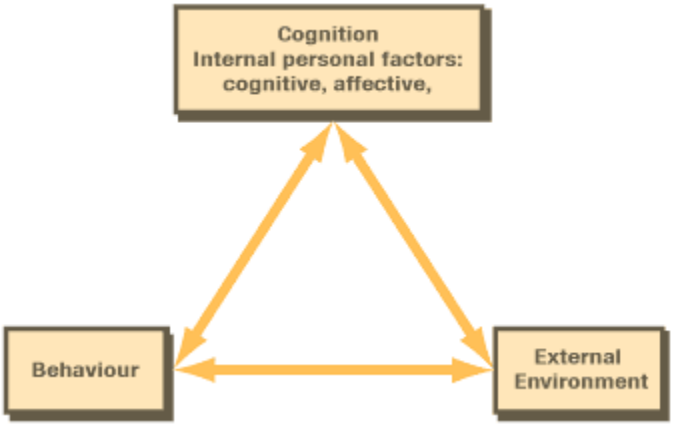

Figure 2. Cycle of social cognitive theory. From "Social Cognitive Theory: An Agentic Perspective," by A. Bandura, 2001, *Annual Review of Psychology*, *52*, p. 9. Reprinted with permission.

Social cognitive theory, related to social learning theory, emphasizes a profound difference between a person's moral competency and moral performance (Alfassi, 2003). *Moral competence* is the ability to behave in a moral way. In contrast, *moral performance* refers to the actual act of following one's idea of morality in specific situations. Moral competence involves what people are capable of, what they know, what their skills are, their awareness of morally accepted rules and regulations, as well as their cognitive

ability of constructing behaviors. Moral competence is the development of cognitive-sensory process, which means that the individual is aware of what society considers right or wrong. For instance, a teenager with moral competence would be aware that teenage pregnancy is wrong and frowned upon by the society. In contrast, teenagers exhibiting moral performance might rationalize about the dangers of unprotected sex (e.g., saying they will do it once only) and engage in it (Alfassi, 2003).

Reciprocal determinism indicates that a person's behavior affects and is affected by the social world as well as personal characteristics (Gore & Leuwerke, 2000). Thus, in addition to vicarious learning, the individual is subject to external stimuli that might reinforce the behavior, including other absent or present people. For instance, students might engage in prostitution to support themselves because of economic hardship. On discovery of this behavior, members of a school's staff might implement strict measures in the school (e.g., restricting the student from going out of the school) so as to prevent the student from having opportunities to engage in the behavior. The student might then starts to hate school, as she cannot raise money for her upkeep. In addition, faculty and members of staff might begin to dislike her because of her notoriety, leading to a more restrictive environment for the student. These environmental and behavioral aspects would then compound each other, resulting in a continuous battle for the student on all three levels (Phillips & Martinez, 2010).

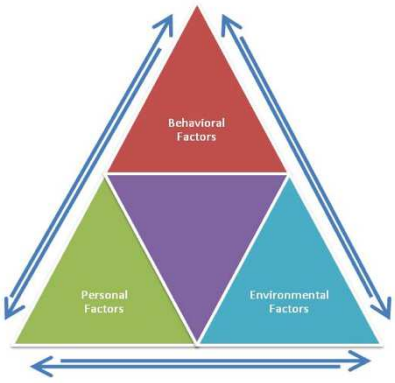

Figure 3. Bandura's triadic reciprocal determinism. Three sets of factors shape Bandura's concept of reciprocal determinism. From "Social Cognitive Theory: An Agentic Perspective," by A. Bandura, 2001, *Annual Review of Psychology*, *52*, p. 19. Reprinted with permission.

Social cognitive theory indicates that behaviors come from intricate interactions of a person's internal world (self-efficacy), influences of the environment (external factors), as well as interactive processes with other people (reciprocal determinism). Most attempts at minimizing teenage pregnancy use the modeling aspect of vicarious learning, such as the use of celebrities to encourage abstinence. It is crucial for adults (e.g., educators) to emphasize self-efficacy and reciprocal determinism, which are especially significant for interventions that involve intimate relationships. This need exists because interventions that lack these components do not account for obstacles. Obstacles include students' lack of funds for personal care and the presence of gender-induced power differences that can prevent students from appreciating the dangers of having teenage sex and achieving the desired behavior (Bandura, 2001; Gore & Leuwerke, 2000).

According to social learning theory, adult stakeholders' notions about teenage pregnancy are likely to be influenced by widespread opinion on the subject.

Consequently, they could be holding traditional perspectives concerning teenage pregnancy, views that could even be unscientific (Bandura, 2001; Gore & Leuwerke, 2000). Additionally, educators could blame teenage pregnancy on diminished societal values. The suggestion comes from modeling, as educators might believe that teenage behavior is influenced by what happens in the environment, such as the glorification of sex and immorality in music and movies. On the other hand, faculty and staff could view themselves as part of the problem, especially when they recognize that they have failed as role models as well as in giving proper guidance and counseling to the youth (Bandura, 2001; Gore & Leuwerke, 2000). Youth need positive models to successfully pursue a positive action (self-efficacy). Such models could be their educators, as well as educators providing proper advice on sexuality. Other perspectives of educators might be linked to the underlying causes of teenage pregnancy as proposed by reciprocal determinism. This could mean that the students' behaviors are a symptom of underlying issues that need to be addressed to guarantee successful intervention (Ruedinger & Cox, 2012).

The current study was guided by the above theories and literature to investigate the perceptions of adult stakeholders toward the implementation of a teenage pregnancy prevention program at school. This approach was pertinent because educators are crucial in modeling behavior for students as they live in the environment, observing and being observed directly by the students. Understanding their perceptions regarding teenage pregnancy prevention programs helps in providing effective programs (Bandura, 2001; Gore & Leuwerke, 2000).

Consequences of Teenage Pregnancy

Parenthood, which can be a joyous experience among those are who already working and are ready to take on the responsibility, is known to be the leading cause of teen girls dropping out of school (CDC, 2010; National Campaign, 2010). The socio-economic effects of adolescent pregnancy and childbirth exact a high toll on both the teenage parents and their children that can be both long term and immediate. Fewer than 50% of teenage mothers graduate from high school compared with 89% among those who had not parented a child during their teens. Fewer than 2% obtain a college degree by the time they reach age 30. Complicating this matter is the observation that children of adolescent mothers perform more poorly in school than children from older parents. They have a 50% greater chance of repeating a grade, are less likely to finish high school, and have poorer assessments on standard scholastic tests than kids of older parents (CDC, 2010; Jerman & Constantine, 2010).

Hoffman (2006) and McCarty-Caplan (2013) reported that children of teenage mothers younger than 17 years tend to have poorer health compared with those of older mothers. The CDC (2010a) also noted that children of adolescent mothers have higher chances of being born prematurely and have low birth weights. This problem can be attributed to the fact that pregnant teenagers generally do not receive adequate and timely prenatal attention with consistency as compared to those who get pregnant at a later age and tend to suffer inadequate weight gain and other health problems while being pregnant. Teenage mothers are also observed to smoke more frequently during pregnancy, indicating a level of stress that older mothers may not have to endure

(Hoffman, 2006). In addition, Guo and Nathanson (2011) noted there is more risk for children of teenage mothers than children with older parents to be abused or neglected. The sons of teenage mothers are 2.7 times more likely to have arrest records, while their daughters are 83% more likely to end up as teenage mothers themselves.

Teenage childbirth costs American taxpayers approximately $9 billion annually due to increased foster care and health care costs, increased imprisonment rates among many adolescent parents, and reduced tax collection from teenage parents entering the workforce who earn less because they completed less academic training (CDC, 2012; Jerman & Constantine, 2010). Hoffman (2006) estimated a higher figure at $11.5 billion in 1996 from food stamps, Medicaid, and other public funding assistance for women aged 17-34 who became mothers as teenagers.

High School Dropout Rates

The Local School Directory (2008a) indicated the Mississippi has a statewide average secondary school dropout rate of 4.6% and ranks 31st in dropout rates among U.S. states (see Table 1). Table 2 shows dropout rates by grade, Table 3 shows dropout rates by race, and Table 4 shows dropout rates by gender.

Table 1

State Rankings in Mississippi

	State ranking
Graduation rate (63.9%)	47
Dropout rate (4.6%)	31
Per pupil spending ($7,705)	46
Students per teacher (14.7)	30
Number of schools (1,097)	34
Number of students (491,962)	31
Number of (FTE) teachers (33,358)	32

Note. Adapted from *High School Dropouts in America*, by Alliance for Excellent Education, 2010, retrieved from http://www.all4ed.org/files/HighSchoolDropouts.pdf

Table 2

Dropout Rates by Grade, School Level (9-12)

	Dropouts	Dropout rate
Grade 9	1,497	3.5%
Grade 10	1,631	4.4%
Grade 11	1,450	4.6%
Grade 12	1,139	4.0%
Grades 9-12 total	6,399	4.6%

Note. Adapted from *High School Dropouts in America*, by Alliance for Excellent Education, 2010, retrieved from http://www.all4ed.org/files/HighSchoolDropouts.pdf

Table 3

Dropout Rates by Race (Grades 9-12)

	Dropouts	Dropout rate
American Indian	3	3.0%
Asian	3	2.0%
Hispanic	23	3.9%
Black	1,042	5.6%
White	426	3.6%

Note. Adapted from *High School Dropouts in America*, by Alliance for Excellent Education, 2010, retrieved from http://www.all4ed.org/files/HighSchoolDropouts.pdf

Table 4

Dropout Rates by Gender (Grades 9-12)

	Dropouts	Dropout rate
Male	3,807	5.5%
Female	2,592	3.7%

Note. Adapted from *High School Dropouts in America*, by Alliance for Excellent Education, 2010, retrieved from http://www.all4ed.org/files/HighSchoolDropouts.pdf

Just a year short of graduation, Grade 11 registered the highest high school dropout rate at 4.6%, while grade 9 had the lowest at 3.5% (see Table 2). Dropout rates in high school registered the highest among Blacks at 5.6%, followed by Hispanics at 3.9%, and Whites at 3.6% (see Table 3). Asians have the lowest at 2% preceded by American Indians at 3%. Considering the fact that only about 50% of teenage mothers graduate from high school (CDC, 2010; National Campaign, 2010), this trend in dropout rates may correlate to the fact that among teenage pregnancies, there are higher incidences among Blacks and Hispanics as shown in Figure 4 from Popkin, Santelli and Kirby (2010) and is consistent with Figure 1 from CDC (2012). Table 4 shows that more boys failed to finish their secondary education than girls.

Graduation Rates

Table 5 shows the graduation rates as of 2007-2008 broken down by ethnicity and shows a composite average graduation rate of 63% (Local School Directory (2008a) which was below the national average of 69% as reported by the Alliance for Excellent Education (Alliance for Excellent Education, 2010) for the graduating class of 2007. Among the local ethnic content of the southern states' high school students, Asians had

the highest graduation rates, followed by Whites and Hispanics. Blacks had the lowest rates and were preceded by American Indians with the second lowest rates.

Table 5

High School Graduation Rate by Ethnicity (2007-2008)

	Graduation rate
American Indian	58.0%
Asian	88.3%
Hispanic	65.9%
Black	60.5%
White	67.0%
Total	63.9%

Note. Adapted from *High School Dropouts in America*, by Alliance for Excellent Education, 2010, retrieved from http://www.all4ed.org/files/HighSchoolDropouts.pdf

Postsecondary Achievement

Hoffman (2008) indicated among high school girls ages 18-19, giving birth reduces the chances of proceeding to and/or completing college, which is a pattern also apparent among younger teenage mothers. The probability of post-secondary education increases by about 10% to 20% for older teenage mothers, if their first births were delayed, putting all other risk factors at bay. In addition, Hoffman indicated that the proportion of older teenage mothers completing a 4-year college degree will more than double, from 3% to 7%. He further asserted that with significant consistency, a mother's age when giving birth to her first child creates an important causative link in determining the probability that a young woman will complete or just attend college. This notion was corroborated by the study of 15-16 year old Hispanics conducted by Basch (2011).

Perceptions of Teenage Pregnancy

Teenage pregnancy has been an issue of concern all over the world for the pregnant teenager, the close relatives, and society as a whole (Braun-Courville & Rojas, 2009; Tolman & McCelland, 2011). This concern originates from the fact that if complications appear during pregnancy or labor and delivery, the life of the mother and the unborn child may be at risk (Brown & L'Engle, 2009). The world is facing the challenge of teenager pregnancy, which is on the rise, especially for those who come from a lower social economic status. It does not matter whether one is schooling or not (Braverman & Snyder, 2012). Many factors are linked with teenage pregnancies: peer and community influence, strength of family relationship, socio-economic status, and parental education on matters of sex. According to McGovern (2012), teenagers in underclass neighborhoods may perceive their options in life in a manner that encourages teenage pregnancy. Adolescents' norms regarding teenage pregnancy differ with their views on sexuality (McGovern, 2012). Women's role as child-bearer, and society's expectations for females in taking care of children, lead to the perception that teenage pregnancy will have a greater effect on girls' lives than on the lives of their sexual partners. Communities tend to view pregnant teenagers as individuals who lack moral values (Ruedinger & Cox, 2012).

A perception of insufficient support prevents some educators and parents from embracing effective sexual health education in schools. The perceived degree of opposition to sex education is typically greater than the actual opposition level; however, administrators and other school personnel may base their decisions about sex education

programs on the perceived opposition, and therefore provide minimal sex education (Hirst, 2012; McNabb, 2010). In some states, like South Carolina, people overwhelmingly acknowledge that teenage pregnancy is a crucial matter that needs to be addressed; hence, they support programs for pregnancy prevention in schools. These program encourages abstinence and gives medically precise and age relevant information about the use of contraceptives including condoms (Englander, 2012).

Pregnancy prevention education and reproductive health information are more commonly provided by public schools because few health clinics can meet this demand (McNabb, 2010). This lack of services elsewhere necessitates that communities provide services such as child day care, teenage-mother mentoring, and community education programs on the consequences of sex and early pregnancies (Phillips & Martinez, 2010). McNabb (2010) suggested encouraging parents to involve their children in discussion of sexual matters. In a Northwestern University study (Chicagohealth77.org, 2011), one of the respondents said, *"*The hardest thing is getting a mom talking to her son about pregnancy, getting the dad talking to his daughter about sex. I mean, they just don't do it*"* (p. 1). Although parents seem to struggle with talking about sex with their teenagers themselves, most tend to see early sex education in schools as positive (Tortolero, Johnson, Peskin, Cuccaro, & Markham, 2011). Tortolero et al. (2011) found about 80% of parents thought sex education ought to be initiated in middle school. Two-thirds of these parents suggested that information concerning contraception and condoms ought to be included (Tortolero et al., 2011). Most of the parents who supported the idea of sex education and information concerning contraception and condoms were Hispanic.

Parents' support of sex eduction was based on the notion that the instruction would include medically authentic information on the subject of contraception and condoms. The study substantiated the need to change policies regarding sex education to reflect the opinions of the parents.

Newton (2010) indicated the public health sector feels tasked to undertake the issue of sex education as one of its mandates and form coalitions with other nonhealth facilities to foster sex education among the teenage population, focusing on pregnancy prevention and youth development service. Newton also noted educators feel more obliged to tackle the issue of teenage pregnancy and rise to the occasion before the situation escalates (Newton, 2010).

Recent History of Teenage Pregnancy Prevention

Teenage pregnancy, what was once a sporadic, if not invisible, social issue, emerged into public consciousness in the late 50s and early 60s. Since then there have been fluctuations in the teenage pregnancy rate. Figure 4 taken from a study by Popkin et al. (2010) and corroborated by the Hamilton, Martin, and Ventura (2011) of the National Vital Statistics, shows teenage birth rates across the country's population by ethnicity peaked in the early 90s and since then have had an overall decline. The federal government under the Johnson, Nixon, and Carter administrations enjoyed legislative support that funded reproductive health laws and a wide assortment of public programs to assist teenage mothers and struggling families; support included expanding the Aid to Families with Dependent Children (AFDC). Advocacy groups such as the Guttmacher Institute and the National Campaign to Prevent Teen Pregnancy have spearheaded

information outreach about the consequence of teenage childbearing and teenage parenting or adolescent mothers (Furstenberg, 2007).

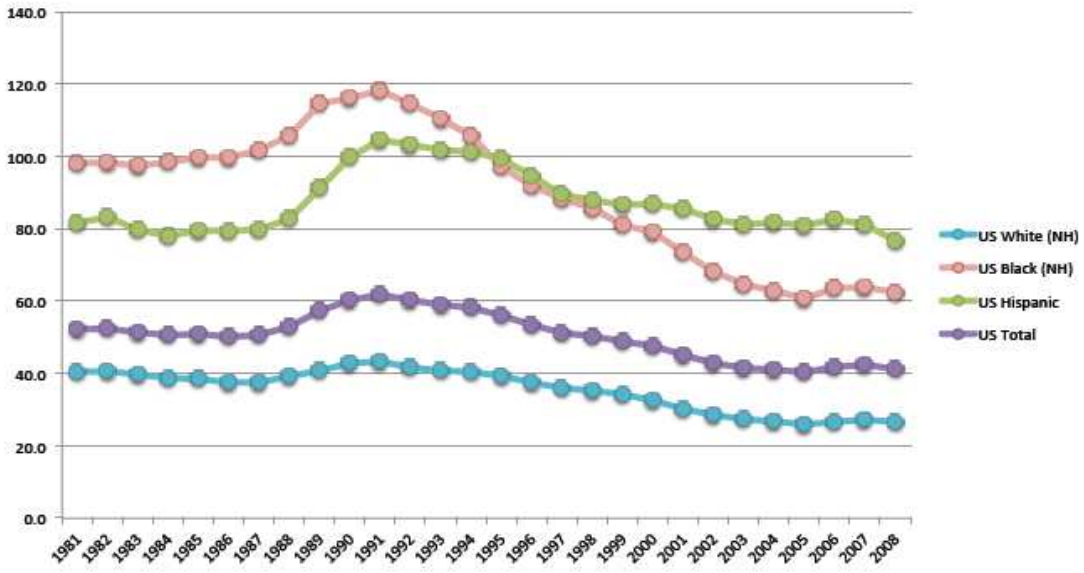

Figure 4. Teenage birth rates by ethnicity in the United States from 1981 to 2008. From *Comparing State Trends in U.S. Teen Birth Rates: 1981–2008*, by R. Popkin, J. Santelli, & D. Kirby, 2010, retrieved from http://paa2012.princeton.edu/papers/12248 . Reprinted with permission.

In the last quarter of the 20th century, contraception became more widely available to teenagers than ever before. It came at a time when sexual liberation and the associated promiscuity among teenagers grew faster than family planning services. Premarital and teenage sex were effectively abetted by the rise in contraceptive use. HIV and AIDS created a dire threat that only heightened the responsibility to manage one's youthful sex life and made contraceptive use a necessity. Furstenberg (2007) indicated making birth control more readily available does not significantly reduce teenage

pregnancies if it is not coupled with an information campaign to promote safe sex. Furstenberg (2007) also cited changes in the nation's abortion policies starting in the late 1960s with the landmark Supreme Court decision in *Roe v. Wade* legalizing abortion as having significant impact on teenage pregnancies (Levine, Staiger, Kane & Zimmerman, 1999). The decade after the *Roe v. Wade* decision, reported incidences of abortions among teenagers rose rapidly, with the ratio of abortions to live births increasing from 280 per 1,000 in 1973 to a peak of 462 per 1,000 in 1985 (Furstenberg, 2007).

Ineffective and Effective Teenage Pregnancy Prevention Programs

Many programs are ineffective and do not meet the societal and health needs of teenagers. These ineffective programs do not encourage positive behavioral changes that prevent teenage pregnancy (CDC, 2008). Zabin, Hirsch, Smith, Streett, and Hardy (1986) studied ineffective sex education programs. The results of the survey indicated both students not enrolled in a teenage pregnancy program and students enrolled in a comprehensive teenage pregnancy that was not evidence-based were more likely to be sexually active than their peers who participated in evidence-based TPPPs. The study also indicated at schools that do not have an evidence-based TPPP, about 92% of the male students were sexually active compared to about 54% of the girls at the middle school level. For high school girls that figure rose to 74%. Research suggests that effective TPPPs are grounded in solid theoretical models. Kirby (2007) and Yang (2010) evaluated TPPPs and discovered that many effective programs have theoretical models that focus on the following: social learning, perceived control, attitudes and intentions, and four areas of development. One area that can have a dramatic effect on decreasing

teenage pregnancy rates is educational development. TPPPs can be developed and implemented by educators, parents, and community-based agencies that can effectively assist teenagers in creating a positive environment to deter teenage pregnancy (Allen & Carmody, 2012; Anderson, 2011). Examples include setting high standards for all and building partnerships with organizations that encourage teenagers to participate in creating their own programs (Kirby, 2007). This approach fosters a youth development model that engages teenagers in creating a positive environment in which they can seek advice and information on various issues of sexuality (Williams, 2011). To eliminate ineffective TPPPs or to modify TPPPs, pregnancy prevention policies must be flexible (National Campaign to Prevent Teen Pregnancy, 2001b). Between 1980 and 2000, Kirby (2007) evaluated experimental or quasi-experimental TPPPs. Kirby (2007) found the most effective TPPPs focused on sexual and nonsexual risk factors that had particular characteristics. These characteristics included a focus on reducing sexual behaviors reinforced through abstinence and condom use. Educators were well trained and fully invested in the programs. Many of the programs encouraged positive communication to discuss issues related to teenage sexual behavior in a classroom environment that was age and culturally appropriate (Kirby, 2007).

Research indicates that TPPPs should follow a systematic process to identify, modify, and adopt a program that fits or meets the needs of its target population (CDC, 2008). The *fit* is defined as the compatibility between a TPPP and the adolescent population, culture, and community that it will serve (CDC, 2008). The *cultural fit* includes the compatibility of a TPPP to fit the "structure of behaviors, beliefs, values,

customs, language, and practices of the target group" (CDC, 2008, np). Effective TPPPs that meet this criterion have been found to be more successful at preventing teenage pregnancy (Vivancos, Abubakar, Phillips-Howard, & Hunter, 2013).

In December 2009, President Barack Obama and the U.S. Congress supported a new initiative under the Office of Adolescent Health to decrease the teenage pregnancy rates in the United States. The President's Fiscal Year (FY) 2010 budget included the new Teenage Pregnancy Prevention Initiative (TPPI), which was intended to use evidence-based pregnancy prevention models and innovative approaches to pregnancy prevention to combat the high teenage pregnancy rate (CDC, 2008). The Consolidated Appropriations Act, 2010 (Public Law 111-117), Division D, Title II of the Act provided $110,000,000 in funds to support implementation of quality TPPPs through competitive contracts and grants (CDC, 2009).

The TPPI recognized 28 TPPPs that are evidence-based and decreased teenage pregnancy, sexually transmitted diseases (STD), and HIV. The identified research-based TPPPs comprise proven methods that have been shown to provide sex education, encourage safe sex behaviors, and prevent teenage pregnancy (CDC, 2008). Villarruel, Jemmott, and Jemmott (2006) conducted a randomized controlled trial study among the Latino youths to determine the efficacy of evidence-based TPPPs (*Cuidate and Be Proud! Be Responsible!)* in reducing sexual risk behaviors. The study's findings provided evidence of the effectiveness of HIV interventions in reducing sexual association and also an increase in the use of condoms among the Latino teenagers.

Evidence-based programs offer comprehensive and diverse approaches that include peer support, parenting skills, and educational opportunities as effective interventions to prevent teenage pregnancy and encourage teenagers to make more informed decisions related to their sexual and health-related behaviors (CDC, 2011; CDC, 2008). Schools that seek funding are encouraged to select from these identified 28 TPPPs because research suggests these science-based TPPPs work (CDC, 2008). Grant funders are increasingly likely to expect receiving organizations to implement science-based programs (CDC, 2008). Expecting use of research-proven programs helps ensure grant dollars support programs that are likely to produce positive results (CDC, 2008).

Evaluating and measuring teenage pregnancy prevention programs facilitates determining the effectiveness of these programs in reducing teenage pregnancies. Many studies have examined factors that affect teenage pregnancy and the effectiveness of teenage pregnancy prevention programs. Few of those studies have reported theoretical constructs in these investigations (Tortolero, et al., 2011). Perceived self-efficacy is one theoretical construct that has been used to examine factors that affect and prevent teenage pregnancy. Bandura (2001) defined self-efficacy as individuals' beliefs in their ability to attain particular goals. Self-efficacy influences individuals' motivation to act and can impact their abilities and behaviors. Boonstra (2012) found that teenagers at risk for becoming pregnant had lower self-efficacy and lower levels of social support than other teenagers. These teenagers also had an increased risk for contracting sexually transmitted diseases than teenagers with higher self-efficacy and higher social support. Hillenbrand-

Gun, Heppner, Mauch, and Park (2010) also found self-efficacy to be associated with teenage sexual behaviors related to AIDS-prevention intentions and abstinence.

Evidence-based teenage pregnancy programs are being used to effectively increase teenagers' awareness of the teenage pregnancy issue and the risk of sexually transmitted infections and diseases, and to change teenagers' perceptions and attitudes about early engagement in risky sexual activities that could lead to pregnancy (Lagus, Bernat, Bearinger, Resnick, & Eisenberg, 2011). Evidence-based programs have changed adolescent risk-taking behavior (Lamb, Lusig, & Graling, 2013). Milhausen et al. (2008) stated that hierarchical communication is vital in gender education programs that enlighten teenagers about abstinence as the most competent way of preventing the transmission of STDs.

Several teenage pregnancy prevention programs of the National Campaign and the U.S Department of Health and Human Services have focused on youth development, parent involvement, community wide involvement, curriculum-based education, and service learning programs that keep teenagers constructively engaged in community services. Twenty-eight of these programs have been evaluated as being evidence-based and highly effective in meeting the objectives for reduced teenage pregnancy. Jemmott, Jemmott, and Fong (1998) studied *Making A Difference,* which was one of the 28 evidence-based TPPPs identified as being effective. The results of this study indicated that culture-responsive, cognitive-behavioral intercessions that emphasize abstinence and the use of condoms help in reducing risky sexual behavior among Black teenagers and reducing HIV infections. Jemmott, Jemmott, Braverman, and Fong (2005) studied the

effectiveness of evidence-based TPPPs focused on reducing the cases of unprotected sexual intercourse among Latino and Black females. The skills-intervention respondents had minimal unprotected sexual contact compared to health-control-intervention and information-intervention respondents. It is, therefore, apparent that skill-based HIV/STD interventions can reduce sexual risk behaviors and STD rates among Black and Latino adolescent girls in clinic settings. Jemmott, Jemmott, Fong, and Morales (2010) also studied the effectiveness of HIV/STD risk-reduction approaches for adolescents when a community-based organization implement them. The findings of the study indicated that community-based organizations have the capacity to effectively operationalize HIV/STD risk-reduction.

These TPPPs represent programs that could be selected by the study site to modify, adapt, and tailor to the population in this study to reduce teenage pregnancy at the high school in the southern state. Incorporating the program features of successful interventions when developing future programs and/or making improvements to existing programs may help researchers and program planners have a more positive effect on teenage pregnancy (Lamb, et al., 2013). These research-based programs may help to take the focus off of ideological debate and turn the focus to preventing pregnancy.

Implications

The data collected from this research study may inform adult stakeholders of practices that support successful implementation of a teenage pregnancy prevention program. This research study used social learning theory as the basis for a systematic gathering of information about the perceptions of factors that promote and impede

implementation of a teenage pregnancy prevention program at T High School. Perceptions elicited from administrators and staff members may assist the nonprofit organization and the school district in considering new evidence-based TPPPs for the high school or enhancing the current program. The data collected from this research study will be used for future project directions related to implementation, evaluation, sustenance of an evidence-based TPPP, and for garnering support from the school district and community.

Literature Related to Methods

This section discusses methods used in studies aimed at determining the effectiveness of evidence-based TPPPs. In evidence-based TPPPs there are a number of methodologies that are applicable for evaluating whether programs are effective and function efficiently. Experimental (randomized controlled trials) or quasi-experimental studies, coupled with rigorous evaluation, are used to ensure more credibility. Rigorous evaluation enables comparison of groups and supports drawing conclusive results while taking into account environmental factors (Cooney et al., 2007).

Jemmott et al., (1998) conducted a study that aimed at testing the effects of *Making A Difference* curriculum compared to a general health education program. The study was based on a randomized controlled trial design. The participants consisted of Black adolescents in sixth and seventh grades with an average age of 11.8 years. Of the participants, 53% were females and 47% male. A pretest and posttest were administered at 3, 6, and 12 months after the program. Villarruel et al., (2006) conducted a randomized controlled trial study among the Latino youths to determine the efficacy of evidence-

based TPPPs reducing sexual risk behaviors among them. The researchers used Latinos between 13 to 18 years old and consisting of 304 females and 249 males. Data were collected prior to and after administration of the intervention along with at 3 months, 6 months, and 1 year (Villarruel, Jemmott & Jemmott, 2006). Zabin et al., (1986) used self-administered questionnaires to evaluate the effectiveness of a comprehensive teenage pregnancy program. The study was conducted over a 3-year period. The researchers used participants from four schools in the Baltimore school system. Students from two schools were administered with the treatment, while the remaining acted as a control for the study. Tortolero et al. (2011) conducted a study aimed at determining the opinions of parents regarding schools providing their children sex education. The researchers acquired the information for the study by conducting a telephone survey of the parents who had children aged 18 years and yonger in Harris County, Texas. Respondents were then asked several predetermined questions. The interviewer was guided by a script. The answers obtained from the respondents were then recorded as the survey continued. Random sampling was used to acquire 1200 participants for the study.

Although approaches such as those described above can measure specific outcomes of a program, they do not provide educators with the opportunity to identify how implementation succeeded or failed within high school setting. The open-endedness of the case study design used for this present study, provided an opportunity to gain insight into what was important to educators, in a way that many of the studies described above could not.

Summary

This section provided an overall review of literature related to teenage pregnancy and evidence-based TPPPs. Teenage pregnancy is an issue that affects every level of society, from individuals to local communities to national governments and the world at large. This issue requires stringent prevention and mitigation programs. In the United States alone, teenage pregnancies account for nearly 7% of all births in the country and 15.4% of all non-marital births (Office of Adolescent Health, 2015). The teenage pregnancy rate increased between the age brackets of 15 through 19 between 2006 and 2007 after a decline beginning in 1991. The teenage birth rate decreased from 2008 through 2013, dropping below the 2006 teenage birth rate. Even though there has been a decrease in the teenage birth rate within 21 of the past 23 years, teenage pregnancy remains a societal issue (Solomon-Fears, 2015). Teenagers become increasingly comfortable with unprotected sexual activities, which make them vulnerable to getting diseases such as STD's and HIV infection (Santelli & Melnikas, 2010). Teenagers who engage in early sexual activity may experience confusion and betrayal because of the transient nature of teenage relationships, and may have difficulty establishing and maintaining long-term romantic relationships in adulthood. Additionally, teenage pregnancy is associated with higher school dropout rates for females and poorer-long-term financial outcomes (Santelli & Melnikas, 2010).

Teenagers are engaging in a number of negative behaviors, such as premarital sex, that are taking a toll on schools and communities locally, statewide and nationally (Lesesne el al., 2008). Teenagers seeking to avoid unplanned teenage pregnancy often

engage in oral or anal sex, but fail to consider the risk of contracting STDs and HIV that are easily transmitted by these routes (CDC, 2010). CDC adapted RAND Corporation's step-by-step summary of the 2004 GTO guide to teenage pregnancy prevention. In 2008, it published 10 Steps to Promoting Science-Based Approaches (PSBA) to teenage prevention using GTO. The science-based planner offers a clear and accessible process for local practitioners to follow for delivering TPPPs using a systematic approach to their work (CDC, 2008).

Families of teenage parents usually incur huge, unmanageable health costs and face social costs of pregnancy as well. Innovative health education programs become a necessary aspect to prevent the probability of such cases growing. Programs have been set up to ensure teenagers become educated and have the necessary resources to help them avoid teenage pregnancies. Setting up evidence-based programs in schools, clinics and community facilities has become a norm when mitigating teenage pregnancies. Implementation of these TPPPs requires assessing the needs and resources of each high school and developing a process for implementation that takes many years (CDC, 2010). Most programs target middle and high school teenagers and are usually molded to target specific age groups and gender. As of 2014, only 35 programs had been developed to meet effective teenage education criteria, but a recent 2015 study has increased two more programs to bring the total to 37 (Goesling, Lugo, Lee, & Novak, 2015). The main objective of these programs is to positively affect teenagers' sexual behavior or their reproductive health outcomes.

Teenage pregnancy requires immediate attention to help the community as well as other social structures to assist teenagers in avoiding pregnancy. This problem calls for multidisciplinary action that prompts policymakers and other relevant stakeholders to generate programs that operate effectively to aid teenagers in becoming more aware about sexual behavior and consequences. Furthermore, gaps in literature exist on parents' and students' perceptions on the implementation of these evidence-based TPPPs in high schools.

Section 3: Methodology

Introduction

This section contains a description of the design of the study, sample, data collection, analyses, and interpretation of the data collected for the study. The purpose of this case study was to identify successful practices and areas for improvement in the implementation of a teenage pregnancy prevention program at T High School based on the perspectives of adult stakeholders. The rationale for this study was that addressing the implementation of a teenage pregnancy prevention program might have an effect on children, families, communities, and the nation.

Research Design and Approach

To address the research questions, the framework of this research study followed a case study design that used a qualitative construct to capture information from participants about how they perceived the implementation of a teenage pregnancy prevention program. The product of a qualitative inquiry is descriptive. Qualitative research methodology was used because the study was intended to help create an understanding about concepts related to implementing a TPPP that could not be gained by quantitative methods. This method was flexible so that I could discover ideas, gain insight, discover or examine a theory, and ultimately formulate a problem for further investigation (Monsen & Van Horn, 2008). Researchers use qualitative methods to examine concepts that establish the basis for their own actions in certain social settings (Monsen & Van Horn, 2008). Yin (2009) noted that real-world experiences are not finite and cannot be measured. Such experiences are addressed in qualitative research. The goal

of this research study was not to test a hypothesis. Rather, the goal of this study was to give voice to school administrator and staff perceptions and attitudes toward a teenage pregnancy prevention program so that "structures and patterns relevant to the phenomenon under study" could come to light (Walker & Koroloff, 2007, p. 445).

Phenomenology, narrative, case study, grounded theory, and ethnography are all strategies used by qualitative researchers (Creswell, 2009). I considered several methods such as observations and survey. A case study approach was selected as the research design because it engages participants in in-depth interviews. Case studies use data sources in addition to interviews, and for this study, I used program materials provided by the school as well. Case study research design is often used to elucidate issues or to expand knowledge that has been gained through other research studies (Yin, 2003a; 2003b). Case studies, which are used broadly in research, focus on bounded situations, examined within their respective context. In the social sciences, researchers use case study to examine real-life issues. Yin (2003a, 2003b) described case study as a research method for which multiple sources are used to gather empirical data. Further discussion of the conceptual framework and the qualitative methodological approach to this study will be presented in subsequent chapters.

Case studies use participant interviews as the primary data collection approach, which was a fitting qualitative research method. This approach facilitated the exploration of adult stakeholders' perceptions of the implementation of a TPPP at a southern state school that has a comparatively high rate of teenage pregnancy. Interviews are flexible and provide opportunity for the researcher to investigate how individuals think and feel

about a topic and why they hold certain opinions (Berg, 2004). There are many other advantages to interviews. They are socially constructed experiences (Qu & Dumay, 2011), and as such are appropriate for approaching the research subject from the perspective of social cognitive theory, which posits that an individual's actions or behaviors are influenced by others' previously observed actions and behaviors (Bandura, 1997). Interviews allowed participants to explain how these learned behaviors influence how they make decisions about the behaviors in which they engage, which directly relates to social cognitive theory (Bandura, 1997). They also provided a setting that was more conducive to addressing sensitive topics. The more time an interviewer spends with participants, the closer the conversation will get to revealing truth (Creswell, 2009). Additionally, interviews add a human dimension to impersonal data (Creswell, 2009). Interviews are facilitated by a researcher who meets with the participants to gain an understanding of their viewpoints, knowledge, and opinions related to what is being studied. Interview questions should be open-ended rather than close-ended. The open-ended questions should be used to seek information about the attributes and influences of the phenomenon under study (Creswell, 2009). The total number of participants is rarely more than a dozen people (Creswell, 2009). A qualitative approach also allows for the "study of individuals in the natural setting" (Creswell, 1998, p. 17). This approach was the most pertinent to the research questions for this study because it was essential that the adult stakeholders respond openly and honestly. This current study was intended to explore the nature of adults' perceptions of teen pregnancy based on the adults' lived

experiences, and the use of an interview format allowed me to create an environment in which adult educators and staff members shared their thoughts and perspectives.

Research Questions

The research questions for this study included the following:

1. How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?
2. What aspects of the program for the TPPP do the participants perceive as having been implemented well?
3. What aspects of the program for the TPPP do the participants perceive as needing to be improved?
4. What are best practices that can be identified from this case?

Context of the Study

The high school in this research study was located in a southern state. For the 2012-2013 school year, T High School enrolled a population of 1,200 students. The total population of the high school included approximately 166 staff members. Ninety-three percent of the students lived in households with an annual salary of $14,000 or less per year (Alliance for Excellent Education, 2010). The racial/ethnic demographics of the student population were as follows: 95% Black, 3% White, 1% Hispanic, and 0.2% Asian. The racial/ethnic demographics for the educators were 92% Black and 8% White. Seventy-nine percent of the educators were female, and 21% were male. The participants for this research study came from faculty and staff at T High School.

Ethical Protection of Participants

Walden University's Institutional Review Board (IRB) approval number for this study was 08-18-14-0119200, and it expires on August 17, 2015. I followed consent procedures established by the Human Subjects Protection Review Committee at Walden University. I complied with ethical guidelines established by Walden University's IRB when implementing my research study. I made every effort to protect the confidentiality of the adult participants and preserved their rights in this qualitative research study. I used one type of data collection involving human subjects, which was interviews (Appendix A). All educators received an invitation and informed consent form (Appendix C) through their school email. The first 12 school administrators and staff members to respond were chosen to participate in the research study. Although there may have been some participants who fell in a protected category (e.g., pregnant women), there was no need to control for such characteristics, as the risks for participating in this study were minimal and inclusion was initiated by the participants.

The informed consent form introduced me as the researcher, explained the purpose of the study, assured prospective participants that their identity was confidential, and described the benefits of participation. In addition, it provided my contact information and contact information for the IRB. The identity of all participants remained confidential. Although I knew who the participants were because of the nature of personal interviews and the need to be able to follow up with participants as necessary, I assigned pseudonyms to each participant to be used for all reporting of the data and findings. No one was required or obligated to participate in this research study, and

participants were advised that they could leave the study at any time, for any reason, without fear of consequence. I had no direct supervisory role in relation to the adults (faculty and staff) at T High School.

No personal information or identifiers linked to the participants or school site were disclosed. Confidentiality was maintained during the interviews. Participation in the interviews was strictly voluntary, and participants had the right to refuse to answer any questions. I did not use any information for any purposes outside of this research study. Also, I did not include participants' names or anything else that could identify participants in any report of the study.

I hoped the adult participants would answer the questions in the interviews honestly. There were no known risks associated with participation in this research study. The participants did not derive any tangible personal benefit from participating in the study, but they had the satisfaction of having contributed to the development of a needs and resource assessment that may assist researchers and educators in the development of effective programs to understand and prevent teenage pregnancy at this high school as well as other high schools in this state and beyond. A needs and resource assessment is a systematic gathering of information about the causes of teenage pregnancy. This step could help identify risk and protective factors that are associated with teenage pregnancy.

I was the only person to have access to the interview data. I stored hard copies and the external flash drive on which files were saved at my residence in a locked file cabinet. Information stored on my Macintosh laptop remains password protected. All information was printed onto a hard copy, as well as copied to an external flash drive. All

information will be subsequently erased from my flash drive after completion of the study. The information gathered from the interviews will be maintained for a minimum number of 5 years specified by Walden University after publication of manuscripts. At that point, I will shred all documents in my personal shredder in my home. Information contained on my flash drive will be deleted.

Role of the Researcher

I was a high school business education teacher with 10 years of total teaching experience and 6 years of professional teaching experience. I taught at the local school that was used as the site for this research study for 3 years. I had a positive relationship with most staff members, having worked with them in past group studies and faculty meetings. I did not directly supervise any staff members, and I did not have routine contact between staff members and myself.

I have always had a passion for helping with teenage pregnancy prevention and parenting programs. I noticed the number of expecting teenagers increasing on campus. There are numerous teenagers who are already mothers. In addition, several cases were reported of teenagers participating in risky behaviors on and off campus. On several occasions, as I was doing hall duty, I heard conversations of students who were impregnated after events such as prom, house parties, and other activities that teenagers use as opportunities to participate in risky behaviors. The campus newsletter reported that teenage pregnancy was one of several reasons teenagers drop out at T High School. My awareness of these issues prompted me to collaborate with other teachers and the nurse on campus about teenage pregnancy. I learned that previous sex education programs

taught at the high school were ineffective. At that time, T High School did not offer an evidence-based sex education program in the health classes. Additionally, I learned that no nonprofit organizations, faith-based organizations, or any other entities for high school teenagers were offering programs to combat the high rates of teenage pregnancy. Now, T High School is offering a research-based TPPP, and I investigated the staff and faculty members' perceptions of its implementation.

Criteria for Selecting Participants

Stakeholders are considered tangible human resources and have been identified in previous studies as key participants for planning, implementing, and evaluating components of a TPPP and its effectiveness. Teachers, health officials, community leaders, faith-based organizations, administrators of nonprofit organizations, school personnel, students, and parents have been identified as being among the key stakeholders in teenage pregnancy and prevention initiatives (CDC, 2008; Johns, Moncloa, & Gong, 2000). For this study, I focused on school administrators and staff. All school administrators and staff members at TS High School were eligible to participate in the study.

I used purposeful sampling to select the participants. Purposeful sampling consists of strategically selecting participants based on their ability to provide information needed to answer the research questions and address the purpose of the study (Creswell, 2003). I invited the school principal, the TPPP program director, the TPPP outreach coordinator, the TPPP program facilitator, the school nurse, and the health teacher to participate. Additionally, I made an open invitation to teachers at the school, asking them to

participate. From this call for participants, I selected seven teachers. Generally, I accepted participants in the order in which I received communication from them indicating their interest; however, I did decline some prospective participants' involvement as needed to accommodate the goal of having at least one teacher per grade level represented in this study. This approach to participant recruitment facilitated collecting data from a broad array of school administrators and staff members.

Data Collection

This research study was conducted in T High School only upon written authorization of the principal. The school system requires that those conducting research studies avoid undue effects on or interference with the daily operations of the school. The principal signed a letter of consent allowing the research to take place.

After I received IRB approval from Walden University, data collection began. I emphasized that participation was strictly voluntary and that there were no consequences for choosing not to participate. I provided a special video-recorded presentation in a faculty and staff meeting to offer prospective participants information about the study. The participants signed informed consent forms prior to participating in the interviews. They were notified that the interview process would be audio recorded and transcribed. The interviews took approximately 30-45 minutes.

I sent out the invitation and consent form by email to prospective school participants. Some prospective participants were identified based on the roles they played in the TPPP implementation. I had a set number of teacher slots, and once they were filled, I let additional teachers who responded know that the study had been populated

and informed them that I would put their names on a list of people to contact in case one of the original participants left the study. Beginning at the point when prospective participants began responding to my initial email, all of the communication with prospective participants was through private email, so there was no opportunity for stigma to be attached to either participating or declining participation. I sent out a second email to the participants asking them to let me know the date and time convenient to them for an interview. Interviews took place using one of the following techniques: telephone or computer-based video streaming such as FaceTime or Skype. Participants responded via email or by phone to indicate which interview technique was most comfortable and convenient for them for the interview. I anticipated being able to conduct the interviews with the school administrators and staff members within a 2-week period.

In addition to interviewing participants, I collected document-based data from the school principal. I requested copies of any information sent home to parents, provided to faculty and staff, and provided to students regarding the implementation of the program. I obtained items sent before, during, and after the program was presented at T High School. These documents contained data that supported or exemplified items discussed by participants. I requested curriculum documents. I received the parental consent letter and the handout sent to the parents about the program and a detailed timeline of when and how the facilitators would implement the curriculum in the health classes. Also, I received a copy of an overview of all modules from the *Making a Difference* curriculum. These printed materials allowed me to gain a better understanding of the program.

Instrumentation and Materials

The principal instrument in this research study was the interview protocol (Appendix A). The questions followed an interview guide approach to give focus to the areas and topics that I wanted to explore and investigate (Patton, 2002). Patton (2002) noted that interview guides are helpful for researchers and the participants. Using Patton's recommendation on interview guides, the final list of questions for the interview guide were open-ended questions that were directly tied to the research questions.

Data Analysis

The interviews were audio recorded using an Olympus digital recorder. I uploaded the interviews on my computer, made a back-up copy, and then used NVivo to play the recordings as I transcribed. The interviews were transcribed following each interview session. Hatch (2002) suggested transcription should take place right away to give the interviewer a sense of confidence in the data collection. This process reduced gaps in the data (Hatch, 2002). The transcription process involved listening to the digital audio recorder from the participant interviews and typing word-for-word using the Microsoft Office Suite Word 2010. Documents were saved in .rtf format. I recorded any overlaps and pauses. I typed each transcript, double-spacing, and retained a 2-inch left margin, in which I wrote codes and fieldnotes (Creswell, 2007). Checking for accuracy was conducted during interviews. During the interviews I restated information and then questioned the participant to ensure I understood responses correctly. Additionally, I provided a summary of the findings related to each interview for participants to review. The overall goal of this process was to provide authentic findings. This member check

provided the participants with an opportunity to review and react to my interpretations, and it served as a second check for accuracy. Participants submitted any other comments and suggestions via e-mail. The feedback from the member checks was incorporated into the final summary.

NVivo, a qualitative analysis program, was used for the data analysis process due to the large amount of data. Creswell (2007) explained NVivo aids in reviewing qualitative data. Creswell (2007) suggested this software is user friendly, storing the database and files together in a single file. One advantage of NVivo is the software "allows large amounts of information to be analyzed" and stored "according to the identified themes" (Morrissey & Higgs, 2006, p. 169). As the researcher, it was my responsibility to derive meaning from the data (Wong, 2008). According to Wong (2008), when using NVivo to code data, the researcher separates the raw data into categories. The process of coding uses "tags or labels for allocating identified themes or topics from the data compiled in the study" (p. 14-15). I used Creswell's (1998) coding process to analyze the transcripts and documents I imported into Nvivo.

After transcribing the interviews and typing the notes from my hand-written research journal, I saved them in an rtf format to import them to NiVivo. After my files were organized, I identified statements from the transcript by using open coding. I looked for key points made by the participants and I started to see dominant themes arise as participants' points overlapped. This process is called tagging, and identifies single ideas (Creswell, 1998). I tagged single ideas for each theme and created a category (or *node* in NVivo). I continued this process until I created nodes for each theme.

I scanned any documents provided by the school, unless they were provided in an electronic format. I used the optical character recognition function of my scanner to convert the scanned pages to text. I then coded the document-based data in the same manner as described above.

Validity and Reliability

Validity and reliability in this qualitative case study research took on different connotations than they do in quantitative research (Golafshani, 2003; Patton, 2002). Creswell (2007) recommended researchers should use at least two different strategies to check for accuracy in research findings. Strategies I used included clarifying bias and member checking.

I took field notes during the interview process and used it as an opportunity for bracketing any personal biases and creating an audit trail (Merriam, 2002). This journal created an ongoing record of my interaction with the participants and the data they generate. Another way I used clarifying for bias as a technique for checking accuracy was asking participants for clarification throughout the interview process, and asking them if I was understanding them correctly.

I used member checking to verify my findings were accurate. After I coded data for each respective participant, I provided a report that identified themes related to the responses and provided an overall summary of the participants' experiences. Participants were asked to review these documents and return them, along with information regarding any corrections to be made.

I used rich, thick description (Creswell, 2007). Verifying the information and ensuring thoroughness was important for showing the study was reliable and accurate (Shank, 2006). Thick, rich description provides a level of detail that the reader can use to compare the information taken from each source (Creswell, 2007) by highlighting the characteristics that the sources have in common. When information is consistent among the participants and throughout the study, the study can be considered reliable (Shank, 2006).

Summary

This section included discussion of how a qualitative case study was used to gather data. The methodology discussed allowed me to gather information related to the beliefs, perceptions, and attitudes about implementation of a teenage pregnancy prevention program from the adult. Other topics discussed in this section include protections of human subjects, setting and sample population, instrumentation and materials, data collection, role of the researcher, data analysis, validity and reliability, assumptions, limitations, scope, and delimitations.

Section 4: Results

Introduction

The purpose of this qualitative case study was to identify successful practices and areas for improvement in the implementation of a teenage pregnancy prevention program at T High School based on the perspectives of school administrators and staff members. The research questions addressed were the following:

1. How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?
2. What aspects of the program for the TPPP do the participants perceive as having been implemented well?
3. What aspects of the program for the TPPP do the participants perceive as needing to be improved?
4. What are best practices that can be identified from this case?

Presentation of Findings

Data Collection and Data Analysis

Data analysis consisted of a detailed process. The principal signed a letter of consent approving the research to take place at T High School. I collected the data from interviews and documents for this case study. The interview questions followed an interview guide approach to give focus to the areas and topics that I wanted to explore and investigate (Patton, 2002). The interview questions from the interview guide were open-ended questions that were directly tied to the research questions. I collected document-based data from the school principal. I requested copies of any information

sent home to parents, provided to faculty and staff, and provided to students regarding the implementation of the program. I obtained items sent before, during, and after the program was presented at T High School. I also requested curriculum documents. These printed materials allowed me to gain a better understanding of the *Making a Difference* TPPP.

To protect the quality of the collected data from the adult interviews, a strict protocol was followed. I made every effort to protect the confidentiality of the adult participants and preserve their rights in this qualitative research study. Each participant's data were saved under a separate file name and assigned a pseudonym to protect the participant's identity. I placed the interview data within each participant's folder, which contained the participant's name and demographics. Prior to data collection, I continued to keep in touch with the principal. I sent out the invitation and consent form by email to prospective school participants. I conducted the interviews with the school administrators and staff members within a 3-week time period. Participants responded via email to indicate which interview technique was most comfortable and convenient for them. Each participant had the option to select telephone or computer-based video streaming such as FaceTime or Skype. Ten participants chose telephone, and two participants chose FaceTime. Because I now live outside the United States and the time and financial costs would have been prohibitive, I did not conduct any face-to-face interviews.

The interviews were recorded and transcribed immediately after they were conducted. During the interviews, I thoroughly followed the interview guide and asked questions that pertained to each participant category. In an effort to make participants feel

comfortable, I spoke slowly and listened very closely to each participant, asking for further clarity when needed on some comments. I actively updated my journal during the interviewing process. All interview data and my research journal were transcribed using Microsoft Office Suite 2010 and saved as .rtf documents. Mills (2011) advised that transcripts be read repeatedly. I analyzed the documents and placed them in a folder. To become familiar with participants' individual transcripts, I read each transcript several times.

Rubin and Rubin (2005) emphasized that trustworthiness is ensured through member checking. Member checking was conducted during interviews. I restated information and then questioned the participants to ensure accuracy. I also provided a comprehensive report of findings related to each interview for participants to review via email. The overall goal of this process was to provide authentic findings. This member-check technique provided the participants with an opportunity to review and react to my interpretations, and it served as a second check for accuracy. Participants submitted any other comments and suggestions via e-mail. The feedback from the member checks was incorporated into the final summary. Three participants emailed me additional comments.

I used NVivo qualitative analysis software to be effective and efficient. The software facilitated ease in the coding process, and I finished data analysis within 2 weeks. I labeled each transcript with the respective participant's pseudonym and then copied and pasted the corresponding transcript in the file. After the files were organized using this method, I identified statements from the transcripts by using open coding. I looked for key points made by the participants, and I started to see dominant themes arise

as participants' points overlapped. I tagged single ideas for each theme and created nodes. Also, the principal emailed me the parental consent letter and the handout distributed to the parents, which contained a brief overview of the *Making a Difference* TPPP. I received an overview of a detailed description of all eight modules from the *Making a Difference* curriculum. In addition, I had first-hand experience with the curriculum when it was implemented at the middle school. I was able to review the actual curriculum in its entirety and other resources associated with the curriculum. The parental consent letter, the handout the school distributed to the parents, the detailed description of the curriculum, and my journal notes were uploaded into NVivo and then reviewed and analyzed for any emerging themes.

Interview Findings

During the interview process, participants exchanged perspectives, knowledge, and/or opinions on the implementation of a TPPP at T High School. The data were used to find common concepts among the adult participants and develop emergent themes. Table 6 provides background information on those who participated in the study.

Table 6

Adult Participants

Participant	Pseudonym	Faculty/Staff	Grade level	Gender
Participant 1	Alpha	Program coordinator	9^{th}-12^{th}	female
Participant 2	Beta	Program facilitator	9^{th}-12^{th}	female
Participant 3	Gamma	Principal	9^{th}-12^{th}	male
Participant 4	Delta	Teacher	9^{th}, 10^{th}, 11^{th}	female
Participant 5	Epsilon	Health teacher	9^{th}	female
Participant 6	Zeta	Teacher	9^{th}, 10^{th}, 12^{th}	female
Participant 7	Eta	Nurse	9^{th}-12^{th}	female
Participant 8	Theta	Teacher	9^{th}	female
Participant 9	Iota	Teacher	11^{th}, 12^{th}	male
Participant 10	Kappa	Teacher	12^{th}	male
Participant 11	Lambda	Teacher	9^{th}, 10^{th}, 11^{th}	female
Participant 12	Mu	Teacher	9^{th}	female

Research Question 1

Research Question 1 was "How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?" Four themes emerged pertaining to Question 1. The themes identified included *appropriate beginner sex education curriculum*, *promoted abstinence*, *served high-risk populations*, and *culturally sensitive staff*. The themes characterize the perceptions of the implementation of the teenage pregnancy prevention program. Table 7 illustrates the themes and subthemes for Research Question 1.

Table 7

Themes Related to TPPP Implementation

Themes	Subthemes
1. Appropriate beginner sex education program curriculum	Age-appropriate In-depth discussions Goal setting and dreams Evidence-based Role-playing Culturally relevant Program for male and female
2. Promoted abstinence	Decision making Refraining from sex Saying no to sex Waiting until marriage
3. Served high-risk populations	Low income Pregnant and parenting Poverty Single-parent homes
4. Culturally sensitive staff	Nonjudgmental Black females and males

Appropriate beginner sex education program. Overall, the teachers, nurse, coordinator, facilitator, and principal felt that the *Making a Difference* program was a good start for the high school as a newly implemented sex education program. According to feedback from study participants, the program had a positive effect on students' attitudes toward sexuality, STDs, HIV, and pregnancy. For example, many of the students shared testimonies with teachers about the misconceptions they had about contraceptives. The TPPP provided the students with correct information about STDs and risky behaviors. Some students were told by their parents that certain contraceptive methods could be used to prevent teenage pregnancy. However, Beta stated that three

students got pregnant due to incorrect information given by parents about contraceptives. The information in the curriculum was age appropriate, was culturally sensitive, and provided students with facts about STDs and pregnancy. Analysis of the *Making a Difference* curriculum showed that participants' perception of the curriculum mirrored what was actually contained in the curriculum. All eight modules had age-appropriate language to explain in detail the consequences of HIV, STDs, and pregnancy. The participants wanted sex education to evoke behavioral change in their students. Mu stated, "These students need to be educated on what's factual versus false beliefs about conception and contraception." The nurse stated that many students at the high school believe they can use the pullout method and not get pregnant. Lambda stated, "Many students feel if they engage in oral sex, this will protect them from STDs." Participants felt that the students were engaged in the discussions because they needed a place where they could openly discuss sexuality. The curriculum document review showed several age-appropriate questions to allow the students to express how they felt about their sexuality. The small-group settings separated by age and gender were highly effective, according to Mu. Mu stated,

> I think this program was a good starting sex education program for our kids here. It's an outlet for them to talk openly especially if they have no support at home. Its two-folded though because some parents don't feel school is the right place to talk about sex. Some people think that's not what the school should be discussing about with kids. But I see these kids every day and listen to them. They need this program to help educate them about the truth about sex and pregnancy.

The participants expressed excitement about the sex education program being evidence based. They felt that evidence-based programs could benefit the students more than programs that had no statistical data or no proven history of reducing STDs and pregnancy. Analysis of the curriculum documents showed that *Making a Difference* decreases sexual activity among teenagers for at period of at least 3 months after implementation of the curriculum. In addition, the participants said that *Making a Difference* had a positive effect on the students' attitudes and behaviors about the risks of unprotected sex and methods of avoiding unprotected sex. Many participants had discussions about their experience with the program. Their students expressed how they enjoyed the role playing. Participants indicated that their students took ownership in making better decisions when placed in peer-pressured situations in relationships. Participants expressed how students were asking questions to adults about sex and condoms. Students expressed to the teachers that the sex education was great because they talked to adults who listened. Curriculum documents supporting *Making a Difference* had scripted responses for the facilitators to use with the students.

Promoted abstinence. The majority of the participants felt that the students really needed to be exposed to the word *abstinence* and its full meaning. Module 2 in the curriculum addresses the advantages of practicing abstinence. This module provides detailed information about the advantages of practicing abstinence. For example, it indicates that one reason for remaining abstinent is religious doctrine. Other reasons include focusing on school, extracurricular activities, and educational goals. Also, Module 2 involves discussion of the reproductive anatomy of females and males. The

participants felt that many students did not realize that remaining abstinent is an option. Many students lived in homes where teenage pregnancy is a generational issue. Participants expressed how students felt that they were obligated to give in to sex and suffer the consequences later. Some students relied heavily on the welfare system as a back-up plan in case they did get pregnant. Gamma stated,

> We saw an increased number of freshmen being pregnant. We caught several students having sex in the bathrooms, behind the gym, or even on the bus. Many teens are all for sex, some teens' attitudes suggest they can live without it, and a few teens are willing to practice abstinence, which was a very small amount. The students weren't getting any education about sex and the hardships that come with teenage pregnancy. They weren't getting any information about STDs. We have a high number of STDs reported at our school. Our students don't realize how life-threatening STDs can be.

Theta and Iota said that they believed the sex education program provided many solid reasons to practice abstinence. They said that they believed society should promote the concept that marriage takes place before having babies. Participants said they felt that more information should be distributed to the students about practicing abstinence to reduce the number of STD cases on campus. Participants saw attitudes change when students realized that practicing abstinence is 100% effective. Alpha stated that *Making a Difference* was used in the district's middle school. Some of the language and examples used in the modules were modified for the middle school students. The results from the survey administered to the middle school students after the program indicated that 50%

of the students would recommend it to others as a beneficial program. Seventy-five percent of students who participated were more likely to be sexually abstinent. More than 97% said that they were abstaining or had put off having sex because they participated in the program. As a result, *Making a Difference* increased students' knowledge regarding teenage pregnancy, HIV, and STDs. Alpha stated that the students had a more positive attitude about abstinence.

Served high-risk populations. Participants expressed that *Making a Difference* catered to their high-risk students. The high school was awarded a grant for the entire student population to eat lunch for free. Many of the students come from low-income, single-parent homes. Participants expressed their feelings on how many students are dealing with adult issues. Students worry about how the light bill will be paid. Teachers expressed how some students would drop out of school just to work to make money. Epsilon stated that she had a student admit to selling drugs just to take care of his younger sibling. Epsilon also stated that some students brag about smoking marijuana with their uncles. Many of the students' mothers are in their late 30s or early 40s. Participants expressed how many parents smoke marijuana with their kids. Students cannot concentrate in school because of mental and physical abuse. Teachers and the nurse expressed that there is gang activity among the students, as well as discipline problems. There are girls who are joining gangs to feel as though they belong to an important cause. The principal said at the beginning of the school year that some students did not attend school because they had no uniforms or supplies (students normally wear uniforms at the school). Teachers said that the majority of the female students are

pregnant and parenting. The principal and teachers expressed that there are numerous fights stemming from social media. Iota stated, "Our Black boys need more work. They are seeking attention and thinking having sex or drugs will fix their problems." Many students are in the juvenile justice system for stealing, drugs, assault, and other related misdemeanor crimes. The program facilitator and teachers expressed how many of the teenage girls were dating older men.

Culturally sensitive staff. According to teachers, students told them it was important to have facilitators with the same ethnic background as the students. The students feel more comfortable with people who they perceive as having similar backgrounds. All of the facilitators were Black females. The student population consisted of 95% Black, 3% White and 1% Hispanic. Based on document analysis, the faculty and student body have a similar ethnic make-up. Mu stated, "Our kids have to know that you care about them and somehow students feel they can relate when it's their own [background]." The principal and teachers felt that the facilitators did not talk down to the students. The students felt comfortable when interacting with the facilitators. Some teachers believed this is why so many students enjoyed the role-playing. Regardless of their background, the students felt like they were a part of something that was meaningful to them.

Research Question 2

Research question 2 was, "What aspects of the program for the TPPP do the participants perceive as having been implemented well?" The themes identified are

utilizing health classes, using teaching strategies, modeling, and practice of communication. Table 8 illustrates the themes and subthemes for research question two.

Table 8

Themes Related to Positive Perceptions

Themes	Subthemes
1. Using health classes	State-mandated Appropriate class setting Separating males and females
2. Using teaching strategies	Informational handouts and presentations Visuals Group setting Hands on Engaging Gift cards
3. Modeling and practice of communication	Negotiation strategies Refusal skills

Using health classes. The principal, program coordinator and health teacher said the health classes were used to implement the *Making A Difference* curriculum. Health is already a state-mandated course students must take in school. The health teacher and nurse felt the sex education could really enhance the health classes. Epsilon saw a change in the attitudes and behaviors among the students in her class after the sex education program. Epsilon stated the students were hungry for more information about sex education. She stated the students really enjoyed the program. Some teenage mothers shared their stories about becoming pregnant and the hardships a person could have. The teachers felt the health classes were an appropriate setting for the students to continue to engage in conversations about STDs, HIV, and pregnancy. Beta stated:

> The program is great because we have a place to talk about sex or other personal questions. Each student was given a number to maintain confidentiality throughout the program. The school counselors and parent liaison held a parent meeting about *Making A Difference*.

Parents had the opportunity to preview the curriculum and participation was voluntary. Even if parents gave consent for their child to participate in the program, students still had the option to opt in or out of the program. Students were enrolled in the 8-hour program in which they discussed issues such as relationships, sexuality, and the consequences of sexual activity. It took one class period every day for 2.5 weeks. Curriculum documents showed that *Making A Difference* takes approximately 8 to 10 hours to complete. The curriculum consisted of eight modules, which were equivalent to 8 hours of instruction. The facilitators divided the eight modules into 60 minutes segments. The curriculum was designed to teach middle and high schools and focused on meeting the needs of several target audiences: Blacks, Hispanics and Whites.

Using teaching strategies. Participants expressed how the *Making A Difference* curriculum had so many educational tools for the students. The curriculum is designed to empower teenage students to make a difference in the way they make decisions about sex. The curriculum documents provided an educational perspective about how to prevent pregnancy, reduce the possibility of getting STDs and the benefits of practicing abstinence. Students received worksheets that featured vocabulary words and puzzles to complete in class for each module. Other handouts were distributed to the students as well with detailed information about STDs, HIV, and teenage pregnancy. Gamma stated

the program comprised more than just giving students numerous worksheets. The teenagers saw interesting videos and were given informational pamphlets. Some students kept a personal binder just for the information. Overall, the methods used in the curriculum were hands-on and engaged the students throughout the duration of the program.

Modeling and practice of communication. The program facilitator stated that the students were given the opportunity to build confidence with practicing abstinence in role-playing activities. Students had the opportunity to work in groups to build cohesiveness and play games that build skills and knowledge. The program coordinator said students really enjoyed interacting with other students instead of listening to lectures from the facilitators. The nurse stated, "Students have to get used to idea of choosing to practice abstinence." The nurse felt it is like speaking a new language to the students when discussing how to refrain from engaging in risky behaviors. The teachers said they felt the students had the opportunity to role-play when placed in challenging situations. The program facilitator, principal and teachers said students were much more aware of the pros and cons of teenage pregnancy after the program. Teachers said students seemed to be knowledgeable of what to do and not do when having sex, thanks to the opportunity to practice responding to negative situations. Eta stated, "Students need to hear themselves say 'no' to their peers when asked to have sex. The more students hear themselves saying it, the more they are apt to refrain from sexual activity." Mu stated, "We need to educate our students by continuously reinforcing abstinence daily." The curriculum provided the students an opportunity to overcome obstacles when they

encountered challenging situations where they had to make positive choices to prevent STDs and teenage pregnancy. Module three in the curriculum provided scenarios for students to practice decision-making skills.

Research Question 3

Research question 3 was, "What aspects of the program for the TPPP do the participants perceive as needing to be improved? The themes identified include increase teacher and parent buy-in, identify related risk and protective factors for high school, improve scheduling and extend length of program, need more male involvement, integrate life skills education, emphasize education, and high aspirations. Table 9 illustrates the themes and subthemes for research question 3.

Table 9

Themes Related to Areas for Improvement

Themes	Subthemes
1. Increase teacher and parent buy-in	Teacher information meeting Train teachers curriculum
2. Identify related risk and protective factors for highschool	Responsive to gender roles sexual sexual Ongoing generational problem Single-parent homes No outlets
3. Improve scheduling and extend length of program	Not enough students Absenteeism Extend length of program Suspension problems Disciplinary issues
4. Need more for male involvement	Male role models Male community facilitators
5. Emphasize education and high aspirations	Academic achievement Support high aspirations Employment opportunities

Increase teacher and parent buy-in. Teachers and the principal felt improvement were needed in getting teachers and parents involved more with the sex education program. Even though there was an informational meeting for the parents, the attendance was very low. Alpha stated, "The school should conduct several parent meetings to get the parents involved." The parental consent letter and handout sent home to the parents about the program, illustrated the school's commitment to support an approach that involved the parents in every aspect of the program. The principal and

teachers expressed how parental involvement is critical in a student's education. Participants expressed the amount of parental involvement is family-specific and the outcomes of the program depend on the family dynamics. The nurse and teachers felt that students who came from intact homes were more apt to do better compared to students who came from single-parent homes with less parental involvement. There should have been a faculty meeting about the sex education program. Alpha stated she would have been happy to attend the parent and faculty meetings to give presentations on the curriculum. Some teachers expressed that there should have even been others involved instead of just employees of the school and district. The principal and teachers stated there were a few parents who worked at the local universities that could have been guest speakers. Alpha stated,

> There needs to be greater buy-in from administration and making it work. For example, getting adequate classroom space. Involve parents more in the process, families. These teenagers need to be well supported in order to be successful. Include male partners to help facilitate the curriculums. A lot of literature we read relates to women; we need to see more images related to men. We need more images of men and having all-male support groups.

A number of the parents at the school were teenage parents themselves, and the students would have benefited from their testimonials.

Identify related risk and protective factors for high school. Participants expressed how the school, district, and organization could have done a better job conducting a needs and resource assessment specifically for the high school. Gamma

stated he was aware that an area needs assessment was conducted for both counties. Also, the district did a good job in surveying parents' views about implementing a sex education program. Gamma stated, "We need data on our kids alone." The nurse said they needed to know exactly what is making the students engage in unprotected sex and what they can do to help. Participants felt the students need more outlets in the community. Mu stated that she would like to see more pageants or talent shows for females and males. She stated that many of the students have so many talents such as singing, rapping and playing a variety of instruments. Mu stated that having pageants or talent shows would boost morale and promote self-confidence if given the opportunity to demonstrate his/her skill set. Teachers expressed that they feel families condone the students having babies because they had babies at a young age. Teachers said the program needed to integrate life skills education. Mu stated:

> To me they get out of school early; I think having sex was just something to do. Not engaged in other extracurricular activities. It's a pattern that they think its ok to have babies. A lot of our Black families have embraced that it's okay to have babies before marriage.

Many of the students engage in sexually risky behaviors outside of school hours. Participants felt that TPPPs needed to be extended in the community and churches so students would have a positive outlet outside of school. *Making A Difference* is designed to be implemented in schools, churches, and communities.

Improve scheduling and extend length of program. Participants expressed that scheduling needed to be improved. The *Making a Difference* curriculum suggests groups

should be small: 6-12 students. Many students were absent or suspended during the program, which made it difficult to carry out the instruction, because on some days there were not adequate students present within some groups. Sometimes the students were pulled from class for tutoring at various times. The facilitators had to reteach modules to students who were absent, which delayed the school from moving forward with implementing the program. Further complicating the situation, on some days, when multiple students were making up missed TPPP instruction, the classes exceeded the 12-student threshold.

Students were separated by gender for instruction. This is a Mississippi mandated policy that must be followed to prevent noncompliant issues with the Mississippi Department of Education. Also, the curriculum discusses female and male anatomy so students could ask questions about sensitive pertinent gender-based information. The principal and nurse stated they thought this was a good policy because students could feel uncomfortable if the classes were mixed with both genders.

Participants expressed that the sex education program needed to be extended along with additional educational resources.

Delta stated:

> I understand that the sex education program is only for a certain length of time but why not add on to the end of the sex education program by helping the students in other areas. These students need more than just a few weeks.

Teachers felt the students needed the program to meet more often to reiterate information and to follow-up with the students' attitudes and behavior. The program coordinator and

principal agreed with the teachers. They felt the program needed to be more than eight modules. All participants felt that more time was needed daily with the students to really make an impact on their lives. Expanding the program was considered a positive way to prevent teenage pregnancy. Although the dropout rate had improved significantly at school, the principal stated that many students still dropped out of school because of teenage pregnancy.

More male involvement. All of the facilitators were Black females. Both female and male students were able to relate to the facilitators, but some teachers felt male facilitators were needed to teach the classes as well. The nurse stated having male facilitators would have been advantageous to teach the male students because the classes were separated by gender. Teachers expressed the sex education program needed male community stakeholders involved. Gamma stated:

> We need strong men to help our boys dealing with sexual relations and STDs. Also, with everything going on in the media, we need to be culturally sensitive to really help our teenagers. These teenagers are living in such abuse, violence, and poverty.

Gamma noted more help is needed for discussing concerns men have regarding dating and suggested creating a program of peer ambassadors. Gamma said, "We need a village to make these programs work!" Teachers expressed a need to reach out to low-income apartments to educate/inform male teenagers about abstinence. Participants said they felt more men from all ethnic backgrounds were needed to help with educating male teenagers to really make a connection with the male students in the TPPP.

Emphasize education and high aspirations. Teachers expressed how they whole-heartedly believe academic success begins at home. Due to the high-risk population of students at the high school, participants felt the sex education can fill in the missing gaps or lack of parental support. The principal and teachers expressed how many students do not have anybody other than the teachers pushing them to their maximum academic potential. The students at the high school need structure. Teachers and the nurse felt another area of improvement for the *Making A Difference* program would be more dialogue about refraining from having children before marriage. The principal stated, "Encourage high morals, standards and expectations." Three teachers suggested that students needed to be empowered to have more self-esteem, self-confidence and self-motivation. Participants felt that students needed more encouragement from socializing with positive students with high standards. The curriculum discusses self-efficacy and achieving high aspirations in all eight modules. The principal and teachers felt they could do more in promoting self-efficacy and achieving high academics as well. Participants felt promoting these two items would allow students to make better decisions about their own education and extracurricular activities. Participants had many ideas about building self-efficacy and self-esteem among the students by having more activities during school hours. To build morale, the principal suggested having an "Abstinence Day Party" at the high school at which fathers give bracelets to daughters. The teachers and program facilitator stated that promoting positive messages through media about academic achievement and staying abstinent could be helpful in preventing teenage pregnancy. Other ideas included celebrities or reality stars speaking to teenagers to motivate them to

accomplish their dreams and continue their education. In order to motivate students to their highest potential to empower students, Gamma stated,

> We need to develop after school programs and utilize local faith-based entities to implement TPPPs. Link the *Making A Difference* program to dances on weekends (find ways to incorporate question and answer about abstinence, provide positive outlets for the students). We need to include everyone in the intervention. We must start educating these kids at an earlier age. The community stakeholders need to volunteer—speaking in classes time at schools—and try to plant seeds to make a difference.

Another way to promote self-efficacy, according to the teachers, would include having small group discussion sessions (separated by gender and age) weekly in the homeroom classes. Teachers felt that students needed mentors and life coaches to help reach their educational goals and aspirations in life outside of school.

Research Question 4

Research question 4 was, "What are best practices that can be identified from this case?" The themes identified are *implementing evidence-based TPPP with fidelity, community buy-in and awareness*, and *access to reproductive health care*. Table 10 illustrates the themes and subthemes for research question four.

Table 10

Themes Related to Best Practices

Themes	Subthemes
1. Implementing evidence-based TPPP with fidelity	Teach the curriculum Make no changes
2. Community buy-in and awareness	Needs and resource assessment Conducting pilot program ongoing evaluation
3. Access to reproductive health services	Access to screenings Clinics Contraceptives

Implementing evidence-based TPPP with fidelity. Participants expressed that *Making A Difference* was a successful sex education program because much planning took place. Alpha stated, "My organization was awarded a 5-year Federal program on September 30, 2010 by the Teenage Pregnancy Prevention Initiative." The biggest task was hiring staff, budgeting, and then planning. A major university in the area was chosen as the program evaluator. Alpha stated, "Once that took place, we selected the *Making A Difference* program that was approved by the state as well." The organization chose the *Making a Difference* curriculum because the TPPP assists teenagers in the delay of sexual activity; reduces the risk of STDs; and includes uses a variety of modes for conveying information. The nonprofit organization proposed to serve youth in school districts, as well as faith-based and community-based organizations. The *Making a Difference* curriculum was designed to be carried out in two counties beginning Fall 2011. Alpha stated, "My main job was to oversee all functions of the program including training and

management of staff, ensuring goals and objectives of curriculum were met. Also, to ensure sufficient data was collected." The organization had several meetings with staff to discuss program implementation and assessment. Obstacles and barriers to program success were discussed. Alpha stated, "We were concerned about the sensitive objectives in the curriculum. We were concerned about student absenteeism, illness, school issues and weather. Many conversations took place how to reach more students. We conducted an area needs assessment in both counties and a pilot program was conducted."

Community buy-in and awareness. Prior to implementing the TPPP, a focus group meeting was held with the community and educators to inform them about the grant, as well as to get other perspectives on teenage pregnancy in the community. The focus group consisted of the following: teachers, principals, parents, preachers, doctors, lawyers, and even college students. Alpha stated, "We also had a teenage pregnancy coalition and council meetings held with community stakeholders. In addition, we had a girls conference called, "A Girls Matter Conference" which focused on issues related to wellness and self-esteem." Alpha stated that a coalition or council of key community stakeholders and community members in both counties was established. The purpose of the council was to inform and collaborate with the communities that serve the teenagers who participated in the TPPP and their families. The coalition was to increase the community's investment in the sex education program and other health-related issues. Teen representatives from each county, age group, and gender were invited to participate when possible (school personnel selected teens). Alpha said, "These teens are our ears to how this issue impacts them directly and can provide additional information on how to

effectively encourage teenagers to make positive choices as it related to sexual activity." Stakeholders were identified as individuals who were already interested and involved in making a difference in the life of young people, and who could bring additional resources that complement the needs of the TPPP.

Access to reproductive health services. The program coordinator suggested that one of the program strengths is providing students with free healthcare as an incentive. She stated that her nonprofit organization has partnered with the Health Department to provide services to the students in the program with top priority. Teachers expressed that they appreciated knowing free health care screening and treatment are available to teenagers at the high school in the program. The nonprofit organization has an on- and off-campus clinic for student visits and clinics throughout the community if they need it. Female students in the program have access to annual check-ups by professional doctors and nurse practitioners. There is no cost to students for medical care if needed. In addition, all students in the program have access to the local Health Department and can receive services for pregnancy tests, protective methods, and HIV/STD tests. The Health Department and high school both have a parenting program for females for those students in the program that are parents. Several nonprofit clinics on and off campus offer free health screenings, free pregnancy tests, and free protective methods to the students in the program.

Summary

This chapter provided the results of 12 interviews related to adult perceptions of the implementation of a teenage pregnancy prevention program. Qualitative analysis

methods were used to identify themes and subthemes. These were summarized and arranged according to the research questions for this doctoral study. In general, the interviews revealed the participants agreed the *Making A Difference* program affected the students' attitudes and behaviors about STDs, HIV, and pregnancy. The curriculum empowered the students to make informed decisions regarding their sexual health and promoted abstinence. Research Question 1: How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?

For research question 1, the focus was to reveal how the participants perceived the implementation of the teenage pregnancy prevention program. Overall, the principal and teachers felt *Making A Difference* was a good curriculum for the high school. They expressed their excitement to implement the program. All the participants wanted to encourage all students to refrain from sex and practice abstinence. They wanted the students to achieve high goals in order to be productive citizens with the community. The content was age-appropriate, promoted abstinence, and served high-risk populations. Many of the participants had very positive comments about the program. The participants were satisfied in knowing that the TPPP was evidence-based. Participants expressed their thoughts about how the TPPP impacted the teenager's attitudes and behavior about sex.

Research Question 2: What aspects of the program for the TPPP do the participants perceive as having been implemented well?

The principal, nurse and teachers expressed the TPPP was age-appropriate and culturally relevant. Implementing the TPPP in health classes was a great beginning. The

principal perceived the instructional materials as being very effective. The principal thought the TPPP and facilitators engaged the students and saw a difference in students' attitudes and behaviors towards teenage pregnancy, HIV, and STDs.

Research Question 3: What aspects of the program for the TPPP do the participants perceive as needing to be improved?

The program coordinator, program facilitator, principal and teachers discussed a number of barriers. Scheduling was a prominent concern because many students were absent, pulled out for tutoring, and suspended from school. The participants felt the TPPP was too short and needed to be extended. They wanted to see topics discussed such as students having high aspirations and setting goals. Teachers wanted to see more male role models involved with the program and wanted to develop male support groups that could assist males in staying away from drugs. The program coordinator and principal wanted to see more teachers and parents involved with the TPPP. The principal expressed how students should not have the option to opt out after parents already consented for their children to participate in the TPPP.

Research Question 4: What are best practices that can be identified from this case?

After reviewing the information distributed to the parents about the program and listening to responses from the interviews, identifying best practices from the program implementation was easy. Best practices include conducting a needs and resource assessment and providing access to health care after the program. The nonprofit organization made an effort to involve the community in implementing the *Making a*

Difference TPPP. The coalitions that were established allowed additional stakeholders from the community to discuss barriers and resolutions about the curriculum prior to the implementation of the TPPP. All participants provided positive feedback about *Making A Difference* positively impacting students.

Section 5: Discussion, Conclusions, and Recommendations

Introduction

This section includes a concise synopsis of the doctoral study and the findings. The research questions, findings, and an interpretation of the findings are discussed. Implications for social change and recommendations for further study are presented as well.

Summary of the Study

The purpose of this study was to identify successful practices and areas for improvement in the implementation of a teenage pregnancy prevention program at T High School based on the perspectives of adult stakeholders. A qualitative case study approach was used to gather information from one program coordinator, one program facilitator, one principal, one nurse, and eight teachers, including the health teacher. Interviews were conducted with administrators and staff members at a public high school in Mississippi. Findings revealed that, in general, participants perceived the program as positive as it relates to STDs, HIV, and teenage pregnancy prevention.

These research questions were used to provide an understanding of adults' perceptions of the implementation of a teenage pregnancy prevention program.

1. How do school administrators and staff members perceive the implementation of a teenage pregnancy prevention program at T High School?
2. What aspects of the program for the TPPP do the participants perceive as having been implemented well?

3. What aspects of the program for the TPPP do the participants perceive as needing to be improved?
4. What are best practices that can be identified from this case?

Interpretation of Findings

This study was an attempt to illuminate the nature of the perceptions of school administrators and staff members regarding the implementation of a teenage pregnancy prevention program. Bandura's social cognitive theory was the conceptual framework, as discussed in the literature review. Past research had explored the content of teenage pregnancy programs, but there was a gap in the literature as it related to the perceptions of evidence-based teenage pregnancy prevention programs in high schools.

For Research Question 1, administrators and staff members were asked about the overall TPPP implementation process. Overall, the study findings revealed that the adult stakeholders believed that the TPPP had a positive impact on the students. The patterns of findings indicated that the TPPP had a substantial effect in increasing the knowledge of students about STDs and promoting self-efficacy and abstinence. According to research, evidence-based TPPPs are known to change risk-taking behavior in high school students (Lamb et al., 2013). The program coordinator selected the *Making a Difference* curriculum because the TPPP was one of the evaluated TPPPs that were identified as capable of changing sexual behaviors (Jemmott et al., 1998). *Making a Difference* is an evidence-based theoretical framework based on three theories, which include Bandura's social cognitive theory (Jemmott et al., 1998). The repeating ideas and emerging themes in this study speak to Bandura's social cognitive theory. According to Bandura (1977,

1988), a relationship exists between behavior and the environment. Bandura suggested that it is an individual's beliefs that control actions and thoughts and ultimately affect behavior. Participants from all groups indicated that the primary benefit of the TPPP was that it provided the students with an opportunity to learn about key information in a social context. Additionally, participants indicated that learning about the information presented in the curriculum in the presence of their peer group helped students feel empowered to make appropriate decisions to prevent teenage pregnancy and STDs.

Successful TPPPs rely on appropriate motivation and training, as well as encouragement from program administrators and educators. A barrier to successful implementation of TPPPs consists of educators' abilities in implementing and sustaining science-based programs (Robin et al., 2004). Participants in the study indicated that students felt more confident in their ability to prevent pregnancy and STDs. Findings from the interviews from all stakeholders revealed that the program helped the students have a positive outlook about abstaining from sex and the benefits of doing so. The interviews provided clear information about the overall implementation process. The administrators and teachers shared similar viewpoints. They all agreed that a TPPP was needed at the high school. All stakeholders were eager to know that the curriculum used was proven to decrease STDs and teenage pregnancy. The administrators at the school viewed the program as having been very instrumental in helping the students achieve higher educational goals, increasing morale, and improving the overall high school dropout rate. The literature review suggested that evidence-based TPPPs are grounded in theory. Evidence-based TPPPs provide classroom settings in which students can discuss

teenage pregnancy and related issues in a manner that is appropriate for their age and culture (Kirby, 2007).

Further, findings showed that all stakeholders viewed teachers as being among the most important factors in making the program positive. These findings support the assertion of McNabb (2010) that public schools can play a key role in meeting the need for providing TPPPs. To get complete buy-in from the teachers, the logistics of the implementation process were discussed in several meetings that focused on involving the teachers in continuing the sex education discussion in the classrooms. Teacher buy-in occurs when administrators have open communication with teachers and collaborate with them about the TPPP. All stakeholders agreed that the teachers needed more training about the program so that they would be completely knowledgeable about the content of the program. Ultimately, the teachers would have the greatest effect on perceptions of students regarding the TPPP because they teach the students on a daily basis. The teachers are very instrumental in shaping student opinion about academic success and goal setting. Teachers who set high standards promote and create a classroom environment that encourages students to imitate the teacher's behavior (Bandura, 1997). Among the positive responses, the principal thought the program would assist students with making better decisions when they contemplated participating in risky behaviors. The *Making a Difference* TPPP has been proven in evaluation studies to reduce teenage pregnancy (CDC, 2008).

Culturally sensitive staff was a repeated theme shared among the principal and teachers. Ninety-five percent of the students at T High School are Black. Ninety-two

percent of all faculty and staff at the high school are Black. Statistics for adult participants were as follows: 17% White, 83% Black, 25% male, and 75% female. Jemmott et al. (1998) indicated in a study that *Making a Difference* reduced risky behaviors among Black teenagers. All teachers, including the health teacher, provided positive responses about the *Making a Difference* curriculum and its ability to positively affect the high school students. The program coordinator and facilitator had very similar views about the program being relatable and relevant to the students. All the teachers thought that the curriculum was easy to understand and appropriate to serve the high-risk students in the program. Only two teachers had mixed views about the appropriateness of the curriculum compared to six teachers who believed that the program curriculum was appropriate to the age group. The two teachers thought that the content in the curriculum needed to be stronger in terms of showing visual pictures of STDs to make a stronger impact on the students. The two teachers thought that the students needed to hear real-life testimonies of students who were teenage parents. The findings revealed a literacy gap between Black boys and girls. Many of the boys had questions about the content in the program and needed a deeper explanation, whereas the girls were able to comprehend the information. Two teachers provided responses about the reading literacy at the high school. Many of the Black boys were reading on an elementary level or could not read at all.

For Research Question 2, the administrators and staff members were asked what part of the TPPP was implemented well. Responses included inserting the TPPP in the health classes, curriculum content, and using role playing. These responses indicated that

there was a cultural fit for this TPPP at the high school (CDC, 2008). TPPPs that have a cultural fit are most successful in preventing teenage pregnancy, which would indicate that *Making a Difference* had a positive influence on sexual behaviors of students. This TPPP has been successful in reducing rates of teenage pregnancy, STDs, and HIV (Vivancos et al., 2013). The program coordinator, program facilitator, and principal agreed with giving gift cards as an incentive to participate in the TPPP. However, teachers disagreed with giving gift cards to the students because some of the students only participated to get the gift card. Getting the gift card became the focus for the students rather than learning the content of the TPPP.

For Research Question 3, the administrators and staff members were asked about what aspects of the programs needed to be improved. All adult stakeholders agreed that parents needed to be more involved with the program. Administrators felt that parents needed to be aware of the implementation of the TPPP at the high school, and findings revealed that the teachers felt that there needed to be increased communication with parents about contraception, abstinence, and STDs. According to Bandura (1977), the higher their self-efficacy, the more likely teachers will be to engage in behaviors leading to a goal. Because the teachers valued parental involvement, they may have had a higher desire to include parental involvement practices in implementing the TPPP. However, all of the teachers indicated that they felt inadequately trained to communicate with parents about the TPPP, which means self-efficacy may be a barrier to encouraging parent involvement. Flynn (2007) stated that teachers need to be trained properly in teacher educator programs to work with families. Administrators identified that scheduling and

time constraints needed to be improved. The main barriers reported were lack of time and scheduling conflicts impeding the identification of appropriate classrooms to accommodate the delivery of curricular activities. This is consistent with other research that has shown that these barriers may adversely affect program implementation (CDC, 2008). In order to minimize these potential barriers, the program coordinator and facilitator should be cognizant, understanding, and accommodating of the school's schedule and agenda.

For Research Question 4, participants were asked about what they considered as best practices. The common theme shared among all the participants was that using an evidence-based TPPP to combat teenage pregnancy was effective in reducing teenage pregnancy. The nurse also indicated that an evidence-based TPPP was effective in addressing prevention of future STD/HIV cases. Without contraception, there is a 90% chance of pregnancy within a year for sexually active teenagers (Santelli & Melnikas, 2010). The TPPP modules teach that abstinence is 100% effective in preventing teenage pregnancy and STDs/HIV. *Making a Difference* can be provided to teenagers, their families, and the communitiy to decrease the rates of teenage pregnancy. Research has suggested that these programs are promising programs that change sexual risky behaviors in teenagers (Ventura & Hamilton, 2011). At the same time, consistent and correct use of condoms is encouraged among sexually active teenagers.The TPPP was modified to meet the needs of the students at the high school and to make the TPPP a good fit for the students; however, the program coordinator and facilitators used fidelity when implementing the TPPP by ensuring that all the core components of the TPPP were

included. The TPPP fit the students' language, beliefs, and customs. The students felt that they could open up with the facilitators about sensitive topics in the curriculum.

Implications of Social Change

This doctoral study may allow stakeholders to better understand school administrator and staff member perceptions of the implementation of a TPPP. Understanding what went well and what could be improved from this TPPP implementation may aid other school districts seeking to implement the same program or one like it. The school district in this study can use the model and the data to continue to evaluate the program and to improve the quality of instruction students receive. This improvement may affect students at the high school by increasing their knowledge of ways to make positive decisions about sexual behaviors and improve self-efficacy, ultimately reducing teenage pregnancy. Also, the surrounding high schools in the city, county, and state and school districts within other states can identify, select, and adapt an evidence-based TPPP to combat teenage pregnancy and use findings from this study to inform their implementation process.

Research literature suggests that teenage pregnancy is a societal issue and that social stigma is attached to it in the United States as well as in other industrialized and developing countries (Tolman & McClelland, 2011). Teenage pregnancy is associated with many risk factors. Cultural and economic barriers, limited access to sex education programs, limited access to health care, and limited access to teenage pregnancy prevention programs are all factors that influence the teenage pregnancy rates in the United States (Jerman & Constantine, 2010). These factors also affect or influence

teenagers' decisions to become sexually active and influence their perceptions about other lifestyle issues such as contraception use (Kost, Henshaw, & Carlin, 2010). Ultimately, this study may help other schools successfully implement TPPPs, and it may help reduce the problem of teenage pregnancy.

Recommendations for Implementation of TPPP

The following recommendations should be considered based on interpretation of the findings from all participants in the study. The program planners should coordinate with the high school to increase teacher and parental awareness about the potential evidence-based TPPP prior to implementation. Professional development sessions should be conducted to train teachers on the evidence-based TPPP. Providing teachers the opportunity to be trained on the evidence-based TPPP will equip them to be more knowledgeable and better able to discuss with the students key components of the curriculum. The Mississippi Department of Education should support the school district in identifiying other evidence-based TPPPs to fit the full needs of the students at the high school. The interpretation of findings supported recommendations to provide the female and male students with more resources such as follow-up care and peer support groups. Program planners and the high school should monitor the receptiveness of students. Differentiated instruction should be used to engage students who appear unchallenged by the TPPP.

Recommendations for Further Research

Having reflected on this study, I have formulated several recommendations for further research based on the findings. My first recommendation is to interview more

stakeholders (parents and students). Due to time and financial constraints, I was only able to interview teachers; however, there is limited research about students' perceptions on the implementation of TPPPs, and it would be beneficial to have students report their reactions to the TPPP first hand, rather than to rely on teachers' reports of student reactions. Parents could also supply useful data in evaluating TPPP implementation, as parental perception can be a roadblock for TPPP implementation, and understanding how parents feel about the implementation of the program might help the district ensure parental support of continued implementation.

Some of the participants talked about attitudes of Black men and women toward premarital sex. Their perception was that current attitudes encourage premarital sex and lead to teenage pregnancy. More research needs to be done on this topic to better understand these attitudes and to identify ways that TPPPs might support changes in attitude that would reduce the likelihood of teenage pregnancy.

Some participants indicated that social media and reality TV related to teenage pregnancy are glamorizing teenage pregnancy and may contribute to its prevalence. More research is needed to better understand the nature of messages regarding teenage sexuality and pregnancy conveyed through these media. Also, research is needed to understand how these media might affect choices teenagers make regarding sexual activity and pregnancy prevention.

Though the TPPP in this study was implemented as part of school curriculum, other individuals in addition to educators have potential to shape teenagers' attitudes about sexual activity and pregnancy prevention. More information is needed regarding

the role of parents and community members in teenage pregnancy prevention. Research concerning generational and cultural differences in parent-child communication related to this topic is needed.

Reflections on Researcher's Experience

As a teenage pregnancy prevention practitioner, I am dedicated to the cause of helping others in the field of teenage pregnancy. My experience as an education practitioner for 10 years and teenage pregnancy prevention practitioner for more than 7 has been very rewarding. I have always sought ways to improve my teaching abilities and work with many teenage pregnancy programs in my community. I am always finding ways to be innovative with all of my students and I want to continue to add to the growing body of knowledge in the field of education and teenage pregnancy. Scholarship is important for a student in the field of educational leadership. The scholarship in the field of teenage pregnancy has brought many challenges, but has been very rewarding for me. Scholarship was a mental and physical process for me that occurred in stages through my studies. First, scholarship taught me to be an investigator and establish goals. I attended many teen pregnancy seminars and symposiums throughout the various stages of the process to gain a deeper understanding of the teenage pregnancy issue. I asked probing questions and established goals on how I wanted to approach the issue of teenage pregnancy. I realized that teenage pregnancy affects many cultures and ethnicities, and race and socio-economic background are factors that contribute to the likelihood a teen will become pregnant. Through this investigation, I realized that teenagers in the 21st

century differ from their predecessors, and some of these differences create challenges in terms of preventing teen pregnancy.

Second, scholarship has taught me to prepare for the investigation through literature searches and other forms of background searches. I spent many nights reading journal articles and searching for literature. I searched through Walden University's database, my local library, and two major universities' libraries. I continually read articles on teenage pregnancy in my local newspaper and even in the state capital's newspaper as well. I was constantly reading and organizing my data to reach my goals.

Third, I gained knowledge on how to select methods of inquiry appropriate to the discipline and the circumstances. I had to learn to filter and purge out information so I could narrow to what was appropriate to reach my goals. Again, it required me to read and organize information that was critical to my field of study in scholarship.

Last, I gathered data in such a manner as to provide significant results, to present results publicly, and to receive colleague review and critique so others can build on my work. After going through the steps discussed above, I finally developed the skills to rigorously investigate and collect data that lead to discovering many theoretical models and science-based approaches to effectively decrease teenage pregnancy.

Conclusion

The findings of this doctoral study revealed adults' perceptions of a teenage pregnancy prevention program. This study showed the evidence-based TPPP was successfully implemented at T High School and offered some suggestions for improving implementation for the future. This study showed that there is a need to adapt TPPPs to

the population being served. From the findings it can be concluded that if more teachers, parents, and additional community stakeholders were involved, the positive outcome for students might be enhanced.

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Appendix A: Interview Guide and Questions

Date:

Time:

Your participation in this interview is greatly appreciated! All participants will receive an assigned pseudonym and I will write down demographic information for each participant associated with the assigned pseudonym. All participants will be identified by their pseudonym during the interview sessions. No personal information or identifiers linked to the participants or school site will be disclosed. Please remember that there are no right or wrong answers to any of these questions. It is important to be honest, but please realize that you don't have to say anything about yourself that makes you feel uncomfortable. Confidentiality will be maintained during the interviews. There is no negative consequence if you choose to be dismissed or withdraw from the interview process without preconceived judgment or opinion. If you experience anxiety or stress during the interview, you can terminate your participation at any time. Participation in the interviews is strictly voluntary and participants have the right to refuse to answer any question at any time.

The interviews should last about 30-45 minutes and will be digital audio recorded and then transcribed. I will ask you some brief demographical information and then ask you questions pertaining to the teenage pregnancy prevention program at T High School. You will receive a report with your pseudonym profile to add, clarify or refute any statements. You can email me any additional comments you have about the interviews.

Do you have any questions? Let's begin. (I will ask questions below as they relate to the participant's role at the school).

Program Director and Outreach Coordinator

- Describe the overall implementation process. When was the program started? How long did it take to fully implement? What factors affected the length of the implementation process?
- What aspects of the implementation were most successful? Explain why each item identified was successful?
- What barriers where there to implementation? How were those barriers overcome?
- If you were to do the implementation over again, what would you do differently? Why? How would you change the process or procedure?
- Describe the curriculum. Why was this particular curriculum chosen? Where there any barriers to choosing this curriculum? Were there other curriculum options considered but rejected? If so, why were these programs not chosen?
- Who has benefitted most from this program? Who has benefitted the least? What factors might have lead to any disparity in benefit? What could be done to improve the benefits of the program?
- How are students responding to the program? In your opinions, what have they found helpful about the program? What about the program do they find least helpful? What elements do they wish were in the program but are not?

Program Facilitators

- How have students responded to the program? How engaged are they in the instruction? When do they seem most engaged? Least engaged? What could be done to help students be more engaged in the program?
- What parts of the curriculum have been the easiest to implement? Most challenging?
- In what ways have you seen students' attitudes about teenage pregnancy and sexual behaviors change in response to the program?
- What additions or enhancements to the program would be helpful? What need would these changes fill? Why would they be helpful?

Principal

- Describe students' attitudes about teenage pregnancy before implementation of the program. Describe students' attitudes about teenage pregnancy since implementation of the program?
- What aspects of implementing the TPPP have gone most smoothly? What aspects of the implementation could be improved?
- How successful is the TPPP based on your observations? What would you do to improve the effectiveness of the TPPP?
- Describe the feedback you have received from various stakeholder groups: students, parents, faculty and staff. What does each group seem to like least and most about the program?

Health Teacher, School Nurse, Other Teachers

- How do you feel about the implementation of the TPPP? What about the implementation has gone well? What could be improved?
- In what ways have you seen students' attitudes and behaviors regarding teenage pregnancy and sexuality have changed in light of the TPPP? What aspects of student attitudes and behaviors in this regard have not changed?
- Based on what students have said, behaviors you have observed, and attitudes you have noticed how effective is the program?
- What aspects of the program do you perceive to be most effective and/or engaging for students? What aspects of the program do you perceive to be least effective and/or needing improvement?
- Do you perceive that students have been more or less apt to inquire about issues related to teenage sexuality since the implementation of the program? What do you believe has contributed to these behaviors?

Appendix B: Invitation to Participate

Dear Participant:

This email serves as an invitation for you to participate in an interview. Your responses will be helpful in possibly addressing the implementation of an evidence-based teenage pregnancy program that will fit the high school teenagers and project planning. I am writing this email as a request for assistance from you as I complete my Ed.D. in Administrative Leadership through Walden University. The interviews is strictly voluntary. If you decide to participate, please print and sign the consent form or electronically sign the consent form to be forwarded to me. You will receive another email with a time frame for me to conduct the interview outside the school. At that time, you can indicate how you want me to interview using one of the following techniques: telephone or computer-based video streaming, such as FaceTime or Skype. The interviews will take approximately 30-45 minutes. The information you provide will be kept confidential and will not be shared with any members outside this research study. The interviews will be audio recorded and transcribed and I will email you a report with your assigned pseudonym to clarify, add or refute any statements you made. The information will be used to implement, evaluate and sustain an evidence-based teenage pregnancy prevention program at TS high school.

Educationally Yours,

Sharon L. McConnell-Smith, MBA

Faculty Mentor:

Katherine Norman, PhD

Appendix C: Adult Consent Form

My name is Sharon L. McConnell-Smith and I am a doctoral student at Walden University. I am a former co-worker; however, I no longer work at the high school. You are invited to take part in a doctoral research study to participate in the interviews because you are an educator at TS High School. I am inviting you to participate in the interviews that deals with teenage pregnancy at the high school used in this research study.

Background Information:
The purpose of this study is to access school administrator and staff member perceptions of the implementation of a teenage pregnancy prevention program. Your responses will be helpful in possibly identifying an evidence-based teenage pregnancy program that will fit the high school teenagers and project planning.

Procedures:
If you choose to participate, please print and sign or electronically sign this consent form and forward it to me. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part and to inform you of your rights as a participant. My personal contact information is below. I will contact you via email to set up a time frame and interview method that is comfortable and convenient for you. Interviews will take place either by phone, computer-based video streaming, such as FaceTime or Skype call. The interviews will take approximately 30 to 45 minutes to complete. The interviews will consist of brief demographical questions and open-ended questions. Your candid and honest response to questions will be appreciated. The interviews will be audio recorded. After the interview, I will transcribe our conversation. If I have any follow-up questions, I will contact you. Any subsequent contact, if needed, should not take more than 5 minutes. After I have completed all interviews, I will send you a summary of my findings to review and to provide feedback as appropriate. Your review and feedback should take approximately 30 minutes or fewer.

Voluntary Nature of the Study:
No personal information or identifiers linked to the participants or school site will be disclosed. Confidentiality will be maintained during the interviews. You will be assigned a pseudonym for the purposes of the research study and interviews. Participation in the interviews are strictly voluntary and participants have the right to refuse to answer any question at any time or to end their participation.

Risks and Benefits of Being in the Study:
There are no known risks associated with participation in this research study. You may not derive any personal benefit from participating in the study, but you will have the satisfaction of having contributed to the development of a needs and resource assessment that may assist researchers and educators in the development of effective programs to

understand and prevent teenage pregnancy at this high school as well as other high schools in this state and beyond.

Compensation:
There will be no compensation for being in the study.

Confidentiality:
Any information you provide will be kept anonymous and confidential. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in any reports of the study.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via telephone [redacted] and email [redacted] or [redacted]. My home address is [redacted]. My chairperson name is Dr. Katherine Norman and her email address is [redacted]. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 3121210. Walden University's approval number for this study is 08-18-14-0119200 and it expires on August 17, 2015. The researcher will give you a copy of this form to keep.

Statement of Consent:
I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Written or Electronic* Signature _____

Researcher's Written or Electronic* Signature _____

Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

Appendix D: Confidentiality Agreement

Name of Signer: Sharon L. McConnell-Smith

During the course of my activity in collecting data for this research: "School Administrator and Staff Member Perceptions of a Teenage Pregnancy Prevention Program." I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

- I will not disclose or discuss any confidential information with others, including friends or family.
- I will not in any way divulge, copy, release, sell, loan, alter, or destroy any confidential information except as properly authorized.
- I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
- I will not make any unauthorized transmissions, inquiries, modification, or purging of confidential information.
- I agree that my obligations under this agreement will continue after termination of the job that I will perform.
- I understand that violation of this agreement will have legal implications.
- I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: _____ Date: _____

Appendix E: Permission Letter From Principal

Contact Information:

August 2014

Dear Mrs. Sharon L. McConnell-Smith,

Based on our discussion of your research proposal, I, NAME, the principal of T High School, give permission for you to conduct the study titled, "School Administrator and Staff Member Perceptions of a Teenage Pregnancy Prevention Program." You will have full access to school staff as needed for your study. You have permission to contact school staff directly to solicit participants and collect data.

As part of this study you may invite members of this school to participate in this study, whose names and contact email can be provided to you as needed. Their participation will be voluntary and at their own discretion. I understand the school and participants have the right to withdraw from this study at any time if circumstances change. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission of Walden University IRB.

Sincerely,

NAME
Authorization Official

Adapted from Walden University Institutional Review Board for approval to conduct research (2010). irb@waldenu.edu. Walden University.