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A Community's Perception of Pregnancy and Sexually Transmitted Infections and Prevention Programs

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MA, Albany State University, 2007

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Dissertation Submitted in Partial Fulfillment

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Abstract

The United States has the highest rates of teenage pregnancies, births, abortions, and sexually transmitted infections in the industrialized world. African American teen pregnancies and sexually transmitted infections are on the rise in many rural southwest school districts in the State of Georgia where the sex education curriculum is nonexistent or solely focuses on abstinence. Georgia ranked 4th in cases of primary and secondary syphilis, 6th in AIDS, 12th in gonorrhea, 14th in teen pregnancies, and 17th in chlamydia in the United States in 2012. The purpose of this qualitative study was to evaluate the perceptions of residents of a primarily African American rural southwest Georgia community regarding the importance of sex education and their knowledge of the school district's sex education curriculum. It specifically investigated abstinence-only sexual education using Bronfenbrenner's ecological learning theory. Study participants (n = 25) were African American youths in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates. The research questions were designed to investigate participants' knowledge of sexual health and effective sex education curricula for their school district. Data were collected from the participants via semi-structured interviews. MAXQDA 11.1 software was used for thematic analysis of transcribed interviews. The findings demonstrated community support for a comprehensive sex education curriculum and the need for a new paradigm in social policy that suggests initiatives should be evidence-based to achieve maximum efficacy in policy analysis. The study provides a baseline for school officials to assess community opinions regarding the acceptance of a comprehensive sex education curriculum.

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Dedication

To my son, Tiyance Jamaal Dewberry, Jr., thanks for your unselfishness as I embarked on this journey to transform the way we live in this world. You have been the inspiration behind this study. I cannot convey enough gratitude and thanks for your unwavering support. For years, you allowed me to forfeit many hours of our bonding time (tear) – thank you. Thank you for not giving up on me.

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To my cousin Shabreka, I know you're in Heaven screaming "Go Nikki!" To my niece Ka'Javia, I know you're proud of this research. Rest in Peace, my loves.

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Chapter 1: Introduction to the Study

Introduction

Abstinence-only (AO) federally funded programs in the United States that target low-income students have failed to prevent teen pregnancy. AO education is a form of sex education that teaches abstinence from sex and often excludes many other types of sexual and reproductive health education, particularly regarding the use of contraceptives (Weiser & Miller, 2010). AO education was first introduced in 1981 as part of the Public Health Act to prevent teenage pregnancy across the United States. To maximize the benefit of AO education programs, Title V was established as part of the Welfare Reform Act of 1996, which provided funds to U.S. schools that implemented abstinence-only education. The amount each state received depended on the percentage of low-income students residing in the state; thus, the higher the percentage of low-income students, the more funds the state was eligible to receive (Georgia, 2011).

Due to the correlation between low-income families and underrepresented populations, Title V resulted in higher amounts of aid for states with larger populations of African American children in the United States. However, AO education has not decreased the sexual activity rates of students when compared to students who participated in comprehensive sex education classes (Kohler, Manhart, & Lafferty, 2008). Furthermore, teen pregnancy rates after the program were higher among students who had AO education, as opposed to the rates of students affiliated with comprehensive sex education pedagogy (Kohler et al., 2008). At the school district used as the study site, it was not clear at the time of this study why the preponderance of data supporting the value

of a comprehensive sex education program had not resulted in the adoption of comprehensive sex education.

It is important to understand how African American youth, their parents, school officials, religious leaders, politicians, and health advocates perceive the purpose and the need for a sexual health curriculum. There is an abundance of research that addresses school curricula designed to address abstinence and other topics associated with combating teen pregnancy. The intent of this study was to evaluate the sex education curriculum in the district, or the lack thereof, in hopes of bringing this discussion to the forefront.

The district's current curriculum at the time of this study was not formal. At the time of this study, the district's education policy stated that the school system provided educational programs to its students, teachers, and employees in AIDS, its spread, and its effects. The educational program emphasized abstinence from sexual relations, which has been demonstrated to be ineffective (XYX County School, 2003). This study was designed to promote positive social change by exploring the perceptions that African American youth, their parents, school officials, religious leaders, political leaders, and health advocates have regarding the sexual health curriculum, and to identify information that will be of use to educators in determining the impact of curricula in general and to understand the beliefs of the community/stakeholders.

This chapter presents an overview of the federally funded AO programs, the impact of teen pregnancy/sexually transmitted infections, and its possible social implications. Although Title V funds do not distinguish African Americans as the sole

recipient group, a significant portion of the funds are earmarked for low income students, which includes a significant portion of African American students in the State of Georgia. It was important to examine the needs of this group because of the elevated rates of sexually transmitted disease and HIV within this group.

Background

The issues regarding sex education in U.S. public school systems are vast and widespread, but two of the more significant points that I have identified are quantity and quality. The quantity (of teen pregnancy and sexually transmitted infections rate) and the quality (of the accuracy and appropriateness of the information received) of sex education pedagogy are essential in assessing the efficacy of policies related to sex education. It is essential to provide medically accurate information about the risks of unprotected sexual intercourse and how to avoid those risks.

Age, developmental, and cultural appropriateness are three parameters that define effective sex education curricula (Advocates for Youth, 2008). Age appropriateness addresses what information is suitable for a particular age group in a sex education curriculum. For example, toddlers should be able to name all the body parts including genitals (CDC, 2016). In contrast, developmental appropriateness describes an approach to teaching that respects both the age and the individual needs of each child (CDC, 2016). For example, one could teach a toddler about body parts using pictures. Cultural appropriateness demonstrates an awareness of a group's civilization, especially their beliefs and customs (Parrish & Linder-VanBerschot, 2010). For example, a teacher could

use people and pictures that are African American to help bridge the gap between information being processed and the cultural identity of the student.

STI and HIV rates are often reported separately, excluding pertinent information such as risk factors (Newbern et al., 2013). At the time of this study, 22 states and the District of Columbia public schools taught sex education, 20 of which mandated both sex and HIV education, and one of which mandated sex education alone (NCSL, 2014). Based on current literature, increases in infections may be the warning signs for a new epidemic of HIV among young adults during the next 5 to 10 years (Newbern et al., 2013, p. 1876). Failure to develop structured and consistent sex education policies may result in the dissemination of information that is not medically accurate, age appropriate, or culturally sound, affecting a child's ability to make a positive sexual health decision (Kirby, Laris, & Rolleri, 2009; Vescolani, 2009).

Teen Pregnancy

The United States has the highest rates of teenage pregnancies, births, abortions, and sexually transmitted infections in the industrialized world (GCAPP, 2011). Children born to teenage parents cost taxpayers an estimated $10.9 billion annually (The National Campaign, 2011). Three out of 10 girls become pregnant at least once by the age of 20 (GCAPP, 2013). Birth rates in 2007 among teenagers ranged from 15.7% in New Hampshire to 55.0% in Mississippi (Matthews, Sutton, Hamilton, & Ventura, 2010). These rates differ by region, ethnicity, and socioeconomic status. The United States Census Bureau recognizes four official regions; of these, the South and southwestern states historically account for the highest teen birth rates, while the Northeast and upper

Midwest rates are lowest. Poverty, race, socioeconomic conditions, and culture contribute to the disparity (Matthews, Sutton, Hamilton, & Ventura, 2010).

The debate regarding who is to blame for the pregnancy of adolescents has continued for decades. A quick Internet search of the phrase "who is responsible for teenage pregnancy" returns more than 4.5 million results, many of which suggest that the blame lies with the teen in question, the parents, the school, or the federal government. A closer examination of the Internet results shows that these include various chat rooms that further demonstrate how polarizing this topic remains. One of the earliest accounts of a nationwide discussion regarding teenage pregnancy took place during the mid-1970s when healthcare professionals and family advocates presented this issue to the public. Initially, there was an immediate pushback from many parents and concerned citizens regarding the inclusion of sex education in public schools with the notion that it would encourage youth to engage in early sexual activities. However, advocates and educators used the rise in teenage pregnancy and the HIV/AIDS epidemic to push for policy changes that included resources and training for school-aged children (F.O.S.E., 2013).

The U.S. federal government initially took responsibility for the development and implementation of sex education policies before it delegated this task to the states during the mid-1980s (Ziegler, Shirley, Ooms, & Mayden, 1990). As a demonstration of the federal government's dedication to the cause, the Surgeon General C. Everett Koop published a report in 1986 calling for the institutionalization of sex education, including information on preventing the transmission of the HIV virus through safe sex efforts, in public schools starting at the elementary level (Koop, 1986). Nearly 90% of all U.S.

schools offered sex education programs by 1988 (Jeffries, Dodge, Bandiera, & Reece, 2010; Lamb, 2010).

The 1996 Welfare Reform law expanded U.S. federal investments in AO education. Federally funded state programs collected $440 million over a five-year span to support local sex education programs that refrained from all discussions of sex outside of marriage for people of any age, and prohibited any positive discussion of contraception despite evidence that comprehensive sex education delays teenage sexual activity (Jeffries et al., 2010; Lamb, 2010). The George W. Bush presidential administration enforced Community Based Abstinence Education (CBAE) in October 2000 to support Abstinence-Only-Until-Marriage programs (AOUM). CBAE portrayed sexual abstinence prior to marriage as an approach that would lead to a happier life (i.e., a healthier marriage and children, better earnings/education, and responsible parents). Furthermore, the program content claimed that adolescents who pledged AOUM have fewer psychological disorders, avoid drug, alcohol, and tobacco use, commit fewer crimes, and have a longer life span than adolescents who engaged in early sexual activity (SIECUS, 2013). The AO education approach to sex education fails to address adolescents who are sexually active, are currently parents, did or did not use contraceptives, or have a sexually transmitted infection.

The effects of teenage pregnancy in the United States extend far beyond the health-related issues of sexually active teens. Several studies have shown positive correlations between increases in the number of children born to teenage parents and increases in the number of children affected by poverty, low educational attainment, and

higher incarceration rates (Finlay & Neumark, 2008; Francisco, 2007; Reynolds, Ou, & Topitzes, 2004). Years of overarching themes such as child poverty, low educational attainment, and sexually transmitted infections have also shaped public policy at the federal level (SIECUS, 2013). President Obama's administration established the Teen Pregnancy Prevention Initiative (TPPI, 2012), which grants funds to organizations that provide medically accurate and age-appropriate programs aimed at reducing teenage pregnancy and associated risk behaviors. The TPPI also covers all costs associated with administering and evaluating the program (SIECUS, 2013).

TPPI is a significant departure from previous policies under the George W. Bush Administration, which promoted AO education. President Obama's administration has allotted $50 million to continue funding rigid AO programs that were originally launched under George W. Bush's Administration (Solomon-Fears, 2013, p. 9). The Obama Administration encourages a comprehensive sex education program based on statistical evidence because studies have shown that teen childbearing positions the child for poorer academic and behavioral outcomes than children born to older parents (Perper, Peterson, & Manlove, 2010; Sawhill, Thomas, & Monea, 2010). This change in policy had significant ramifications; fewer babies were born to U.S. teenagers in 2010 than in any year since 1946 due to the increased use of contraceptives (CDC, 2012).

A new paradigm in social policy suggests that initiatives should be evidence-based in order to achieve maximum efficacy in policy execution. The funding for the past social programs that have proven ineffective, like the Bush Administration's Abstinence Only Until Marriage, Community Based Abstinence Education, and Administration for

Children and Families, has been re-allocated to programs that provide evidence of their effectiveness (e.g., comprehensive sex education) (Haskins & Baron, 2011). The Teen Pregnancy Prevention Initiative (TPPI) demonstrates the effectiveness of innovative, multicomponent, community-wide initiatives in reducing the rates of teen pregnancy and births to teen mothers in communities with the highest rates, with a focus on reaching African American and Latino/Hispanic youth aged 15–19 years (Center for Disease Control [CDC], 2011a, 2011b). As part of TPPI, the CDC is collaborating with the federal Office of the Assistant Secretary for Health (OASH) to reduce teenage pregnancy and address disparities in teen pregnancy and birth rates.

Sexually Transmitted Diseases and Infections

In the United States, sexually transmitted diseases (STDs) pose a serious and widespread threat to youth. There are about 20 million new infections each year in the U. S., costing the healthcare system roughly $16 billion in direct medical costs (CDC, 2013). According to the NRC (1997),

> STDs are hidden epidemics of tremendous health and economic consequences in the United States. They are hidden because Americans are reluctant to address sexual health issues in an open way and because of the biologic and social characteristics of these diseases. All Americans have an interest in STD prevention because all communities are impacted by STDs, and all individuals directly or indirectly pay for the costs of these diseases. (p. 1)

Sexually transmitted infections are noted to increase the risk for HIV transmission (CDC, 2013). There are eight common STIs: Chlamydia, Gonorrhea, Hepatitis B virus (HBV),

Herpes Simplex virus type 2 (HSV-2), Human Immunodeficiency Virus (HIV), Human Papillomavirus (HPV), Syphilis, and Trichomoniasis (CDC, 2013). Half of all new STIs are diagnosed in young people ages 15-24, though this age group accounts for only 25% of the sexually experienced population (CDC, 2013).

STIs/STDs affect all races, ages, and sexual orientations (CDC, 2012). However, when individual risk behaviors are combined with barriers to quality health information and STD prevention, some Americans are at greater risk than others in protecting their health (CDC, 2012). Specifically, African American youth have been considered less responsible than their white counterparts in protecting their sexual and reproductive health (Youth, 2008).

Both chlamydia and gonorrhea are underdiagnosed and underreported due to the lack of STD testing (CDC, 2012). Chlamydia is the most costly commonly reported infectious disease in the United States (CDC, 2012). African Americans are the racial/ethnic group most affected by STDs, with a rate seven times as high as whites and three times higher than Hispanics. African Americans' infection rate for gonorrhea is 17 times higher than that of whites and 8 times higher than the rate among Hispanics (CDC, 2012). This group also accounts for 67% of gonorrhea infections.

African Americans also account for nearly half of all reported primary and secondary syphilis cases (CDC, 2012). The rates for black women are 17 times higher than white women, and syphilis rates for black infants are 15 times higher than for white infants (CDC, 2012). According to the CDC (2012), the majority of cases are among black men who have sex with men, particularly young black men. It is important that men

who have sex with men be tested annually for syphilis because those with untreated syphilis are at an increased risk of acquiring HIV. Georgia ranks number one in terms of prevalence for primary and secondary syphilis primarily in the southern United States and some urban areas (CDC, 2013). The majority of syphilis cases in Georgia occur in the predominately African American-populated counties of Fulton and DeKalb (Georgia Department of Community Health, 2010).

These alarming rates of STDs in the African American community suggest the need for a more realistic change in interventions. The increase in STIs affecting adolescents now could herald an expansion of the HIV epidemic over the next few decades (Newbern et al., 2013). Effective interventions that reduce adolescent STIs are needed to avert future STI and HIV acquisition (Newbern et al., 2013). If a person lacks resources or faces challenging living conditions, the journey to health and wellness is harder and can lead to circumstances that increase the risk for STDs.

Rural Areas

The spread of HIV to rural areas is a significant threat to public health, though the greatest threat is the rapid spread of sexually transmitted infections. The 2009 report *Tearing Down Fences: HIV/STD Prevention in Rural America* specifically addressed the threat of sexually transmitted infections in rural areas. Based on the report, rural areas in the United States are not far behind highly populated urban areas when it comes to the transmission and acquisition of chlamydia **(**Rural HIV/STD Prevention Work Group, 2009). Higher rates of gonorrhea, chlamydia, and syphilis indicate not only unprotected sex, but also that there is a larger population of people who are more susceptible to HIV

because they already have another STD. African Americans and Latinos in the rural South face a disproportionately high infection rate of syphilis **(**Rural HIV/STD Prevention Work Group**,** 2009), a statistic that shows the need to reduce sexually transmitted infections in the rural South. The authors state, "Despite, the compelling epidemiological evidence relative to HIV and STD in rural America, little is known about the prevalence of sexual risk-taking behaviors among rural Americans in comparison to individuals from metropolitan areas" (Rural HIV/STD Prevention Work Group, 2009). The present study was designed to address this need.

There are studies that provide a starting point for investigations of HIV/STD risk behaviors and their antecedents among rural Americans, specifically women and young adults (DiClemente et al., 2002; Kogan et al., 2010; Mihausen et al., 2003). At the time of this study, there was limited literature available on sexually transmitted infection prevention among adolescents in the rural South. In past studies, the common theme for African American women in rural areas versus their metropolitan counterparts was that the African American women were reported as never using a condom, worrying about HIV/STD, having a sexual partner who had not been tested for HIV, and believing that their partner was HIV negative even without an HIV test (Crosby, Yarber, DiClemente, Wingood, & Meyerson, 2002; Crosby, Yarber, & Meyerson, 1999).

Sexual networks are mostly based on geographic location. It is apparent that *rural risk* and *urban risk* for any single sexual behavior may vary due to differences in the size of the pool of infection. Sexually transmitted diseases (STD) are a primary concern

because untreated STDs act as transmitters for HIV. Moreover, STDs can be cured and treated while HIV cannot be cured and its frequency declines only as a result of death.

Poverty

African American culture has been described as the catalyst that influences the way African Americans act on, perceive, and process information. Numerous studies have linked culture to poverty. A consideration of culture is essential in addressing the sexual and reproductive health needs of young people of color, including gay, lesbian, bisexual and transgender (GLBT) youth of color (Calsyn et al., 2012; Centers for Disease Control and Prevention, 2010). The way an individual views the world comes from his/her life experiences. Hispanics/Latinos face cultural barriers to using contraception due to the highly valued sense of machismo and Catholicism's opposition to birth control (Mitchell-Bennett et al., 2009). A cultural barrier among African American women links a refusal to use contraceptives to a fear of communicating a lack of trust to their male partners as well as a fear of rejection or violence (Parrill & Kennedy, 2011). An abundance of well documented disparities shows that white females have greater access to health care services and trust in health care providers more than any other race (Musa, Schulz, Harris, Silverman, & Thomas, 2009; Welti, Wildsmith, & Manlove, 2011). Where non-Hispanic white youth have greater access to health care, minority youth eligible for Medicaid suffer from the lack of Medicaid providers in their neighborhoods/ communities, which poses additional barriers to youth protecting themselves.

Though self-identified Hispanic/Latino and self-identified African American teenage parents represent only 35% of the total population of 15- to 19-year-olds, they

account for nearly 60% of U.S. teen births (CDC, 2012). This statistic suggests a disproportionate relationship between the number of children born to persons identifying as Hispanic/Latino and African American. Teen pregnancy and childbearing pose a greater threat for low-income blacks and Hispanics. The consequences are more serious, and the causes are more deep-rooted and interrelated with other social and community problems (Ziegler et al., 1990). Researchers have attributed increased pregnancy rates among minority youths to their desire to be pregnant (Advocates for Youth, 2008), attitudes of invincibility (Zolkoski & Bullock, 2012), negative perceptions of contraceptives (Welti et al., 2011), lack of knowledge/access (Augustine, Alford, & Deas, 2004), religious barriers (CDC, 2010), and little interest in pursuing additional education (Lau, Lin, & Flores, 2013; Vescolani, 2009). Nonetheless, advantaged adolescents have considerably higher academic success and lower teenage birth rates due to financial exposure and lack of stress from external factors such as racism, poverty, and basic survival needs.

Neighborhoods infested with drugs, crime, teenage pregnancy, and unemployment are the major factors that qualify African Americans from such environments as *at-risk* (CDC, 2010). According to the Centers for Disease Control (2012), a person's social environment can determine the availability of healthy sexual partners. Much research has shown that untreated sexually transmitted diseases are more prevalent in the African American community than any other because they tend to choose sex partners within their own community and face a greater chance of infection (Friedman, Cooper, & Osborne, 2009; Schmid & Kretzschmar, 2012). It is unlikely for an

adolescent to focus on academics when he/she is unable to envision where his/her next meal will come from, if he/she will survive another day due to violence in the community, or if he/she will be placed in foster care due to poor living conditions. Concerns about HIV could be secondary to basic needs such as housing, food, transportation, and childcare (CDC, 2010; Wyatt, 2009; Youth, 2008).

Culture

The rates of teenage pregnancies and sexually transmitted infections are higher amongst African American adolescents in rural populations (Rural HIV/STD Prevention Work Group, 2009). The rural United States is extremely diverse and far from being culturally monolithic. Cultural differences in the rural United States present additional challenges to the prevention of teenage pregnancy and teenage STD infection. African American culture developed through a language interaction among a history of oppression, struggles to survive within an oppressive social order, struggles against oppression, and struggles that take place within the community, national, and global social orders, which in turn have created a mixture of beliefs, ideals, values, norms, and myths (Friedman, Cooper, & Osborne, 2009, p. 6). People will accept or reject information about risk in a way that is acceptable according to their cultural values, beliefs, or spirituality. As a result, it is important for interventions to include information that is culturally sensitive (Kahan, Braman, Slovic, Gastil, & Cohen, 2009).

To better understand the cultural variations of African Americans, an examination of the constitutive elements of their culture and how they interact with sexual/drug use subcultures, sexual networks, and behaviors towards STI prevention should be conducted

(Friedman et al., 2009). For the purposes of this study, in order to combat the epidemic in the black community, there must be a greater understanding of the fundamental social factors that have influenced beliefs, perceptions, and behavior.

For many communities, specifically the African American community, there is a long-standing culture of distrust of the American government and healthcare system, which may impede HIV/STD prevention efforts (Parrill & Kennedy, 2011; Thomas et al., 2012). As a result of The Tuskegee Syphilis Experiment, where African American men were purposefully injected with the syphilis virus to see how their bodies would react without treatment, African Americans have distrust in both medical and governmental systems (King, 2003). A past study suggested that black students perceive and receive information differently if they can identify with the person providing the information (Friedman et al., 2009). More to the point, black students are more receptive to information coming from people who look like them. These data further suggest that sex education programs need a diverse pool of educators to reach students from culturally diverse backgrounds (Friedman et al., 2009).

The larger U.S. society has failed to fully realize the depth and breadth of religious institutions' influence on the health of communities (Samuels, 2011). African Americans and women are considered more religiously involved than any group (Holt, Clark, Debnam, & Roth, 2014). Some have viewed the Black church as the source for coping with oppression and stress as well as disguising or ignoring the less desirable lifestyle of some if its congregants rather than dealing with issues of sex and health (Holt et al., 2014; Nunn et al., 2012). Due to prejudice and medical mistreatments of African

Americans, there is evidence that fatalism has influenced societal factors. Fatalism is the surrendering of power to external forces which leads to hopelessness, mistrust, and despair (Plowden, James, & Miller, 2000). When African Americans experience diseases, they view it as a sign of punishment from God or a test of faith to alleviate negative emotional consequences of life circumstances, which Holt et al. (2014) referred to as *religious coping*. Wyatt (2009) states that although historical experiences of African Americans resulted in cultural strengths as survival skills, those survival skills have in turn transcended the groups' risk for HIV/AIDS transmission (Wyatt, 2009).

Churches have played a major role in the development of African American communities from centers of spiritual growth and development to political and civic activity, as well as health promotion and disease prevention, but few have addressed teen pregnancy and HIV/AIDS prevention programs (Coleman, Lindley, Annang, Saunders, & Gaddist, 2012), both of which have been in some way a result of African American low self-esteem. According to Samuels (2011), the church became a place where self-esteem was discovered, though it had been denied in the larger context of the world. As it is evident, religion plays a major role in the social, political, and sexual lives of the black community (Guttmacher, 2010). However, religion is often overlooked when it comes to interventions to change risky sexual behaviors via policies or school-based curricula. As this study addressed African Americans' perception of a sexual health curriculum, it is imperative to include the perceptions of the people from a religious point of view, considering that women in black churches make up 70% of all new HIV cases. This

implies that empowering and educating black female youth is still a priority and the church is a gateway by which to reach them.

Abstinence Versus Comprehensive Sex Education

AO sex education teaches abstinence until marriage as the only option for teenagers. Advocates for AO education argue that if students are exposed to information on safer sex, it might encourage sexual activity (Motherway, 2010). Alternatively, comprehensive or "abstinence plus" sex education includes information about abstinence and contraception equally. Abstinence plus teaches abstinence as the preferred choice with the inclusion of contraception. Advocates for comprehensive sex education argue that while students should be taught abstinence until they are emotionally and physically prepared for sex, information about birth control and disease prevention is essential for those who are already sexually active (Motherway, 2010).

Sex education wars regarding the effectiveness of AO education in reducing teenage pregnancy versus Comprehensive Sex Education (CSE) continue nationwide. With over 3 million new cases of STIs occurring in teenagers each year in the United States, people under the age of 25 accounts for half of all new Human Immunodeficiency Virus (HIV) infections. In 2003, African Americans made up only 12% of the U.S. population, yet they accounted for 50% of diagnosed HIV/AIDS cases according to the Centers for Disease Control and Prevention (CDC). In addition, the survey data suggested that African American high school students are more likely than their Hispanic or Caucasian counterparts to have had sexual intercourse and more likely to have had four or more sex partners (Shuger, 2012). Correspondingly, in Georgia's 13 congressional

districts, African American (AA) adolescent teen pregnancy and STDs rates exceed those of all other ethnicities. African Americans are at particular risk.

AO education has long dictated sex education policy in U.S. public schools. Most states have a policy requiring HIV education, usually in conjunction with a broader sex education. According to the National Conference of State Legislatures (NCSL, 2014), 21 states and the District of Columbia require public schools to teach sex education (including HIV education); 35 states, including the District of Columbia, require that students receive instruction about Sexually Transmitted Infections (STIs) and HIV/AIDS; and only 17 states require sex education curricula to be mandated, age appropriate, and medically accurate. The term "medically accurate" is determined by state policies, some of which adopt only curricula reviewed and approved by state health departments. In an effort to validate their sex education pedagogy further, several state policies require that information be derived from published literature that medical professionals trust. Georgia's public schools are required to teach sex education and sexually transmitted disease (STD)/HIV-prevention education in conjunction with health education but are not mandated to provide medically accurate instructions or peer-reviewed publications. According to DoSomething.org (2012), more than half of the districts in the southern U.S. have an AO education policy compared to 20% of districts in the Northeast. Today, most states have policies regarding HIV education in conjunction with a wider range of sex education (Guttmacher, 2011).

Sex Health Policy

There are currently no federal or state policies mandating comprehensive sexual health education (Guttmacher, 2011). The Georgia State Law O.C.G.A. 20-2-143 directive requires each local board of education to prescribe a course of study in sex education and AIDS prevention instruction. The Georgia Board of Education has the responsibility of enforcing the most suitable sex education curriculum for its individual district.

According to an earlier study by The Henry J. Kaiser Family Foundation in 1999, sex education will be taught at least once between the 7th and 12th grades in nine out of ten of the 20 million public schools in the U.S. The causes of teen pregnancy and the most efficient methods of sex health education have undergone intense scrutiny and research. The study found that the mere fact that some form of sex education was taught in public secondary schools did not necessarily determine its effectiveness, particularly when the content of that curriculum was at the discretion of the school district and there were no definitive mandates. Also, the specific pedagogy may vary drastically. The results of the Kaiser study showed that over half of the principals summed up their idea of comprehensive sex education as "young people should wait to have sex, but if they do have sex, they should use birth control and practice safe sex."

Still, the U.S. has higher rates of pregnancy and disease among adolescents than any other developed country because other countries accept that older teenagers will engage in sex and there is little societal pressure to remain abstinent. These countries emphasize that sexual activity should occur within committed relationships, married or

otherwise (Guttmacher, 2006). Scientists remain perplexed by this phenomenon. This lack of understanding of the relationship between sex education and real-time behaviors has resulted in the underlying mismatch of written sex education policies and actual curricula.

Researchers, policymakers, and educators have yet to discover a clear understanding of students' general perceptions and knowledge regarding sexual health. This study was needed for several reasons: to compare what is taught versus what is learned; to provide information that will aid in making policymakers and board members cognizant of the needs of students; and most importantly, to find out where the deficiencies lie in student knowledge of sexual health in the community where the study took place.

Problem Statement

Georgia has the 14th-highest teen pregnancy rate in the nation, along with one of the highest AIDS rates specifically in the African American community. In 2008, there were over 152,000 sexually active teens in Georgia and many public school systems had AO education or no sex education curricula despite the constant rise in teen pregnancies and sexually transmitted diseases/infections in high-risk areas (Youth, 2008). Currently, school boards of education enforce what they believe to be the most effective sex education curriculum for their district needs. Research indicates that federally funded AO programs, which target minorities, have failed to prevent teen pregnancy and that African American youth are not as well informed about sexual health as their white counterparts (Kuehnel, 2009).

This problem greatly impacts the African American community in southwest Georgia where unplanned teen pregnancy rates are the highest, resulting in communities of increased poverty, crime, dropout rates, and single parent households. The factors surrounding teenage pregnancy are plentiful. Socioeconomic conditions, family, education, culture, religion, self-esteem, geography, and inadequate or incomplete information provided by AO curricula have all been implicated in this epidemic. The gap in literature is a substantive investigation of the perceptions that African American youth in a 9th Grade Academy, parents, school officials, religious leaders, policymakers and health advocates have in regard to sexual health, including the environments in which they live. The disconnect lies between the Georgia state sex education policy, a southwest Georgia school district's sex education curriculum, students' sexual activities, and what students know in regard to healthy sexual practices.

Purpose of the Study

Adolescent pregnancies and sexually transmitted infections negatively affect the lives of students by intruding on their ability to live a healthy life. Compounding the question of good health and prosperity are the school policies that stress AO versus comprehensive sex education. The purpose of this study was to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education in their district. This study explored the participants' general understanding of sexual health. The results of the study have the potential to provide useful information that will allow school administrators to tailor a sex education curriculum that collectively addresses the

multifaceted needs of all students but is sensitive to the needs of African American students while complying with the state of Georgia's sex education policy. By gathering the perceptions of different groups in this investigation, I aimed to uncover the needs of African American youths while helping educators, parents, and stakeholders become better informed about the impact of a sex education curriculum in an effort to reduce the rates of teen pregnancy and sexually transmitted infections among youths.

Research Questions

The research questions in this study were:

1. What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education in XYZ County?
2. Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?
3. What knowledge**,** beliefs, and/attitudes do the target audiences have regarding the offerings of abstinence-only versus comprehensive sex education?

Theoretical Framework

I used the social learning and ecological theory to frame this study. In 1969, Albert Bandura's *Principles of Behavior Modification* investigated the determinants and processes by which human thought, affect, and behavior are apparently influenced by observing the behavior of others and its effects for them. The social learning theory (SLT) is based on the assumption that learning happens through interactions with others,

and thus we can change the behavior of others by applying the key components of observational learning, imitation, and behavior modeling.

Social learning theory has provided evidence that comprehensive sex education is essential for adolescents' well-being. This theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences. There have been prevention-based sex education studies that have used the SLT to frame a change in the participants' behavior either to increase condom use or avoid sexual involvement (Resource Center for Adolescent Pregnancy Prevention, 2009). In order to change the behavior, we must first understand the social context that has shaped that behavior and reverse the learning process (Bandura, 1977), which leads to the newly named bio-ecological theory.

Urie Bronfenbrenner's ecological theory of 1979 focuses attention on both behavior and its individual and environmental determinants. According to the theorist, everything in a child's biological make-up and his environment influences to some degree the way that child grows and develops. The levels of environmental influences are divided into micro-, meso-, and exosystem levels of influences (Paquette & Ryan, 2001). The importance of the ecological model in social sciences is that social sciences view behaviors as being effected by and affecting the social environment (McLeroy, Bibeau, Steckler, & Glanz, 1998). There are variations of Bronfenbrenner's model for health promotion, and the common theme of these models is behavior as the ideal outcome of interest. The health models emphasize that intrapersonal factors, interpersonal processes,

institutional factors, community factors, and public policy determine behavior, which ultimately sums up Bronfenbrenner's systems.

A few studies have implemented the ecological theory: *Ecological Factors Associated with Adolescent Pregnancy* (Corcoran, Franklin & Bennett, 2000); *Applying Ecological Perspectives to Adolescent Sexual Health in the United States* (Salazar et al., 2010); and *An Ecological Perspective on Health Promotion Programs* (McLeroy, Bibeau, Steckler, & Glanz, 1988). The three research questions of this study solicited critical information from six groups that are described as critical factors of the ecological model. Further analysis of how the ecological theory has been used in the prevention of teen pregnancy and transmitted diseases is provided in Chapter 2.

Conceptual Framework

Ineffective public policies have led to eras of poor oversight where policies directed at certain groups have not included the experiences or preferences those groups could contribute, particularly in the case of AO sex education in America's public schools. Public policies are authoritative actions of government that reflect the decisions, values, and/or goals of policy makers. Public policy is used to organize the framework of purposes and rationales for government programs that deal with specific societal problems such as teen pregnancy.

This study examined the conceptual framework Communities Coping with Change (CCC), which identifies multidimensional influences that bring forth change in a community or uphold the norms, which can then be applied to decision-making regarding the design of a sex education curriculum. The CCC model provided a possible

mechanism for decision-making while acknowledging the characteristics of the community for which the decisions are being made. Moreover, the CCC model primarily identified facets that influence change in a community's social, economic, and political environments (Kelly & Steed, 2004) and is discussed in more detail in Chapter 2.

The CCC model was appropriate for this study because it provided a greater insight into the way a southwest Georgia rural community copes with problems, namely the lack of a sex education curriculum. The manner in which communities cope with problems is known as a collective strategy. The CCC model applies six strategies for change introduced by Checkoway, as cited by Kelly and Steed (2004): mass mobilization, social action, citizen participation, public advocacy, popular education, and local services development.

The CCC model was based on a social science theory that has been applied to facilitate effective collaborative decision-making among people with diverse viewpoints on critical issues. This model described how a community's mobilization of strategies is dependent on the collective assessment of the change event, the nature of the event, and the characteristics of the community (Kelly & Steed, 2004). This model related to the research questions by guiding the collection of factors that described the decision-making process in a community. The framework of this text provided insight into a community's relevant collective strategies for embarking on a sex education curriculum (the change event).

The instrument development (Appendices E, F, and G) consisted mainly of interviews and self-designed, open-ended questions used to assess a rural, southwest

Georgia community. The CCC model related to the instrument via an understanding of the teen pregnancy prevention phenomenon as it related to the lives of its participants. The CCC model guided the research in collecting valuable data on the characteristics of the community and collecting first-hand views from state leadership and other influential members of the local government. According to Kelly and Steed (2004), Communities Coping with Change models the way a community at large interacts with decision makers to prioritize problematic issues, weigh alternatives, and implement solutions as well as influence the quality of life.

Nature of the Study

The nature of this exploratory study involved a qualitative approach and case study design to gain information regarding the convoluted sense of dissonance between Georgia's state sex education policy, a district's sex education curriculum, and the perceptions that African American 9th graders, their parents, school officials, religious leaders, policymakers, and health advocates had towards sexual health curricula. According to Yin (2011), a case study design should be considered when the focus of the study is to answer *how* and *why* questions.

A plethora of research has been conducted on the causes and effects of teen pregnancy in the African American community, yet very little research has focused on the perceptions of those students. It was relevant to assess the relationship between mandated federal or state policies and high pregnancy and sexually transmitted infection rates in African American communities. A research design that would allow the collection of various data demonstrated in the CCC model was essential along with

subsequent straightforward data analysis. A case study design was selected to explore the contextual conditions due to their relevance to the policies and the elevated teen pregnancy rates indicated by other studies where the boundaries were not clear.

The methodology included interviews from the community's decision makers, parents, religious leaders, school officials, health advocates, and purposively selected students who assented to the study with signed parental consent forms. The interviews with all student participants took place in person. Interview dialogue was transcribed accordingly. Student interviews took place individually at a privately owned restaurant (City Walk Sports Cube) after school hours. The data was analyzed using MAXQDA, qualitative analysis software. In addition, the procedures used to collect and analyze the data protect human subjects. This study identified the driving forces behind local policies in an effort to improve the overall state policy regarding sex education by separating facts, myths, and value judgments to ensure sex education for all youth is effective in Georgia.

Definition of Terms

Abstinence-Only Education: Teaching that focuses entirely on the notion that refraining from the act of sex is the only way to prevent pregnancy and sexually transmitted infections (Youth, 2008).

Comprehensive Sex Education: Teaching that focuses on abstinence as the best method for avoiding STDs and unintended pregnancy, but also includes information about condoms and contraception to reduce the risk of unintended pregnancy and infection with STDs, including HIV. It also teaches interpersonal and communication

skills and helps young people explore their own values, goals, and options (McKeon, 2003).

Culture: Characteristics of a particular group of people, defined by everything from language, religion, cuisine, social habits, and music to the arts (Merriam-Webster, n.d).

Health disparity: A significant health difference that is closely linked with social or economic disadvantage (Centers for Disease Control and Prevention, 2010).

Social determinants of health (SDH): Complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDH are shaped by the distribution of money, power, and resources at global, national, and local levels, which themselves are influenced by policy choices (CDC, 2010).

Social Network: In this study, the term *social network* refers to the Schmid and Kretzschmar definition of a group of people who live in the same geographic area who are connected sexually (Schmid & Kretzschmar, 2012).

Assumptions

This study was based on several assumptions. All participants solicited would accept the offer to participate in this study. Parents would consent to their own participation as well as allowing their children's participation. All participants would answer questions truthfully. African American students were predisposed to AO curricula in rural southwest Georgia communities. This study would bring awareness to

policymakers regarding the ineffectiveness of the current sex education policy and would result in policymakers revisiting the school's sex education curricula in an effort to reduce the rates of unplanned teen pregnancies and the contraction of sexually transmitted infections among adolescents.

Scope and Delimitations

African American adolescents are more likely to receive an AO curriculum even though they have the highest rate of teen pregnancy and sexually transmitted infections (STI) cases. Furthermore, a phenomenon that was once mainly an urban dilemma is more widespread and rampant. As a result, I decided to target a county in rural southwest Georgia where the rates of pregnancy and STDs are higher or equal to more populated areas in the state of Georgia. Recent data from the U.S. Census American Community Survey report that the total population of the state of Georgia is nearly 10 million versus the 24,000 accounted for in rural XYZ County, Georgia. The rate of births to teen mothers (ages 15-19; per 1,000) in this county is 68.7% compared to 41.2% for the entire state of Georgia. In alignment with this disproportionate rate, the incidence of STDs for youth is 37% and 30.1% for the rural county and the state of Georgia, respectively (Census, 2012). The specific focus on a community's or a district's sex education curriculum was chosen because no data was found on the sex education policies within the state of Georgia or the reception of such policies and curricula among African American students.

The boundaries of this study included one of the fourteen poorest counties in southwest Georgia where the study's primary focus was African Americans, while all

other ethnicities were acceptable but excluded. Ethnicities other than African Americans were excluded because this study focused on the group who has the greatest threat of teen pregnancies and sexually transmitted infections.

The perceptions theory was closely related to the area of study and was not investigated because the study focus was not solely on the perceptions of individuals in regards to what shaped their beliefs in favor of a particular sex education curriculum. The results of this study may be applied to similar rural areas where African American students have higher rates of sexually transmitted diseases and teenage pregnancies. Though there is no transferability due to the qualitative data, external validity can be applied, as case studies do not rely on statistical (quantitative) generalizations. I demonstrated transparency by providing the opportunity for each participant to confirm the validity of the written or recorded statements (primitive coding). I demonstrated consistency and coherence through the use of audio recordings to support the accuracy of the translation of the primitive coding (Yin, 2011). For the purpose of this case study, I used a combination of interviews (rich and in-depth descriptions from participants), triangulation, and audit trails.

It is widely reported that disadvantages reported for the African American youth are mimicked in Hispanic youth; hence, the data demonstrated in this body of work may be applicable to that population despite the apparent cultural barriers.

Limitations

This study was limited to qualitative data of participants' experiences. This study was also limited to the analysis of one school district's sex education curriculum. This

study did not presume to investigate teenage pregnancy holistically as the research was targeted towards a small, rural population in southwest Georgia. No generalizations regarding ethnic groups, excluding that of the target population of African Americans, were made. Additional methodological limitations of qualitative studies included: the lack of generalizations that were made, the small sample population targeted for this study, and the myriad interpretations that this research yielded.

As this study was self-conducted, there were constraints of time and financial resources that prevented an extensive investigation in comparing several or all of Georgia's school districts. Another limitation with this study was the ability to include participants from ethnicities other than African American due to the scope of this study and the ethnic makeup of the school of choice (over 90% of the students identified as African American). This study did not presume to investigate the full teen pregnancy issue. This study was not able to generalize ethnic cultures other than African Americans similar to the participants.

Significance

There has been little evidence-based research done on culturally sensitive sex education programs. The contribution of scientific data regarding ineffective sex education curricula, specifically targeting a population that is disproportionately affected by teenage pregnancy and STI's, is a necessary first step in ending this epidemic. First, the data from this case study will bolster changes in educational and public policy by filling the gap in literature regarding evidence-based research for underrepresented populations. Second, I aimed to broaden the scope of Georgia's state policy through

encouraging local policy makers to seriously consider the culture of teenagers, which greatly influences their sexual behaviors, when developing, implementing, and executing policies. This study has the potential to propel the issue of teenage pregnancy to the forefront of the nation's recognized epidemics by reemphasizing to policymakers, parents, religious organizations, communities, and school-based organizations the necessity for collectively designing efficient sex education curricula. The significance of this study on the perceptions of African American teenagers is that the data collected will relay to policymakers and communities that a one-size-fits-all policy is not effective for every culture or district and that a policy that specifically addresses the district's sexual behavior is essential.

The positive social change likely to come from the scope of the study is additional literature that may influence what others consider an effective sex education curriculum that combats teen pregnancy and sexually transmitted infections in their respective communities. The chosen curriculum has the potential to provide students with sexual health knowledge, which they need in order to better protect against disease and to lead a healthy and productive life.

Summary

In summary, sex education is an imperative policy for promoting well-informed sexual decision-making and preventing unintended pregnancies and sexually transmitted diseases among adolescents. This case study was designed to address one school district in rural southwest Georgia where the cases of teen pregnancy and STDs are at an all-time high in the African American community. In regards to the state's policy on sex

education, not every school district enforces a sex education curriculum, which further places students at a greater risk of infection with incurable diseases or birthing children for which they are unable to care.

Chapter 1 provided a brief overview of the study. Research has shown that the social condition in which a person is born, lives, works, and ages is the single most important determinant of his/her health status. Despite the implementation of abstinence curriculum, African American youth, more than any group, are still ranked number one for early pregnancies and diseases. The problem with the sustained statistics in teen pregnancy, sexually transmitted diseases, and other factors associated with sexual behaviors during early adolescence could rest with the school curriculum. Examining the perceptions of African American youth, their parents, school officials, religious leaders, policymakers, and health advocates regarding the sexual health curriculum is one way to explore this social reality.

Chapter 2 provides a review of the current literature that provides arguments for and against sex education curricula as well as literature regarding social learning and ecological theories, and it provides arguments for and against the types of sex education curriculum content that best eliminates teen pregnancy in the African American community.

Chapter 2: Literature Review

Introduction

The State of Georgia has the 14th highest teen pregnancy rate in the United States; its African American community also has one of the highest AIDS rates in the country. In 2008, there were over 152,000 sexually active teens in Georgia and many public school systems had abstinence-only education or no sex education curricula despite the constant rise in teen pregnancies and sexually transmitted diseases/infections in high-risk areas (Advocates for Youth, 2008). The purpose of this study was to explore the perceptions of rural African American 9th-grade students, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education health curricula in their district. This study also explored the participants' general understanding of sexual health.

This chapter summarizes findings of the literature review conducted to support the intent of the study and presents a clear connection to the problem statement, theoretical frameworks and conceptual framework. The theoretical framework for this study is one's environment frames his or her reality. This review includes relevant literature on the following major topic areas: environment, church, culture, communication, sexual behavior, human rights, school-based curricula, and effective sexual health programs.

Literature Search Strategy

The literature review process included database searches of the professional literature through selected word searches. The scholarly databases used in the search

included EBSCOHOST, ERIC, JSTOR, ProQuest, PsycINFO, PUBMED, SAGE publications, SocINDEX, Taylor and Frances Online, and the Walden University library database. The following key search terms and combination of search terms were used: *African American youth, African American culture, teen pregnancy, adolescent, sex education, sexual health, abstinence only, comprehensive education, sexually transmitted diseases/infections, sexually transmitted diseases and infections in rural areas, HIV/AIDs, Bronfenbrenner's social ecological theory, and religion* and *African Americans.*

Theoretical Framework

In 1979, Bronfenbrenner's social-ecological systems theory provided a theoretical perspective of why this social issue persists and how individuals are influenced over a period of time by social interactions within their social environments. This theoretical framework created a foundation that was used to explore how school administrators interpreted reported incidents of bullying and decided whether an incident was bullying, harassment, or inappropriate behavior, and how they determined subsequent actions for the bully, bully-victim, and the victim.

Bronfenbrenner named the ecological model in *The Ecology of Human Development: Experiments by Nature and Design* (1979). Bronfenbrenner's original work was developed using a physical sciences perspective to explain human behavior. Today, this theory is referred to as the bio-ecological theory. Many theoretical frameworks incorporate environmental factors to some extent, yet two environmental influences that many theories fail to address are funding and policy directives, which are

acknowledged within this framework. Environmental influences have been divided into two descriptive systems that effect the child's growth and development—the microsystem and the mesosystem. The following examples further illustrate why this theory is more appropriate than others.

1. The microsystem is the small, immediate environment with which the child interacts, such as family, caregivers, churches and schools. At this level, relationships are influenced bidirectionally. For example, if people in this environment show they lack interest in a child's sexual development, that child will develop what he/she considers the best sexual growth for him/herself, which can be dangerous without the proper knowledge or resources from an adult. The more encouragement and nurturing of these environments the child receive, the better the outcome for the child.
2. The mesosystem describes how everyone in the microsystem works together for the sake of that child. For example, if members of the microsystem are encouraging a child with the same message of sexual protection, it will impress upon the child the importance of safe sexual practices. Conversely, when messages are inconsistent, it could perhaps cloud the child's judgment and hinder his/her progress if such activity is presented.
3. The exosystem includes other people and places that the child may not interact with directly but that still can affect the child's growth, e.g. parents' workplaces, extended family members, and the community. For example, if a child has to

learn self-survival tactics in a poor community, the mechanisms for survival will lead to risky behaviors, which in turn lead to negative sexual practices.

4. The macrosystem includes cultural, economic, and political variables that influence the individual. For example, if a child is sexually active and the only message he/she receives on sexual health is a state directive to abstain, this puts the child further at risk for pregnancies and diseases where he/she might perceive his/her actions as a point of no return.
5. The chronosystem includes internal or external physiological changes. This system is not included for pregnancy prevention.

The conceptualization of Bronfenbrenner's model has been used in theoretical formulations as well as empirical research. Bronfenbrenner's theory has also not been used in public policy or public administration studies. Several studies, however, have chosen variables to represent system levels depending on the phenomenon under study, which has made it difficult to test the ecological model (Cook & Kilmer, 2010). Brodie (2009) used the ecological model to explore the interpersonal and community-related influences of rural adolescent pregnancy. Brodie's study closely relates to the present study because both studies examined individual and social influences associated with teen pregnancy in rural communities where research was scarce. Brodie's study used mixed methods to evaluate the intrapersonal and community related factor, whereas I took a qualitative approach and used face-to-face, semistructured interviews. In Brodie's research, a quantitative survey assessed intrapersonal factors, namely sexual health

knowledge, sex-related attitudes, and self-esteem in pregnant or parenting and nonpregnant or nonparenting groups.

Tobey, Hillman, Anagurthi, and Somers (2011) used Bronfenbrenner's ecological perspective to explore the demographic differences and similarities for race, gender, and age in a diverse urban population in adolescents' sexual behavior, parental attitudes towards sex, the amount of maternal and paternal communication and whether or not school was a source of sex education. The authors argued that despite the fact that sex education in schools is a primary source of sexual information for adolescents, previous studies on this topic have failed to look specifically at demographic differences like image, gender, and race/ethnicity. Tobey et al.'s results showed that as adolescents matured physically and psychologically, parents were more open to speaking to them about sex. This suggests that this approach is ineffective if adolescents have sex earlier than parents intended.

Bronfenbrenner's ecological theory views human development as the product of dynamic interaction between individuals and the multiple interrelated environments in which they are rooted. Gardner, Martin, and Brooks-Gunn's (2013) quantitative study suggested that an adolescent's sexual behavior is parallel to the extent of the disadvantaged environment and the lack of caring from the caregiver. The more disadvantage the area is, the weaker the relationship exist between the caregiver and adolescent.

Gaining a more thorough understanding of STD/STI and teen pregnancy issues required an examination of the interrelated contextual risk factors influencing adolescent

sexual behavior (Salazar et al., 2010), which were addressed in the study at hand. Youth behaviors of sexuality and pregnancy prevention are as complex as the solutions. The ecological model states that there is no single factor that results in early youth pregnancies and that the community as a whole has to be addressed if members of the community are serious about prevention. Auckland, Nguyen, and Le (2013) and Gerges (2011) argued that such variables should not be considered as separate factors whose sole purpose was to fill the gaps in the theoretical frameworks, but rather these modifying factors are often intertwined with the theoretical variables of the ecological model. This model can be seen as a way to organize factors associated with complex social problems so that knowledge building can occur and intervention can be implemented at the appropriate system level (Anthony, Alter, & Jenson, 2009; Cook & Kilmer, 2010; Kilmer, Cook, & Munsell, 2011). Using an ecological approach in observational studies provides a more thorough understanding of the determinants of STD/STI's and teen pregnancy, facilitating the development and implementation of subsequent preventive interventions (Salazar et al., 2010).

El-Bassel, Caldeira, Ruglass, and Gilbert (2009) used an ecological model to show how lack of attention to factors in prevention strategies poses challenges that constitute barriers and prevent African American women from participating in HIV programs. According to the authors, in reducing HIV risk behaviors in African American women, it is critical to assess women for childhood sexual abuse, PTSD, and substance abuse and include specific strategies designed to improve the effects of these stressors. African American women are more likely to become infected by steady sexual partners

and less likely to use condoms with that partner. Ironically, all HIV programs designed for African American women simply empower them to negotiate condom use because of longstanding issues they have with speaking up to male partners. This dissertation was designed to identify why identify stressors of AA women from childhood when an even heavier burden is placed on her to convince her partner to use condoms. This led to the present study's argument that individual approaches are not effective in prevention and the environment in which the adolescent is embedded should be included in developing prevention strategies. Females and males have to see the benefit or buy into the use of condoms if not for others, then definitely for the love of themselves. Not only that, but this notion supports the argument of many authors that HIV prevention should start early in all African American adolescents, although AA girls are at a greater risk.

Several researchers have identified that youth views of sexuality and appropriate sex education pedagogies depend upon adolescents' subcultures, individual attitudes, and beliefs about sex. Religion, politics and current sex-related health issues like teen pregnancy and sexually transmitted infections shape their views.

In terms of policy and service delivery for the prevention of teenage pregnancy, policy initiatives involving macro and mesosystems were needed. Failure to include policy directives in theoretical frameworks that drive program implementation is a major oversight. McLeroy et al. (1988) asserted that policy development, policy advocacy, and policy analysis all play an important role in health promotion. Policy development activities may include increasing public awareness about specific health and policy issues and educating the public about the policy development process. Public advocacy can take

the form of encouraging citizen participation in the political process at the federal, state, or local level. A policy analysis role would include providing policymakers, the general public, and target populations with policy options and promoting public input into the policy making process (p. 366). The ecological theory is important in building linkages.

Conceptual Framework

This study is modeled after the Communities Coping with Change framework, where the community becomes empowered on a local or community level toward a collective social action with the capability to exert influence on changes in policy, such as sex education. An essential statement for the CCC model is the reverence for strong community support in influencing policy development. A recent sex education study took place at the Independent School District in Boise Idaho where the CCC framework was modeled. The community's strength and weaknesses were assessed to depict opportunities for a sex education curriculum change. Elliot (2010) found that the school's sex education curriculum was influenced by cultural, legal, and economic pressures in regards to the type of textbooks the school received and the budget allotted for the curriculum.

The current study benefitted from this framework by identifying professional members of the community who have the ultimate say on the sex education curriculum and by identifying the needs of the parents and students for a collaboration of ideas to enforce the best sex education curriculum for students. This framework allowed me to further promote social change on a community or local level.

Literature Review Related to Key Variables and/or Concepts

Environment

Social determinants are economic systems and social structures that are needed to maintain and improve health; the lack of opportunity or resources of these social determinants places a person at a health disadvantage (CDC, 2010). The structural and societal factors such as social/physical environments and the availability and cost of, as well as access to, health services create barriers to good health. Several studies have identified the environment in which people live as the primary factor that predisposes them to diseases and pregnancies (CDC, 2010; National Research Council, 2001; US Department of Health and Human Services, 2013).

The environment is comprised of the sexual networks in these areas that are dynamic in nature and reflect the diversity of human sexual behavior. Existing research suggests that adolescents' sexual behavior and reproductive health are determined by multiple factors of their own characteristics and behavior, demographics, academic achievement, relationships with peers/caregivers, and distal developmental contexts such as neighborhoods (Collins, Martino, & Shaw, 2010; Gardner, 2013; Kirby, Coyle, Alton, Rolleri, & Robin, 2011; Winters & Winters, 2012; more). As Schmid and Kretzschmar (2012) pointed out, it is more complex than the environment; it is what takes place in the environment that puts a group more at risk than others.

Moreover, there was a gap in the available research exploring why teen pregnancy and sexually transmitted diseases are increasing in rural southern areas. There were only two studies that revealed the attitudes of parents and adolescents in a rural

area. One study depicted how rural African American parents perceive human papillomavirus vaccination, and another study showed how Caucasian adolescents perceive sex education.

Perhaps exploring the perceptions adolescents living in rural areas and their parents have about sex related issues will shed light on how to reduce teen pregnancy and sexually transmitted infections. This research explored the perceptions African American adolescents have about sexual health, which includes teen pregnancy and sexually transmitted infections in a rural community.

Little, Henderson, Pedersen, and Stonecipher (2010) examined the perceptions of teenage pregnancy among high school students in a rural community in Oregon where teenage pregnancy rates were high. The authors hypothesized that the identification of students' perceptions of teenage pregnancy would build and influence changes in the curriculum to address the phenomenon. The study was conducted using 22 students (21 Caucasians and 1 Hispanic) divided into five focus groups where they completed a 90-minute survey during the summer of 2007. The results of the study revealed that 40% of the students came from an underprivileged background, all of the pregnant or parenting teenagers were in the lowest income group, and only four participants' household incomes exceeded $40,000 annually.

In Little et al.'s (2010) study, students' perceptions of teenage pregnancy revealed four major themes. First, the number of teenage pregnancies were increasing and becoming a growing concern. Second, teenage pregnancy posed harm to education and finances. Third, and occurring more than any other theme, women wanted babies as a

status symbol while men only wanted sex. Finally, teenage pregnancy happened by chance or was the consequence of having careless sex even though students were aware of contraception methods through their peers, the media, and family members. The authors proposed that these perceptions were the result of AO programs that had been proven less effective than abstinence-based programs and advised the Sweet Home School District to implement an abstinence-based program with the inclusion of the developmental asset framework where students' internal and external assets are developed with the necessary skills and strategies needed to prevent pregnancy.

The limitations of Little et al.'s (2010) study included a small sample size used to generalize an entire U.S. teenage population. The study provided insight into the minds of teenagers in a low-income rural community similar to the population in the southwest Georgia school district where my study took place. The authors suggested future research to examine the perceptions of teenagers from diverse racial/ethnic backgrounds. My study fills this gap. Two implications from this study offered an effective approach to pregnancy prevention. First, a school-based approach as a part of sexual health class established knowledge and skills. Second, a developmental asset framework with particular focus on external resources (e.g., parents, peers, and school) promoted healthy sexual behavior in teenagers. This study did not have a framework to guide its approach. I used Bronfenbrenner's bio-ecological theory as a developmental asset approach.

Garner et al. (2012) found that the most disadvantageous neighborhoods produced hostile caregivers, which inspired the early initiation of sexual behavior and multiple sex partners among adolescents. Inversely, when neighborhoods are less disadvantageous,

caregivers give warmth to adolescents and adolescents have fewer sexual partners and later sexual initiation. Adolescents with aggressive caregivers become aggressors to their peers and are likely to be unpopular in advantaged environments, yet they are more popular and have increased sexual opportunities in disadvantaged environments.

There was a positive association between aggressive caregivers and adolescents having sex early. However, Garner et al. (2012) did not clearly identify the aggressive manner with which the caregiver taught an adolescent to survive in rough conditions. It was not clear if the rough conditions were due to crime, poverty, or high rates of sexually transmitted infections. The study did not address whether there were aggressive teachings on abstaining from sex or using contraceptives. There is an assumption that caregivers' primary concern skews heavily towards survival rather than safety. For some, prostitution is a reality for obtaining the necessities of life such as food, shelter, clothes, etc. in environments where conditions are economically deprived. In such desperate circumstances, the primary concern is survival.

While this study was generalizable for urban areas, it lacked the qualitative data derived from obtaining personal knowledge of the messages caregivers were relaying. The present study viewed the messages provided to rural adolescents in regards to sexual health. As some studies have shown (e.g., Blinn-Pike, 2008; Royer et al., 2009; Sherr & Dyer, 2010), an understanding from the adolescents' perspective is essential in determining what they think the messages are and how to better communicate sexual health messages regardless of the environment in which one lives. Simply, there is no

guarantee that they will live solely in that environment, so preparation for life is the most realistic approach.

Owusu-Edusei, Chesson, Leichliter, Kent, and Aral (2013) examined the association between income racial disparities by county-level in the U.S. among blacks and whites using quantitative methods. The authors found that the rate of sexually transmitted infections such as chlamydia, gonorrhea, and syphilis was higher for blacks than for whites across counties. Also, the rate of all sexually transmitted infections was higher in counties with a lower male-female ratio. Ironically enough, for blacks in areas where their incomes were higher than whites, STI rates were still higher among blacks than whites. The authors attributed this disparity to the allocation of public resources for STI prevention that is made predominantly by whites without awareness or sensitivity to the issues and provisions of blacks. As several studies have revealed, there has to be sensitivity to cultural needs of a group of people (Romer et al., 2009; Winters & Winters, 2012; Wyatt, 2009) because a one-size-fits-all approach is not effective in preventing sexually transmitted infections. These identified factors of race, income, or environmental disparities are affected by the distribution of power and resources, all of which can be addressed through policy (CDC, 2010, p. 3).

Newbern et al.'s (2013) quantitative study consisted of estimating the risk of HIV association with sexually transmitted infections (STI) in adolescents at a Philadelphia urban high school where an initial STI screening of students reported the rate of STIs as high. They found that adolescents who had STIs had an elevated risk of HIV in adulthood due to common bacterial STIs like gonorrhea, syphilis, and chlamydia. Though gonorrhea

was represented in smaller cases, its role is dominant as a gateway infection for HIV for the general adolescent population. This study identified the sexual environment in an urban area where screening for STIs takes place. It is imperative that more schools offer screening and accurately report the sexual climate of their school. As previously stated, resources have a major role in determining what can take place in any environment. The present study did not address the screening of adolescents. However, by way of interviewing, administrators and health advocates were questioned regarding their knowledge of the sexual climate in their school or environment. There is little to no research on rural schools screening adolescents for STIs. In that case, the Newbern et al. (2013) study may not be generalizable to the rural school district in the present study.

Church

Churches have played a significant role in the development of the African American communities and have been regarded as the center of African American life. There is a scarcity of studies on the role of churches when it comes to the prevention of teen pregnancies and sexually transmitted infections in the African American community. There are few to no current empirical studies targeting the perceptions the clergy have about sexual health and how to better inform teens about topics in rural areas. Moreover, there were a few studies that targeted HIV/AIDS interventions in urban African American churches for adults only. Perhaps exploring the perceptions the clergy have about sex related issues in this research has shed light on how to reduce teen pregnancy and sexually transmitted infections in a rural community.

Chappell, Maggard, and Gibson (2010) stated that religiosity, or at least church attendance, is the predominant theoretical predictor of attitudes toward sexuality. Samuels (2011) furthered this premise by stating there is a direct relationship between church attendance and the utilization of health services. Pastors have an opportunity to enhance health promotion efforts to educate members and serve as a link to the healthcare system, especially in the African American community where medical professionals or the government are not thoroughly trusted (Parrill & Kennedy, 2011; Thomas et al., 2012). However, there was no framework to help churches address the growing prevalence of HIV in their communities.

Coleman, Lindley, Annang, Saunders, and Gaddist (2012) also emphasized the importance of Black churches in HIV prevention. Coleman et al. (2012) conducted a qualitative study on HIV/AIDS prevention programs in African American churches under Project FAITH, a privately funded initiative in South Carolina. They found that without the resources, there was no guarantee the church would continue prevention efforts under Project FAITH and that many members in the church did not support the effort due to the common misperception that HIV/AIDS is a disease associated only with homosexual men or that HIV/AIDS does not affect the community. Based on the findings from the study, the Project FAITH framework calls for people who are passionate and devoted to addressing HIV/AIDS and who can implement strategies for HIV/AIDS prevention through African American churches. However, this framework does not address what adolescents would be taught, being that they are at a disproportionately high risk of

delinquency as well as mental, emotional, and physical disorders given the multitude of factors directly impacting black families (McBride, 2013).

McBride's (2013) study was conducted to learn how to integrate religion in a family health program. The author concluded that partnering with the community increased the likelihood of use and success. Further, in the African American community, protective factors of religion and spirituality are tools for youth against risky behaviors such as alcohol use, delinquency, sexual activity, and depression. This study complimented the present study from the ecological theory precept that behavior changes in adolescents should be addressed from any place adolescents spend time, including their church.

Nunn et al. (2012) studied African American faith leaders' perspectives on reducing racial disparities in the prevalence and treatment of HIV/AIDS infection. The faith leaders identified two primary challenges to addressing HIV/AIDS: 1) not knowing how to address human sexuality broadly from a biblical context and 2) having fear that tithing and offerings would come to a halt if they discussed condom use, risk behaviors, and human sexuality considering that discussions of sex are still taboo in the African American church.

Moreover, faith leaders worried that if they were to discuss HIV/AIDS, they would be perceived to be homosexual. Across the board, leaders believed that discussions of HIV have been linked to sin, homosexuality, and inhibiting the curing of homosexuality. These leaders also believed they did not have the economic or physical

support to take on such a huge responsibility, and they were not comfortable speaking to their congregation on a controversial topic.

Nunn et al.'s (2010) ideal faith-based framework is similar to that provided by Coleman et al. (2012) on HIV testing and leadership rather than risk behavior. Numerous studies have stated that one of the reasons African Americans in low-income areas are susceptible to infections and disease is the lack of knowledge and education (Williams, Wyatt, & Wingood, 2010). With that being said, if churches miss a very critical opportunity to educate their congregation about risky sexual behaviors, those faith leaders will be doing a disservice to their flock.

The previous studies (Coleman et al., 2012; Newbern et al., 2013; Nunn et al., 2012) took place in urban areas, which makes it less likely that the results from the studies can be generalized to rural areas, in which the present study took place. However, those studies did reveal that research on rural African American churches and this matter is virtually nonexistent. The present study fills a gap in literature by allowing faith leaders an opportunity to share their perceptions of rural adolescents' sexual health where sexually transmitted infections have posed the greatest threat to African American adolescents. Thomas et al. (2012) stated that understanding the importance of rural African American parents' knowledge, attitudes, and spiritual beliefs is needed when designing health education programs. In addition, the effect that pastors and churches have on rural African Americans should not be taken lightly, which makes the study at hand study important. Rural culture encompasses religion, spirituality, and sociodemographics (Thomas et al., 2012). Because religion is an integral part of rural

African American culture, premarital intercourse is believed by some to be immoral and sinful, and it may not be deemed as an appropriate topic of discussion for rural church leaders. Moreover, Friedman, Cooper, and Osborne (2009) agreed that to better understand such cultural variations, there must be an examination of what elements make up African American culture and how they interact with sexual and drug-use subcultures, networks, and behaviors.

Culture

African Americans are a diverse group of people bound by historical experiences that have resulted in their survival strengths, which are guided by spiritual and cultural values passed on from generation to generation. There is an abundance of pregnancy and sexually transmitted infections programs. However, there is a very limited number of programs targeting African Americans in rural communities. Research suggests that one-size-fit-all pregnancy/STI prevention models do not address individual differences as needed (Blomquist, 2010; Rosenbaum, Stephan, & Rosenbaum, 2010). Culture has been identified as a critical missing piece in sexually transmitted disease and pregnancy prevention programs that target African Americans (Calsyn et al., 2012; Centers for Disease Control and Prevention, 2010). Culture-specific interventions showed success in reducing HIV-risk sex behaviors among African Americans (Crepaz, et al., 2009). There are little to no empirical studies targeting the perceptions that rural African American adolescents have of how culture influences their views on sexual health and how to better inform teens about topics related to sex and health from a cultural perspective. Exploring the perceptions African Americans in a rural community have about sex related issues in

the present research will shed light on how to reduce teen pregnancy and sexually transmitted infections in a rural community.

Cultural cognition theory implies that people will accept or reject information about risk in a way that fits their cultural values, beliefs, or spirituality (Kahan, Braman, Slovic, Gastil, & Cohen, 2009). African Americans are particular about which they receive information from due to generations of trust issues with government and medical professionals (Friedman, Cooper, & Osborne, 2009). Local culture shapes people's perceptions of risk or perceived vulnerability, and people assign value to an issue on the basis of their experiences and experts who share similar backgrounds (Kahan, Braman, Cohen, Gastil & Slovic, 2010). William, Wyatt, and Wingood (2010) agreed with Kahn et al. (2010) that there is a decreased chance of miscommunication when people who look and sound like the receiving group provide information.

William, Wyatt, and Wingood (2010) identified four Cs of HIV Prevention with African Americans: Crisis, Condoms, Culture, and Community. They assert that more has to be done to combat HIV/AIDS in their communities. They suggest moving beyond basic sex education, condom use, and availability, and they include successful interventions that optimize strategies that integrate sociocultural factors and address institutional and historical barriers that hinder or support HIV risk reduction behaviors. These strategies include the use of theories or conceptual frameworks that are pertinent to African Americans and the sociocultural context such as family community, traditional church norms, cultural pride, and sexual behaviors (Crepaz et al., 2009; William et al., 2010) that may have stemmed from hostile historical and contextual situations such as

poverty, stereotypes, abuses, and incarceration. Furthermore, cultural sex role beliefs and cultural differences in masculinity beliefs may predict condom use and attitudes (Calsyn et al., 2012); however, the use of condoms presented with a sociocultural context can be a powerful weapon against HIV for those already infected (William et al., 2010).

While previous studies identified culture as a significant but not critical component, Ferguson et al. (2008) dispelled that assumption and argued that the content of health-promotion activities should be attuned to the cultural setting in which youth live. The authors further asserted that the content of health promotion programs is strongly influenced by the sociocultural context, which positively or negatively shapes the decisions adolescents make overall. Schalet (2011) found that culturally based teen pregnancy programs are helpful in decreasing sexual initiation among African American students. It requires both political will and cultural innovation (Schalet, 2011). In 2009, the National Conference of State Legislatures (NCSL) briefed state legislatures on the importance of addressing disparities in teenage pregnancy rates of at-risk minority youth. They argued that the legislature's failure to do so in a cost-effective and culturally sensitive way would stop the small progress made decades ago. The brief further stated that research on pregnancy prevention programs failed to take into account culturally sensitive contexts (NCSL).

In 2009, Plybon et al. conducted a study on 156 urban African American girls' relationship with appearance, body image, and sexual refusal self-efficacy. The study found no association between body image and sexual refusal self-efficacy. However, when African American girls have a positive sense of their Afrocentric appearance, they

have greater confidence in refusing sex. It is fair to assume that African American girls might suffer from the lack of self-acceptance; based on studies by Eni and Phillips-Beck (2013) and Plybon et al. (2009), they need a cultural framework that motivates, encourages, and helps them to identify their self-worth in order to combat the inability to abstain from risky sexual behavior.

Schalet (2011) used an A, B, C, and D framework to address the sexual health needs of adolescents. The *A* referred to autonomy of sexuality where curricula involved helping youth discover sexual feelings separately from desires as they learned to anticipate and prepare for sexual acts. Youth who have a greater sense of control in sexual situations are more likely to refrain from sex and use condoms when they do engage in sexual activity. The *B* referred to building good romantic relationships. Positive, age-appropriate material that promotes getting to know someone, building trust over time, dealing well with conflict, striving for power equality, and having fun are components curricula should include. Adolescents' sexual outcomes are positive when good romantic relationships are in place. The *C* referred to adolescents' connectedness with parents and other caregivers. Communication with parents can have positive health effects for youth. Schalet (2011) stated that frequent communication about sex is the solution; Brubaker's study in 2007 dispelled the argument that the more parents communicate with adolescents about sex the more likely these teens will become sexually active. I concur with Schalet's premise. Lastly, the *D* referred to recognizing diversities and removing disparities in access to vital socioeconomic resources. It is logical for

curricula to address the disparities and diversities in those teens' sexual and emotional development, sexual orientation, and gender identification as cultural values vary.

Communication

The source of information about sexual health influences adolescents' sexual awareness. Adolescents are impressionable beings and sexual health messages shared with adolescents have a tendency to shape negatively or positively the sexual health of youth into adulthood. There are few studies that show parents are the primary source of providing information about sex to their adolescents (Dolcini, Catania, Harper, Boyer, & Richards, 2012). Also, numerous studies have characterized African American girls as fearful when it comes to discussing the use of condoms with their sexual partners, which is partly the reason teen pregnancies and sexually transmitted disease/infections peak in African American communities (Byrd & Shavers, 2013).

Parents are not the only people with whom teens spend time. There are many factors, such as medical doctors, peers, and media that influence teenagers' decisions regarding sex and sexual views. The only study on the communication between mothers and daughters about sex was conducted in 2004 with suburban Caucasians (Young, Turner, Denny, & Young, 2004). There is little research on sexual health messages in rural African American communities. Several studies have identified the criticality of communication when it comes to delaying sexual activities among adolescents. The present study's exploration of the perceptions of African Americans in a rural community who communicate sex related issues to adolescents in the present research sheds light on

what needs to be addressed from a rural view in reducing teen pregnancy and sexually transmitted infections.

Musa, Schulz, Harris, Silverman, and Thomas (2009) stated that within minority populations, increasing the cultural sensitivity of medical professionals and institutions could build trust. An effective way to increase preventive service use and reduce health disparities is to use trusted community organizations to disseminate health and prevention information, particularly for minority communities like the one in the present study. I further asserted this ideal by including consistent yet effective messages by way of media. Though mass media has the broadest reach, interpersonal communication is more effective (Romer, 2009). However, if media messages and interpersonal messages portray the same message of using condoms even in serious relationships, this will then be the most efficacious form of communication. Romer (2009) described a culturally sensitive approach to using mass media to promote greater acceptance of safer sexual behavior in the wider African American youth audience and, more importantly, to encourage behavior change (condom use) in the youth most at risk for sexually transmitted infections (STIs), including HIV, through television and radio. Romer (2009) rightfully suggested that those who pass along messages about interventions and how they do so must be consistent with and sensitive to both the "surface structure" and the "deep structure" of an audience's culture. *Surface structure* means the use of language has to be relatable to the target audience along with the chosen channel of communication (e.g., open forum, one-on-one, groups, pictures, videos, plays, etc.). *Deep structure* refers to an underlying understanding of how the audience views sexual health in their lives. The

intent of the present study identified with Romer's premise and, as a result, explored the perceptions African American participants have towards a sexual health curriculum.

In Romer's study, groups with the highest risks received the lowest number of preventative measures, when it has been proven that parents have a major impact on their children's sexual decisions (Sawyer, et al., 2012; Wilson, Dalberth, Koo, & Gard, 2010; Parkes, Henderson, Wight, & Nixon, 2011). Particularly in the black community, girls and boys receive different messages from their parents about sex. As a result, Tobey, et al. (2012) believed there should be a gender inspired curriculum. I opposed separate sex education manuals when the boys and girls have to be around each other in or out of class.

Of all the literature reviewed, Tobey et al. (2012) was the only literature that provided information on the likelihood of fathers communicating sexual knowledge to adolescents. Several studies supported the notion that African American communities in particular hold double standards for girls and boys (Akers, Schwarz, Borrero, & Corbie-Smith, 2010; Teitelman et al., 2009), which confirmed the need for the present study in which an exploration of African American fathers'/males' perceptions filled a gap in literature from a rural perspective. African American adolescents received more communication from their fathers than did Caucasian and Hispanic adolescents (Tobey et al., 2012). This implies two things. One, African American fathers speak more to their sons on the subject of sexual relationships because they too have been taught that the more women a man has, the manlier he becomes. Two, they speak to their daughters about avoiding those young men who tend to have multiple women to save them from

heartbreaks. The irony is that the male influence counsels different values to boys and girls, a double standard that will be perpetuated if another influence does not temper or replace such an attitude. Sexual norms are primarily transferred from one generation to the next (Reed et al., 2012). Reed et al. (2012) and Tobey et al. (2011) support the premise that it is less acceptable for females to have multiple sex partners when in romantic relationships. If a female violates the norm, she might look less appealing. Conversely, adolescent boys with multiple sexual partners are acceptable. Also, younger females of all races receive the least amount of communication regarding sexual health. Fathers are more accepting of premarital sex for their older teens, whether male or female.

Grange, Brubaker, and Corneille (2011) conducted a study examining the effects of the messages African American women receive in a familial context in regards to sex. The authors assert, as prior studies have, that contextual factors of poverty, culture, and access to health care contribute significantly to the overwhelming number of cases of sexually transmitted diseases and pregnancies. Grange et al. (2011) noted that black women's sexual behavior is a direct reflection of the influence of family members, which reinforces Bandura's social learning theory. The study revealed that women received information mainly from three sources: women of previous generations, women of the same generation, and male relatives. The mixed messages can affect a girl's judgment in ascertaining whose information is factual. The National Campaign to Prevent Teen Pregnancy (2013) claims that messages should be consistent across the board to eliminate confusion.

This finding also supported the argument that African American females need accurate sexual health knowledge and guidance to make informed decisions regarding sex and relationships on their own. Furthermore, messages from family about intimate relationships and sex should convey positive sexual health in avoiding unplanned pregnancy and sexually transmitted diseases. Messages from women of older generations and male relatives stressed the importance of women seeking someone who knows how to treat them with respect, who is not abusive, and who does not just want sex, while women of the same generation encouraged women to seek someone who is financially stable. All generations shared personal experiences of what African American women should look for based on their own (family member's) relationships and what to avoid from those lessons learned. The advice given by family members suggested the need for African American families to empower women to recognize their values and self-worth.

Grange et al.'s (2011) study was sound in its approach and theoretical framework in addressing the importance of familial communication when it comes to whose advice women listen to, their study was limited to a small sample size of only 25 African American women, insufficient for generalizing to a target group (2011). In addition, the age range of the participants was 18-26 years old. Numerous studies have shown that sexual intercourse begins earlier than 18 years of age, which means youth under 18 need to be reached. I addressed this gap by interviewing younger females—grades 9^{h} in a rural area in southwest Georgia to explore whom they considered to be the most suitable source of information regarding sexual health. I found it necessary to reach youth early

because the messages they believe as children are the same messages they may have as women.

Sexual Behavior

The manner in which a child perceives life and family will mirror the way in which he/she sees him/herself. How a child views him/herself is a predictor of how he/she will deal with sex related issues. By the time a child reaches the stages of adolescence, he/she should be able to recognize boundaries relevant to sexual behaviors. If this is not the case, the adolescent will likely engage in risky sexual behaviors, and in some cases, their behaviors will become uncontrollable. Although there is a great deal of research regarding adolescents and sex related issues, the available research presents topics such as how they view their relationships (Young, Furman, & Laursen, 2011; Wood, Avellar, Goesling, 2008). There are few empirical studies targeting the perceptions adolescents have about sexual health and how to better inform teens about topics related to sex and health. Furthermore, there are fewer studies that targeted African American adolescents. Explored perceptions adolescents have about sex related issues shed light on how to reduce teen pregnancy. The present research explored the perceptions African Americans have about sexual health behavior and its consequences, which included teen pregnancy and sexually transmitted infections.

In a U.S. urban public school, 57 eighth graders (95% Whites, 4% Latino, and 1% African American) completed a questionnaire regarding romantic relationships, a measure of importance in a romantic relationship, and a measure of sexual behavior (Royer, Keller, & Heidrich, 2009). The framework for the study included three aims for

effective sex education programs from the literature provided by Schalet (2011): 1) to help adolescents develop a sense of autonomy over their sexual selves, 2) to build positive romantic relationships, and 3) to maintain closeness with care providers. Royer et al. (2009) discovered that more than half of the eighth-grade participants believed that approved romantic behavior in eighth-grade romantic relationships ranged from holding hands to sexual intercourse. Unacceptable romantic relationships included sexual intercourse without a condom at 72%. Adolescents' approval of sexual activity was not determined through abstinence messages alone. Eighteen percent of eighth-grade students identified that abstinence was not acceptable while 39% were uncertain. These students participated in a 3-year minimum abstinence-only education program. Moreover, there were students who were unsure about sex with a condom (26%), without a condom (19%), and abstinence (39%). School curriculum should include ways for youth to recognize boundaries and the ability to articulate their sexual boundaries (Ferguson, Vanwasenbeeck, & Knijn, 2008; Royer et al., 2009). A small majority of eighth graders (53%) said that their first motivation for a romantic relationship was growth—to be personally connected with someone and to gain experience with relationships. Students' second motivation for a romantic relationship was popularity—to fit in or to show maturity (social enhancement). Research showed adolescents desire to be listened to and to receive nonjudgmental treatment by health care providers and to be taken seriously.

I agreed with Royer et al. (2009) that if sex education programs are designed based on youths' perceptions, a level of trust and openness may develop between providers and the adolescent. Royer et al.'s study was limited to a majority Caucasian

population in an urban area. However, the aim of my study was influenced by the lack of culturally representation of the school's sex education curriculum where studies have confirmed that African American youth are most likely to become pregnant during the early middle/high school years.

Sherr and Dyer (2010) conducted an empirical study comparing African American and Hispanic youth perceptions of comprehensive sex education administered in the church and the school. The study took place in Miami, Florida in an area with a high rate of sexually transmitted infections and teenage pregnancy. The randomized sample was comprised of 620 African American and Hispanic youth. The subjects participated in a 9-week Project U-Turn where facilitators challenged youth to identify the benefits of healthy relations and to choose abstinence until marriage as the only effective way to avoid sexually transmitted diseases and pregnancy. Sherr and Dyer (2010) agreed that the church is the rightful place for sexually active youth to engage in comprehensive sex education due to the protective role the church plays in the lives of African American and Hispanic youth. The findings of the study suggested that there is a need for more empirical studies of comprehensive sex education that is tailored to minority youth in church and school. It was evident that minority youth need both teachings. Youth in both settings reported feeling that they had more control when facing sexual situations, wanted to remain abstinent, and understood why they should remain abstinent. In addition, combining abstinence and comprehensive education can only help youth achieve greater awareness of and protection from the dangers of risky sexual behaviors.

The study was relevant in combining both venues where youth spend a great deal of time. This study is parallel to the aim of the current study in combining places where youth interact on a given day, whether it is school, church, or after-school programs. The limitations of Sherr and Dyer's study include a convenience sample rather than random sampling, which forfeits an opportunity to generalize to either minority population. The study relied on students self-reporting, which could have been faulty if the subjects merely gave the facilitators what they thought they were looking for. These findings, however, dispelled the myth that knowledge of contraception increases youth sexual behavior. The church has a major opportunity to play a transformational role in teaching youth about healthy relationships, personal goals, and communicating effectively—values all consistent with the church's doctrine—while including a sex education program that distributes accurate information about contraception. The church and school working together can better prepare students mentally, socially, and emotionally to avoid risky behaviors.

Blinn-Pike (2008) conducted exploratory research on the feelings of rural educators regarding school-based sex education in order to create better working relationships between school administrators, prevention researchers, and teachers in their mission to prevent high-risk sexual behavior among adolescents. Blinn-Pike interviewed 24 teachers from four different counties by means of a qualitative survey. The findings from the study showed that according to the rural educators, the social and political communities decided on the type of sex education students received. Interestingly, rural educators boasted about their closeness with their students both in and out of school as

their way of controlling their students' decisions. That could be an opportunity if properly capitalized. Lamb (2010) asserted that the goal is to equip students with sound decision-making strategies when it comes to sex. Interestingly enough, Blinn-Pike's (2008) study did not mention the church's influence on sexual behavior, yet rural educators overwhelmingly acknowledged their attitude towards sex was influenced by personal religious beliefs**.** Educators believed their ineffectiveness or inability to reach or control students' sexual behavior was due to the existing political and religious constraints (Bleakley, Hennessy, & Fishbein, 2010; Blinn-Pike, 2008). Blinn-Pike argued that if rural educators were unable to reflect the community values, rural students would suffer the negative consequences of high-risk sexual behaviors.

Rural educators and students tend to perceive themselves as having better relationships with each other than urban cohorts. This sort of perception could be a benefit to students in terms of trusting educators, yet it could equally be a disadvantage if educators are ridiculed for suggesting sex education that is not reflective of the community's interests. In some cases, such a suggestion could be considered out of bounds and could perhaps result in firing.

Blinn-Pike asserted that educators, community leaders, and adolescents could collaborate in developing a sex education prevention curriculum that specifically addresses the needs of rural adolescents. Though the curriculum would address barriers to preventing teenage pregnancy and diseases, such as geographic location, rural poverty, isolation, unemployment, lack of anonymity, and lack of access to healthcare, it could

discourage adolescents from believing they are impervious to disease and pregnancy because they live in sparsely populated areas as described.

Abraham, Macauda, and Singer (2011) found that many young adults from their study relied on a strategy of using clinic-sponsored STI/AIDS screening when they wanted to discontinue condom use with a partner. Terrifyingly, Abraham et al.'s (2011) data suggested that screening is a common strategy used by many couples to transition to having sex without a condom, though the data showed that most youth do not maintain monogamy even in long-term, serious relationships. Thus, sharing test results may provide a false sense of security in the sexual culture of inner city, minority youth. Medical care professionals may be an important source of sexual information and opportunities to learn about sexual and reproductive health may arise in standard medical visits, but prior research suggests that females are more likely than males to have this opportunity because females spend more time in the doctors' offices than men. Focusing on adolescents with gonococcal infections or multiple STIs might have the greatest impact on future HIV risk (Newbern et al., 2013).

Human Rights/Effective Sexual Health Programs

People in a democracy have the right to accurate information in order to make well-informed decisions. The lives adolescents live today can have a detrimental effect on society tomorrow. Research has stressed the importance of providing minors with accurate information about sex in every effort for them to gain the knowledge and power to protect themselves and others against unplanned pregnancies, diseases, and infections. Ideally, schools are the places where truthful information is transmittable and should

provide sex education in the manner that the community sees fit. Accurate sex education should be an inalienable fundamental right. All are born free and everyone should be able to receive such education regardless of color creed, etc.

Moreover, there was a gap in the available research exploring why teen pregnancy and sexually transmitted diseases are increasing in rural southern areas. Researchers have stated that public health problems such as teen pregnancies and sexually transmitted infections/diseases must be approached from multiple levels—individual, interpersonal, and social-structural (Auckland, Nguyen, & Le, 2013).

Sex education has long been offered under the health curricula. According to Lamb (2010), citizenship and sex education taught together could provide youth with an ethical demeanor towards sex, where they are not limited to narrowly addressing their individual needs but have a moral awareness of the external influences around them. Lamb reviewed both comprehensive and abstinence education and derived ways the school curriculum could include ethics education in conjunction with sex education. Teaching sex education from the perspective of multiple disciplines, such as philosophy and history, has the implication of addressing adolescents as decision makers, sexual citizens, and ethical human beings. With this approach, Lamb argued, health is a component of the curriculum where moral issues are addressed. I agree that real-world discussions about individual rights, consent, and human dignity are beneficial to teenagers (Lamb, 2010). Similar to Boonstra (2011), Lamb supported the notion that sex education should focus less on prevention and more on youth cognitive development in

dealing with the pressures of early sexual initiation. Lamb delved further into social development as a preventive strategy.

Adolescents receiving inconsistent and inaccurate information will influence adolescents' sexual behavior. Adolescents interact with people or things that can positively or negatively influence them on a daily basis, whether it is a parent, teacher, peer, sexually explicit video or song. Mixed messages on what is appropriate can confuse an impressionable adolescent. Abbott, White, and Felix (2010) argued that adolescents are not ready for sex because they have cognitive and emotional limitations that prohibit them from thinking logically. The authors identified 11 limitations:

1. They tend to focus on the here and now. Long-term consequences of behaviors are often ignored.
2. Teenagers have limited impulse control and as a result, passion and pleasure can drive behavior resulting in irrational and illogical choices.
3. Adolescents frequently underestimate the risks in risky behaviors.
4. Adolescent values, not fully formed, can be overwhelmed by peer pressure, media propaganda, and situational factors.
5. Adolescents' egocentrism limits their ability to empathize with others. Their egocentrism may blind them from perceiving the potential harm they may cause to others.
6. Strong emotions can overwhelm rational thinking. Teenagers tend to do things based on the peer group instead of well-reasoned thought.

7. Moral reasoning is precarious. Teenagers grow skeptical of parental, societal, or religious prohibitions as they see faults and hypocrisy and tend to justify breaking rules because others do so.
8. Teenagers are overly self-conscious. Their imaginary audience makes them more vulnerable to self-criticism and subject to the opinions of the peer group. They may be more worried about peer judgment than doing what they know is right.
9. Convergent thinking dominates adolescent problem solving. A teenager relies on his or her unique experience and current knowledge to solve present problems.
10. Teenagers can misinterpret other people's emotional reactions. They misread the verbal or behavioral cues in interpersonal interactions.
11. Alcohol and other drugs have greater influence on the adolescent brain than in adults. The teenage brain is more sensitive to any type of chemical imbalance. (pp. 165-166).

The authors argued that adolescents' abstinence from early sexual activity better protects them from the emotional instability, depression, suicidal thoughts, and other negative behaviors associated with teenage sex. Weinberger's depiction of the brain reveals that an adolescent's prefrontal cortex, which controls many higher order skills, is not fully mature until the third decade of life (cited in Abbott, White, & Felix, 2010). Youth do not naturally choose to abstain from sex; abstinence occurs with the help of the

school, church, and family by instilling reputable values of self-worth, dignity, and respect (Abbott et al., 2010).

Abbot et al. (2010) further argued that sex education in school is a small part of a student's activity, which on its own has no major implication of making a difference in a student's sexual behavior (Abbott et al., 2010). Many others (Bleakley, Hennessy, & Fishbein, 2010; Kelly & Steed, 2004; Shuger, 2012; Smith-Kuehnel, 2009; Solomon-Fears, 2013), however, disagreed with Abbott that sex education in the school is not an important factor in a student's day-to-day activities because Abbott and the others failed to calculate the amount of time students spend in school versus out of school. Sexually active adolescents need proper education and access to contraceptives. Depriving them of accurate information harms society as a whole more than it helps. Abbott et al.'s study closely relates to the current study, which focused on providing an approach in relation to the ecological theory where comprehensive sexual health is the preferred approach. The current study's approach, however, was more specific to the child's perception of what has been taught at school, home, church, or the doctor's office and plans gathered evidence of the child's perceptions of sexual health from the child personally.

Comparing the U.S.'s and northern European countries' approaches to comprehensive sex education, social researcher Boonstra (2011) asserted that the U.S. primarily focuses on pregnancy prevention programs in keeping youth safe whereas European countries embrace youth as rights holders and provide them with the information and education to which they are entitled. These programs are rights based or holistic, which equip youth to protect themselves against STI and pregnancy. As a result,

government supported schools in northern Europe provide and mandate comprehensive sex education and offer easy access to reproductive health services. No study has found evidence that providing comprehensive education increases sexual risk taking. Boonstra (2011) believed there was a disadvantage in comprehensive programs that focused on pregnancy and disease prevention and argued that we should focus more on measurable outcomes of critical thinking skill, confidence, belief in the future, and gender equality in order to measure a program's ability to change individual behavior even if it is taught in different settings. Schools should implement sex education beginning in the early primary grades when it can be integrated throughout a plethora of topics such as health, biology, philosophy, or religion in an age appropriate manner (Boonstra, 2011). Further, she suggested policymakers should integrate sex education programs as part of extracurricular programs as well as in school, accompanied by sexual and reproductive health services where contraceptives and condoms are accessible.

Education along with counseling intermediations aimed at behavior change must include planning, community support, and organizational change (Auckland et al., 2013). Despite health indicators of high teen pregnancy and HIV/STD rates among African Americans, there are very few programs that meet the need of pregnancy and HIV/STD prevention among youth of color, especially young women. Teen pregnancy prevention programs for youth of color have significantly contributed to the decline in teen pregnancy rates among African American young women (The National Campaign, 2011). However, programs have primarily focused on pregnancy prevention rather than

promoting health and effective contraceptive use for the prevention of sexually transmitted diseases and HIV/AIDS.

The American College of Obstetricians and Gynecologists (2007) identified 10 characteristics of successful sex and family-life education programs based on the Centers for Disease Control and Prevention research findings on programs to reduce teen pregnancy:

1. Focus clearly on reducing one or more sexual behaviors that lead to unintended pregnancy.
2. Maintain age appropriate and culturally relevant behavioral goals, teaching methods, and materials that coincide with the sexual experience level of the participants.
3. Utilize theoretical approaches that have demonstrated effectiveness at reducing other health-related risky behaviors such as social learning theory, social inoculation theory, and cognitive behavioral theory.
4. Allow sufficient time for presentation of information and completion of activities.
5. Involve the participants in personalizing the information being presented.
6. Provide basic and scientifically accurate information about the risks of engaging in sexual intercourse.
7. Address social pressures to engage in sexual activity.
8. Model communication, negotiation, and refusal skills.

9. Select teachers or peer leaders who are committed to the program and provide training to help them facilitate the program.
10. Give and continually reinforce a clear message about abstaining from sexual activity and/or using birth control. [This appears to be one of the most important components of effective sex education programs.]

Varying cultural and ethnic groups have different attitudes, values, beliefs, knowledge, and communication patterns when it involves health, sexuality, relationships, contraception, and child bearing (Pagilaro & Gipson, 2001). As a result, sexual health programs/curricula must be tailored to a specific group in order to obtain the desired results of behavior change. Research has shown that the most effective interventions are nearly always gender specific and culturally appropriate (Pagilaro & Gipson, 2001). Research intervention is essential in promoting self-protective behaviors, pride, and self-identification with youth culture. Culturally appropriate programs are identified as those that acknowledge cultural practices and attitudes, address cultural taboos, meet needs arising out of a specific environment, and have staff that represents the target culture.

The Department of Health and Human Services (2013) identified 28 in-school/community-based programs that were found to be effective in preventing teen pregnancies or births, reducing sexually transmitted infections, or reducing rates of associated sexual risk behaviors (as defined by sexual activity, contraceptive use, or number of partners). Of these 28 programs, only one program, *Reducing the Risk*, is culturally sensitive to African American high school youth and can be tailored to suit a rural area.

The American Public Health Association Policy 200610 (2013) states that ethically, governments have an obligation to provide accurate information to their citizens and to eschew the provision of misinformation in government-funded health education and health care services. APHA holds that AO education programs are inherently coercive by withholding information needed to make informed choices. This literature further supports others in that information provided by AO education is insensitive to sexually active teenagers and discriminates against gay, lesbian, bisexual, transgender, and queer (GLBTQ) youth, and youth of color.

School-Based Curricula

Parenthood is a leading cause of school dropout among teen girls. It has been reported that some school districts have used results from parent surveys to quell resistance to pregnancy prevention programs (Shuger, 2012). An effective approach for increasing adolescents' access to sexual health education was to enforce school district policies that mandated high quality sex education (Fagen, Stacks, Hutter, & Syster, 2010). Some states have policies that require sex education that encompasses information on sex and/or sexually transmitted diseases. Unprotected sex that leads to unplanned pregnancy can in turn lead to sexually transmitted infections. So, if schools are going to discuss pregnancy prevention, then it is only logical to discuss the prevention of sexually transmitted diseases as well. However, the local districts decide what type of sex education is suitable for their district. Very few studies investigated the role of state-level sex education policies while there are no studies investigating the role of local level sex education policies.

There are obstacles when implementing effective teen pregnancy and sexually transmitted infections education. However, the obstacles are more prevalent in rural communities because rural Americans generally hold more traditional values, which confine them to the acceptance of abstinence-only sex education. The Rural HIV/STD Prevention Work Group (2009) stated that rural communities might need to create a community advocacy group consisting of parents, students, clergy, PTA members, faith community representatives, health professionals, educators, community leaders, and other community members to mobilize support for HIV/STD education, which comprised elements of Bronfenbrenner's ecological theory framework. In 2011, the University of Georgia researchers conducted an empirical quantitative study that estimated the effect that 39 state-level sex education policies had on youth sexual behavior using data collected over a 6-year span in 2-year increments from four years (2004, 2006, 2008, and 2010) of the Youth Behavior Surveillance System. The data illustrated the vital role state polices have in guiding youth sexual behaviors. The variables used in this study included state policies, student sociodemographics, and student behavior surveys. The Alan Guttmacher Institute data defined the sex education environment as information on sex education, HIV/STD education, or both. The authors found that states that required comprehensive sex education or states that mandate education but left the content to the districts' discretion had a positive effect on sexually active teens; the use of contraceptives was higher and engagement in sexual acts was lower. Contrarily, states that required sex education and promoted abstinence only had the opposite effect, as is currently the case in Georgia (Atkins & Bradford, 2012). This article's approach was

easy to follow and fact laden. This study aligned with the study at hand in adding to the body of knowledge that state policies are a crucial component in shaping the behaviors of youth towards positive sexual health. Atkins and Bradford (2012) suggested policies that mandate sex education and leave the content to the discretion of the district, which requires comprehensive sex education. My study addressed the issue on a smaller scale in rural southwest Georgia.

In 2009, Boonstra rallied for policymakers to support a comprehensive approach to sex education that genuinely addresses the reality of youth being sexually active. Boonstra supported President Obama's approach on common sense sex education, stating that it is "both good politics and policy" (p. 10). It is good policy because of its evidence-based policymaking in reducing both teenage pregnancy and sexually transmitted diseases. It is good politics because it is in line with what Americans want for their children. Boonstra affirmed that polices at all levels need to support comprehensive approaches because there is no one entity that guides policies, such as school boards, city health departments, or legislatures.

Comprehensive sex education can help reduce teenagers' activity and improve the use of contraceptives while the promotion of abstinence programs that withhold vital information from adolescents puts them at further risk. Boonstra (2011) stated that too often youth do not receive basic sex education. Based on the research evidence gathered in 2007 (as cited by Boonstra), the University of Oxford hypothesized that high income settings may demonstrate a higher effectiveness of AO programs, but the study ultimately found that such programs were ineffective at stopping or delaying sexual activity, even

those with rigorous experimental designs. Kuehnel (2009) asserted the premise that AO education is ineffective in reducing sexual behavior in all youth as studies have concluded, though the social ramifications for racial minorities are far more dangerous. The Human Rights Law supports Kuehnel's argument that the government is required to provide sex education to all students. African Americans attach fewer stigmas to early sexual activity than their white counterparts. As a result, their rates of sexual activity, teenage pregnancy, and sexually transmitted diseases are higher, which relatively suggests that AO education is bound to be ineffective (Kuehnel, 2009). The composition of the program is not relative or relevant to what they have already experienced. African American attitudes and values are insufficient to restrain their sexual behaviors in comparison to white American values; the author asserts that African American youth are more willing to have sex than their white counterparts, which suggests a greater acceptance of pregnancy and "different psychological restrictions" than their Caucasian peers (p. 1245).

As Kuehnel (2009) states, numerous studies further support the argument that AOE programs are ineffective, based on the findings that African Americans, representing only 13% of the nation's population, account for almost half of all HIV/AIDS cases. More alarming is the fact that African American youth between 13-19 years of age account for 55% of the documented cases. The increase in the rate of HIV/AIDS among African American youth can be attributed, in part, to their tendency to believe they are impervious to the disease. The results of Kuehnel's study confirmed that teenage pregnancy among African American females is higher than any other racial

group because AOE does not give a true representation of adequate sexual health. The government knows specifically which group needs sex education more than others; AO programs are still being forced on African American communities, setting them up for failure.

The studies Kuehnel reviewed show that 71% of HIV cases were youth who had contracted the virus before the age of 13. Kuehnel further found that U.S. black students were less likely to receive school instruction on HIV/AIDS and birth control when compared to their white counterparts. He identifies three primary funding sources for AOE education, which directly or indirectly target low-income areas where black youth are vested, which means that AOE will likely be introduced to black youth more than white youth (p. 1253). As further studies (e.g., Kirby, 2009; Lamb, 2010) have confirmed, students who receive both AOE and comprehensive education are better prepared to make sound decisions. In summary, both students who receive only messages to abstain from sex and those who do not receive any message suffer from a lack of knowledge that would enable them to make informed decisions about sex.

In 1982, a court decision in Plyer, Texas ruled that AOE fails African American youth based on the notion that youth do not receive basic education, which develops the well-being of individuals on social, economic, intellectual, and psychological dimensions, and these students could not be denied under the Equal Protection Clause. The court's ruling further stated that basic education is not limited to reading and writing only; it extends to anything that interferes with an individual's placement in society.

Kuehnel (2009) suggested that this clause should be applied to comprehensive sex education.

I believed there are complex interconnections between African American youths' perceptions, their communities, school sex education curricula, and state policies that have an influence over African American youth's ability to avoid risky sexual behaviors. It is necessary to use a methodology such as the case study for its ability to incorporate the existing experience of the participants—their actions, thoughts, feelings, and perceptions—as a major focus of the investigation and its interpretations.

Furthermore, the case study design is useful in education when researchers are interested in gaining more information and possibly interpreting the phenomena in real-life situations (Merriam, 2009). As in the case of this study, the ultimate goal was the development and implementation of a sexual health curriculum in the selected district. Rubin and Babbie (2013) state that the case study design works well when learning about unfairly perceived, known situations. Ideally, this research would provide useful information to be applied towards the global revamping of a sex education curriculum which serves to empower, educate, and decrease the rates of pregnancy and STD's/STI's in adolescents.

Summary

The review of literature regarding environment—church, culture, communication, sexual behavior, human rights/effective sexual health programs, school-based curricula—shows the need for continued research concerning the prevention of teen pregnancy and sexually transmitted diseases among all youth, but in particular African American youth

among whom the rates are highest. If the goal is to change the sexual behaviors of youth, a comprehensive sex education curriculum that adequately promotes sexual health knowledge to sexually active and nonsexually active youth should be ideal. This research presented a social concern because although some curricula and prevention programs exist, the problem of teen pregnancy and sexually transmitted diseases persists and the social issue is more prevalent in southwest Georgia's rural communities. Still, prior to this study, no empirical research has addressed the perceptions African American teens, specifically in a rural community, have about sexual behaviors, nor has it explored how African American teens might view sexual behaviors based on their lived experiences in a rural area. This study helped close the gap in literature regarding the perceptions African American teens who live in a rural community have about sexual health and how they perceive a sexual health curriculum. It contributed to curriculum and curriculum implementation by examining perceptions of African American teens, parents, pastors, health advocates, and school officials and policymakers' interpretation of what an effective sexual health curriculum should look like. Consequently, this curriculum analysis has the potential to ameliorate future poverty rates, crime rates, school dropout rates and single parent households, ultimately impacting positive social change within southwest Georgia's rural communities. Chapter 3 outlines the theoretical methods of inquiry, provide justification for using a qualitative research methodology, and describe the research design.

Chapter 3: Research Method

Introduction

Adolescent pregnancies and sexually transmitted infections negatively affect the lives of students by intruding on their ability to live a healthy life. In the United States, high adolescent pregnancy and sexually transmitted disease (STD) rates have been linked with school policies that emphasize abstinence-only over comprehensive sex education. The purpose of this qualitative study was to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sexual education in their district using a case study design. This study also explored the participants' general understanding of sexual health. Following is the Research Design and Rationale, Role of the Researcher, Methodology, Issues of Trustworthiness and Summary.

Research Questions

The research questions in this study were:

1. What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education in XYZ County?
2. Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?
3. What knowledge**,** beliefs, and/attitudes do the target audiences have regarding the offerings of abstinence-only versus comprehensive sex education?

Research Design and Rationale

I chose a qualitative case study methodology to investigate a selected rural African American community in the State of Georgia's knowledge, beliefs, and attitudes about AO and comprehensive sex education curricula and the importance of sexual health. I have added to the literature: 1) African American perceptions of sexual health within a rural school district; and 2) a determination of the community's awareness of the plague of teen pregnancy and STD's/STI's. African American students were the central focus of this study, as their environments expose them to risky sexual acts for which they are ill equipped. African American students generally lack the knowledge and resources needed to protect themselves from diseases and unplanned pregnancies and incorrectly suppose that AO programs are ineffective in delaying adolescents' sexual initiation (Sutto et al., 2011; Jemmott III, Jemmott, and Fong, 2012; Office of Women's Health, 2012; and El Bcheraoui, Sutton, Hardnett, & Jones, 2013). This clashes with public schools' policy obligation to equip students with cognitive skills and strategies to refrain from unhealthy sexual behavior through health education (Durlak, Weissberg, Dymnick, Taylor, & Schellinger, 2011; CDC, 2013). In reality, many schools have not been successful in promoting positive youth development efforts. Very few schools and after-school programs have been successful (Gavin, Catalano, David-Ferdon, Gloppen, & Marham, 2010; Westrich, London, Stokes-Guinan, Mallonee, & McLaughlin, 2011).

The goal of this study was to understand and describe firsthand, through qualitative research, participants' awareness of the different types of STDs/STIs in a rural community that was plagued with high rates of youth pregnancy and sexually transmitted

infections. The most applicable research tradition to capture the data of this study is qualitative research, where the collection of data is sensitive to the people and place under study (Srivastava & Thompson, 2009). I chose a qualitative methodology to conduct an in-depth exploration of the experiences, feelings, thought processes, and perceptions that are not explored when using traditional quantitative methods (Srivastava & Thompson, 2009) and ask the questions of *how* and *what* and not necessarily *why*.

A qualitative study is used to describe, explain, explore, interpret, or build theory through a holistic explanatory approach with unknown variables. In contrast, a quantitative study is used to test the hypothesis, to explain and predict, to confirm and validate, or to test theory through statistical analysis using known variables. Quantitative research is usually based on trying to explain a hypothesis through statistical analysis. In using a hypothesis in quantitative research, I supplied a tentative explanation to be confirmed or rejected through the study (Rubin & Babbie, 2013).

A mixed methods approach takes a combination of both methods. The methods are combined specifically so that the qualitative data can provide descriptions of how quantitative data apply in particular cases and so that the quantitative data can indicate the numerical aspect of cases that fall within the qualitative category (Rubin & Babbie, 2013, p. 86). If the two sets of qualitative and quantitative data contradict one another, then the validity of the findings could be questioned if I was not proficient in both methods. For example, I could have applied quantitative and mixed methods to capture the number of participants who accurately defined comprehensive sex education or knew the frequency of the sex education course. However, the aim was not to generate

statistics, but rather to delve deeply into what knowledge members of the community possess about sex education and what they feel about the effectiveness of XYZ County School's (pseudonym) curriculum on sex education, which could not be answered richly with yes or no responses. As a result, quantitative and mixed methods were not appropriate to capture the naturalistic generalization of what teenagers and parents feel about XYZ County School's curriculum on sex education.

Qualitative research was the best way to acquire a thorough understanding of how participants viewed sexual health and made sense of their experiences in solving their community's problems of teen pregnancy and STDs/STIs. This approach did not require me to quantify the data to depict a better picture. Interactions among people are difficult to capture with numerical measurements only, and those measurements may not be sensitive to issues of race, gender, economic status, and individual differences, some of which were included in the present study (Srivastava & Thompson, 2009). If I had quantified the data, interactions among people could have been captured through mixed methods using a Likert scale for quantitative data and an interview guide to obtain richer data about the reasons behind the strengths of knowledge, attitudes, and beliefs.

Another rationale for selecting a qualitative approach is that the majority of the studies reviewed for this research study also followed a qualitative approach. Those researchers explored and captured the essence of teens' views on issues of sex education quality through observation and interviews through broader, more meaningful interactions with students, parents, and professional members of the community (i.e., administrators, religious leaders, policy leaders, and health care providers); they

discovered themes rather than identifying variables as the causes of teen pregnancies and sexually transmitted diseases. Other studies captured the approach of parents, administrators, religious leaders, policy leaders, and healthcare providers regarding the types of sex education courses that should be offered, by whom they should be offered, and the appropriate grade at which they should be offered. At the same time, they depicted what these groups spoke to youth about. Previous studies relate to my study on the premise that everyone in the environment plays an important role in the development of youth; however, my study adds more depth to identifying specifically why certain programs are or are not in place and how collectively the community can turn around ineffective policies.

A case study design was the appropriate strategy for this qualitative research. Case studies are in-depth investigations of a single person, group, event, or community (Yin, 2011). Qualitative case studies are most suitable for addressing programs directed toward individual outcomes (Myers, 2009). Yin (2011) stated that case studies study both multiple cases and single cases. In this case, I selected six groups (students' parents, school officials, religious leaders, policy leaders, and health advocates) because the literature review revealed that those groups influence school policy and curriculum. I specifically selected ninth graders as part of the study population because of their position in a critical transition from middle school to high school. Studies show that as ninth graders face the social, emotional, physical, and intellectual challenges of this stage of development, it is easy for them to feel overwhelmed, confused, and alone (Healey, 2014; Seng, 2014). As a result of their struggling to navigate large, impersonal,

and competitive environments, ninth graders everywhere have an entire staff to help them further develop into responsible young adults (Warren, 2011). At my study site, 9th graders and their assigned staff were completely isolated from the overall student body.

I rejected several other qualitative research designs. The narrative research format was not appropriate because this study was not an exploration of an individual. Grounded theory was not an option because this study did not aim to develop a theory based on the views of African American participants. I chose a case study research design over phenomenology because this study explored community members' perceptions of how sexual health knowledge can prevent teen pregnancies and sexually transmitted infections compared to the perceptions of individuals who have lived experiences of either pregnancy or sexually transmitted infections. I did not select ethnography because this design disregards the use of theory (Wilson & Chaddha, 2010) and this study centers on Bronfenbrenner's ecological theory, which makes it impossible to separate what people say from the context in which they say it, whether the context is their home, family, school, or work (Srivastava & Thomson, 2009). Grounded theory and phenomenology also do not offer the same degree of flexibility as a case study (Hyett, Kenny, & Dickson-Swift, 2014). The purpose of this research design was not to be a global representation but more simply to characterize participants in a rural southwest Georgia school district by capturing the perceptions of the phenomenon of teen pregnancy and sexually transmitted diseases as understood by the study's participants.

Role of the Researcher

I was the primary instrument for data collection, interpretation, and analysis in qualitative research. I was solely responsible for conducting semistructured interviews with participants. I self-identify as an African American, upper-middle-class, single–parent female who grew up as the youngest of four in the housing projects. I also have personal knowledge of the rural school district where the study took place, and became a teen parent over a decade prior to the study. However, the dynamics of the schools and children changed during the interval, and I had no personal relationships with the students or teachers.

I had biases about the study. I managed biases through transparency. I revealed all biases about this study. I was honest and open about where I stood with the district's curriculum. At the time I became a teen parent, the school district did not have a sex education curriculum in place. It was my belief that a standard curriculum was not in place partly because the community viewed teen pregnancy and sexually transmitted diseases as family rather than community issues. In addition, I believed the community viewed the issue as impossible to surmount due to the lack of financial resources. A further belief was that the predominately Baptist religion in the rural school district has/had influence over the views of teen pregnancy and the issue is still taboo. I also believed administrators have yet to find an unbiased yet politically correct approach to handling the problem.

As the parent of a 16-year-old young man, I was very concerned about the sex education he was receiving as a sophomore and would receive throughout his high school

years. At the time of the study, I believed the school should teach an AO curriculum in elementary school. Middle and high school should cover comprehensive education due to the students' psychological/cognitive and physical development. I believed sex education should start in the home as well as other locations where minors exist, such as school, church, and after-school programs.

I am sensitive to the demands of the school curricula that perhaps make it difficult to direct instruction on sex education; however, it is my perception that the school has a responsibility and a platform to include such discussions due to the amount of time children spend in that educational environment. I consider myself a person of higher beliefs. Through my experiences with Baptist churches in the rural area, I found that church leaders did not speak to youth directly on the issues of early pregnancy prevention; they emphasized saying *no* to sex until marriage (AO education). There was a perception among church members and leaders that parenting females are promiscuous. On the other hand, my nondenominational church in an urban area spoke directly to teens on abstinence while emphasizing the use of protection if they are sexually active (comprehensive sex education). I acknowledged that the above statements were my personal feelings.

One way to manage bias is openness to unexpected outcomes or discrepant data (Kirshner, Pozzoboni, & Jones, 2011). As the data collector, data interpreter, and analyst, I employed a research assistant during the coding and analysis processes to further eliminate bias. Also, a test study was performed to test the interviewing protocol against the makeup of potential participants (Chenail, 2011). In addition to the above, the case

study protocol was recorded and followed meticulously to assist me in refraining from the use of judgmental statements that could perhaps persuade participants during the interviews. Via email on October 17, 2012, the XYZ County School System Board of Education granted me permission to conduct the research study.

Methodology

Participant Selection Logic

The context for this study is a rural southwest Georgia community with a population of 5,084. African Americans make up 64% of the population. (Local Labs, 2014). I chose the XYZ County School District (pseudonym) because the district used an Abstinence Only curriculum, while the county had one of the highest teen pregnancy rates in Georgia at 26.1% compared to the state's overall average of 28.1% per 1000 females and sexually transmitted disease rates at 37% compared to the state's 30.1 % (GAFCP, 2012). These were significant statistics for such a small population. In addition, the poverty rate for the county was 27.3%, 9.9% higher than the state of Georgia. Due to the accessibility of data, the proximity of the sites, and the rapport needed to conduct face-to-face interviews, the district's willingness to participate led me to conduct the study in a rural school district.

The sampling strategy for this study included a combination of purposive (random) sampling of maximum variation and criterion sampling. Combination sampling allows a diverse population to share their dimensions of interests in an effort to discover or uncover central themes or shared dimensions. In qualitative research, purposive or purposeful sampling takes place when a researcher purposively chooses participants by

their exposure to or experiences with the phenomenon in question. Purposive sampling is often used when a researcher selects samples based on his/her knowledge, the composition of the population, as well as the aim of the research (Rubin & Babbie, 2012). Quantitative methods can diminish the richness of participants' experiences and the data derived from their participation (Babbie, 2013). Small sample sizes are not typically problematic when a researcher is not attempting to generalize the findings (Francis et al., 2010).

Purposeful sampling is the practice of choosing cases that are likely to be information-rich with respect to the purposes of the qualitative study (Petty, Thompson, & Stew, 2012). Suri (2011) states that purposeful sampling ensures that the conclusions adequately represent the entire range of variation rather than only the typical members of a subset of the range; as a result, the sample in the current study was designed to include:

- boys and girls in 9th grade,
- single mothers and fathers,
- married mothers and fathers,
- African American/Caucasian men and women of the school board,
- African American faith leaders (male/female),
- African American/Caucasian health advocates (male/female), and
- local politicians (male/female).

The criteria for the six groups of participants are discussed in detail.

The number of participants for this study was small but provided quality data. A sample of 25 was reasonable to provide an in-depth understanding of the phenomenon

from the real-life experiences of the participants and provide an opportunity for me to learn more about the little known subject (Leedy & Ormrod, 2013; Srivastava & Thomson, 2009; Yin, 2011).

The recruitment of parent/student participants was identical and simultaneous. The 9th Grade Academy Principal introduced the study and me to the academy during an assembly. I provided students with an informational packet, which included a Recruitment Flyer (Appendix M), consent/assent forms (Appendices B, C, D) and a Student Interview Protocol (Appendix E). I contacted he parent of the student only if the student returned both consent and assent forms. Parents/students were recruited based on the diversity of the participant pool. I purposefully selected parents from various households such as single male or female parents or married male or female parents.

The professional members of the community were identified by their leading roles in the community. Performing an Internet search where the parameters were local members of the community identified these individuals. I used direct mail and/or email to distribute a recruitment flyer and a consent form to members of the professional community. Members were recruited from those who returned consent forms. Participants were known to meet the criteria based on passing the screening.

Purposeful sampling was done by defining the dimensions of variation in the population that were most relevant to the study and randomly selecting variations of individuals who passed the screening. Purposeful sampling does not aim to achieve population validity, but rather to achieve an in-depth understanding of selected individuals' experiences (Suri, 2011). I preferred to leave room for a variety of

participants as a sampling strategy to represent multiple perspectives about the phenomenon.

The steps for selection of participants had the potential to yield a small sample size. Saturation and sample size have a peculiar relationship. The goal of saturation was for me to obtain a complete, thorough, and rich collection of data from the sample. If I, as the interviewer, lacked the skill to delve deeper, then this subsequently would have hindered the full achievement of saturation. I attempted saturation by targeting six different groups of participants (interviewing both males and females when possible) and individuals from diverse backgrounds (single, married, widowed), and different ages. I was knowledgeable of the community and had increased my skills in recruitment through interview training and tutorials on how to select participants who can provide quality data. As a result, the size of the sample was not as significant as the diversity of the sample population and the quality of the data (Mason, 2010). There is no definitive, mandatory sample size when conducting a qualitative, nongeneralizable study (Francis et al., 2010). I validated the richness of data, collected substantial data from various backgrounds and achieved saturation. If I found data that lacked richness, I continued the recruitment strategy until data richness was matched.

Instrumentation

I was the primary instrument in this qualitative study, per Xu and Storr's (2012) guidelines. As a key instrument in this study (Creswell, 2009), I was primarily responsible for identifying participants' perceptions of a sex education curriculum to address the phenomenon. The most important source of case study information is the

interview (Rubin & Babbie, 2013). As interviewing is a guided, in-depth conversation that aims to elicit rich and detailed materials from the interviewee, this method can be used in qualitative analysis. Hosking (2011) stated that interviews are a type of personal document in which people reveal, in their own words, their own views of their lives or some aspect about them, which was imperative for this study. The instruments that were used to answer the research questions were self-designed.

Researcher Developed Instruments

The case study protocol is critical in establishing validity and reliability within the case study methodology, as is required in all research (Yin, 2011). I developed interviewing instruments that were field tested repeatedly to test the validity and reliability of the questions that are further discussed below. The protocol for this study included the procedures and rules that were followed when the instrument was used, an overview of the issues and topics investigated, field procedures such as access to sites and sources of information, case study questions to help guide the interview process, and a guide for the case study report (Yin, 2011). Yin (2011) asserts this approach is a major component of enhancing the reliability of case study research.

I established sufficiency of the data collection instruments by conducting four test runs using the Matrix in Table 1. Test runs were conducted to validate that the interview questions for both adults and youth were identical in concept. For example, one question asked parents to describe a sexual health curriculum for sexually and nonsexually active youth. The youth corresponding question asked students if they knew what a sex education course was and to describe it. I did not take youth awareness of a sex education

course for granted. Faith leaders' questions consisted of their sex education preference for students. Parents, school officials, policymakers, and health advocates' questions were tailored to determine their perceived knowledge of the school's existing sex education curriculum and the actual sex education curriculum in place, while youth questions welcomed the interviewees to think on their own.

I also selected 10 African American adults from a similar rural district. Participants included a preacher, school teacher, two female parents with teenage daughters, one male parent with a teenage son, a traveling nurse for the district, a city council member, 4 female parents with middle school children, and a member of the school board of education. Each interviewee participated in a phone interview for 30-45 minutes; the interview questions were emailed prior to conducting the interview. I asked 17 interviewing questions that would answer the 4 research questions of the study. After phone interviews were conducted and member checking took place, I found that some of the questions were not clear, some questions were not relevant to the research study, and a couple of questions asked the same question differently. The final results of the test study netted a smaller number of interviewing questions and a revamping of the four research questions to three.

I allowed interviewees to help tailor questions for specificity. Once each participant revisited the questions, I analyzed the findings and found that the new set of questions was applicable in answering the research questions. The content of the youth questions was later tailored to match the specific content of the adult interview questions for consistency and reliability purposes.

The matrix was also used to map each group's interviewing question to the appropriate research question. The iterative process eliminated unwarranted questions that would not yield answers to the three research questions. See Table 1 for an illustration.

Table 1.

Research Questions

	RQ1 What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education curricula in XYZ County?	RQ2 Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?	RQ3 What are the knowledge, beliefs, and attitudes of the target audiences regarding the offerings of abstinence-only versus comprehensive sex education?
Questions for Students	Does your school have a sex education course/curriculum? What is a sexually transmitted disease? What is a sexually transmitted infection? Do you know what prevention of pregnancy is? Do you know what prevention of STD/STI? Can you provide any examples of prevention? Does XYZ County have an active sex education curriculum? How frequent is the course? What are some types of STDs/STIs	n/a	What is abstinence? Who do you believe should be responsible for talking to you about sex (including teen pregnancy and sexually transmitted diseases/infections? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why?

Interviews are the essential source of case study evidence; hence, it is critical for the design of the research questions to capture the true, lived experiences of participants. Researcher developed instruments allow the researcher to tailor questions to the specificity of the study at hand, which allows for flexibility during the field test.

Procedures for Recruitment, Participation, and Data Collection

The methodology flow chart that I followed consisted of five steps:

1. Contact target group
2. Obtain written/verbal consent
3. Screen applicants
4. Recruit for the study
5. Collect Data

I created six categories of participants: Students, Parents of the students, School Officials, Health Advocates, Policy Makers, and Religious Leaders. The following criteria (used in the screening process outlined in the methodology flowchart) were the basis for participant recruitment:

1. Students—students enrolled in the 9th Grade Academy in the rural school district must identify as African American, reside at home, and have written parental permission to participate;
2. Parents of 9th graders—legal guardians of students in the school district, must identify as African American;
3. School Officials—currently employed as a principal or school board member in the rural school district;
4. Religious Leaders—currently serving in a pastoral role in a church within the rural school district;

5. Policymakers—local city council members, local county commissioners, district representatives, mayors, city managers and who are affiliates of the rural school district;
6. Health Advocates—those employed as health professionals (i.e. nurses and doctors) and affiliated with the rural school district. For example, a health advocate who was also the parent of a 9th grader and identified as African American was excluded.

Screenings for all participants took place once I received signed consent/assent forms (parent/student) and adult consent forms (professional community).

Contact target group. I gained permission (see Appendix A) from the school district's superintendent to recruit students from the 9th Grade Academy after research interests were presented before the Board of Education members. I contacted the Principal/Instructional Lead via phone to share my interests in recruiting students in 9th grade, to share the Superintendent's approval, and to provide timelines and instructions needed to conduct the study. I emailed the Data Collection Agreement (Appendix L) before the principal introduced the study and me to students during an in-school assembly. Also, I contacted the owner of a private restaurant via phone to ask permission to conduct interviews outside of restaurant hours to maximize confidentiality when conducting interviews.

I distributed a packet to the students that included a Recruitment Flyer (see Appendix M) describing the purpose and voluntary nature of both the parent and student involvement in the study, along with Parent/Guardian Consent (see Appendix B), Student

Assent (see Appendix C) and Adult Consent (see Appendix D) forms that emphasized student and adult participation only if permission forms were signed, and a Student Interview Protocol (see Appendix E). I distributed to the restaurant owner, via email, the purpose of the study, the owner's role, and timelines, all of which are located in the Confidentiality Agreement (see Appendix L).

I identified participants from the professional community through an Internet search for local churches, clinics, school administrators, and government officials along with their work or business numbers and addresses, which was public information. Once the target group had been identified, I contacted them using direct mail (stamped self-addressed envelopes) or email for school officials. I was responsible for distributing a packet to community members that included a Recruitment Flyer (see Appendix M) and Adult Consent (see Appendix D) form that emphasized participation only if permission forms were signed.

Obtain written consent. I collected the Data Collection Agreement (Appendix J) from the Principal/Instructional Leader of the 9th Grade Academy granting cooperation with the study. Both the Confidentiality Agreement (Appendix J) and Letter of Cooperation (Appendix K) were collected granting permission and accepting roles from the restaurant owner. Parents and their children were recruited based on the submission and completion of consent and assent forms and passing the screening. The community members were recruited based on the submission and completion of consent forms and passing the screening.

I assumed all responsibility in collecting consent (Appendices B, D) and assent (Appendix C) forms from four nontransparent locked ballot boxes (which I provided) on the back walls of the two instructional halls/wings, bus entrance, and the cafeteria. Documents were collected at the end of each school week for up to 8 weeks. I was responsible for collecting written consent from the professional community via email or in person. When few consent forms (Appendices B, C, & D) were returned for participation, I extended collection of those forms for an additional week for both groups. The informed consent provided the adult participant, the student, and the parent with the understanding that only this researcher and possibly the dissertation committee were to know the real names connected to the pseudonyms. Those forms indicated that participation in the study was strictly voluntary and at any given time the participant was allowed to exit the study. Each returned consent and assent form the students returned were recorded in a parent/student, password-protected Excel spreadsheet; the professional community members' forms were recorded in a separate password protected spreadsheet.

I used identical Excel spreadsheets to track what was received and from whom it was received. The spreadsheet for the parent and student forms contained the parent of the child's name, the child's name, Yes or No for consent/assent, Yes or No for passing Screener, phone number, and a five-character alphanumeric pseudonym for parents and students, where the last two digits linked the parent and child. Pseudonyms were used to protect participants' identity. Parents and students were identified by a two-digit code that linked their identity. For instance, for the parent FP11A, *FP* denoted the Female Parent, *1* denoted Participant 1, and *1A* was the student/parent identifier. The

corresponding student/child alphanumeric code read MS21A; *MS* denoted a Male Student, *2* denoted Participant 2, and *1A* was the student/parent identifier. There were no duplications of identifiers for the parent/child group.

Each returned consent form from the professional community was recorded in the professional community members-only spreadsheet that contained the community member's name, profession, gender, Yes or No for consent, Yes or No for passing Screener, phone number, and a three-character alphanumeric pseudonym. For example, *MS1* translated to *M* for Male, *S* for School Official, and *1* for Participant 1.

Screen applicants. All participants were selected and recruited based on meeting the criteria and passing the screening (see Appendix I). The first phone calls were made to adult participants who expressed interest and to parents who consented for their child to participate. I completed the screening application for each person over the phone and recorded details in the appropriate Excel spreadsheet. If contact was not made with individuals from the initial phone call, I followed up with individuals via email to see if they received the information. All screening applications were kept in a password protected folder on my laptop, where only I had access. In each of the groups' password protected spreadsheets, I marked *yes* if the applicant passed the screening or marked *no* if the applicant did not.

Recruit for the study. Once I reviewed the parent/student forms, written consent from the professional community, and screening applications for variation, I placed a second phone call, notifying participants that they qualified and had been recruited for the study. I read the consent and assent forms verbatim, being certain to explain that the

parents' submission of the consent and assent forms did not guarantee automatic inclusion in the study. Furthermore, I provided the disclaimer stating that even in the case of participation in the study, it was possible that the data collected may not be used in the final publication and that the inclusion and exclusion of data was at my sole discretion. Also, exclusion of a child/parent did not mean the parent(s) did not grant permission; it meant only that the parent/child were not selected to participate. At this time, I provided participants an availability schedule and location for the interview to take place.

Data collection. I was the only person collecting interviewing data from students, their parents, school officials, religious leaders, policymakers, and health advocates. The collection of interviewing data took place only once. I ensured the questions were read and understood. Time was given to each participant after each question to ensure I accurately reported what was said if the participant refused to have the interview audio recorded. The duration for the collection of interviewing data for all participants was up to 12 weeks. All interviews were collected on their respective interviewing protocol (see Appendices E-H).

Parents received a copy of the student interview questions prior to interviewing. If a parent identified a question as a possible cause for discomfort to the student, the parent had the option to ask the child not to respond to discomforting questions. Parents were not allowed to see the students' interviews at any time. Student participant interviews took place face-to-face. I did not transport students. Parents of student participants dropped their child off at the site and had the option to wait on their child or return. Interviews for students took place in private in a restaurant after restaurant hours. Adult

participants had the choice to conduct interviews over the phone or face-to-face due to their demanding schedules. The preferred locations for interviews from the professional community were their respective place of employment or the restaurant site for privacy.

Interviews. Qualitative interviews varied in the subject and depth of their focus. For up to eight weeks, I conducted individual, semistructured interviews conveniently during afterschool hours to avoid interruptions and school distractions. Semistructured interviews included open-ended questions, used familiar language, were clear in intent, and were neutral in bias (e.g., "Do you think sex education curriculum should be different for sexual active youth versus nonsexually active youth?"). The model for these interactions was a conversation partner. As previously addressed, rapport building and comfort zone development strategies were key to successful interviews. It was advantageous for me to master the art of conversational skills and be prepared for silent moments to eliminate uncomfortable moments.

The audio-recorded interviews were proposed to last about 60 minutes for those who wished to have face-to-face interviews. The interview questions provided flexibility inasmuch as I probed questionable statements and received clarification regarding any responses that were not clear. The nature of the proposed research questions was to get the perceptions of the community in regards to whether or not the current sex education policy or curriculum was effective in preventing teen pregnancy and sexually transmitted diseases or infections.

Audio recordings. I audiotaped the interviews for accuracy with the participant's consent. If a participant opted out of the recording, he or she was allowed to participate in

the study, and I would rely on written notes. I desensitized and anonymized the information before transcription of the audio recording. A paid research assistant/transcriber transcribed the audiotapes and signed a confidentiality agreement (see Appendix J). The transcriber did not reside in the same rural vicinity as the participants. This researcher utilized the transcriptions and memos collected during the interviews to compile the data, which are further described in the "Data Collection and Analysis" section.

Before interviews took place, it was necessary to build a rapport with participants by nurturing trust and comfort between the participant and me. I did this by telling the participants about myself and my experience of becoming a teen parent, and how this drove my passion to help others. The same concept applied after the interviews had taken place. After each interview, I debriefed the participant, explaining the purpose of the study and why the information provided was important to the overall success of the study and that it was confidential.

The exit strategy included my expressing my gratitude for the subject's participation. During that time, the participant had the opportunity to ask questions in regards to the study. I read the disclaimer that the interview was recorded (if permission was granted in the beginning) and if he or she did not want the recording to be included in the study, the recording file would be deleted and only written notes would be used. I provided student participants with Pizza Hut coupons after debriefing and sincerely thanked all other adult participants for their participation.

The follow-up procedure after each interview included listening to the audio recording to explore the meaning of the participant's experiences. While reading the summary aloud to the participant, I gave the participant the opportunity after each paragraph to assess whether or not it was accurate and to clarify, elaborate, and make corrections to the information where needed. Stopping between paragraphs allowed me the opportunity to ask additional follow-up questions that emerged while synthesizing the initial interview data.

In addition, a paid transcriber transcribed the recordings within 4 weeks of the interview and imported the transcription into MAXQDA, a qualitative and mixed methods data analysis software program that is designed to help researchers process, organize, and work with qualitative research data. After importing the digital audio recordings into a password protected media file and transcribing the interviews, I gave equal weight to each (horizontalization) of the "meaning units" that appeared in the participant's description of the experience.

Data Analysis Plan

This qualitative study comparatively examined the perceptions of varied participants regarding a defined sex education curriculum in a southwest Georgia school district. The study provided for the collection of data to address such perceptions through interviews. I achieved qualitative content analysis and findings with MAXQDA 11.1.

Analysis of data through detailed descriptions and the development of themes guided the entire analysis of this study. I coded and analyzed data using a basic typological analysis scheme, which was applicable when analyzing interviews and

observations. Interviews were connected to the three research questions by eliciting greater insight from the participants. Each research question allowed a specific participant to provide his or her reality of teen pregnancy and sex education. The study explored the perceptions of African American youth in 9th grade, their parents, school officials, religious leaders, policy leaders, and health advocates have towards sexual health curricula. Each of the five groups of people was assigned a colored code for the organizational structuring of data. For example, youths had purple; parents had red; school officials had green; religious leaders had black; policy leaders had orange; and health advocates had blue codes. I found this method more manageable and objective than the classic long table, scissors, and colored pens approach (Krueger, 1998).

Once the interviews were complete, I allowed the participant to review his or her statements on a password-protected laptop. If I did not accurately display what the participant intended to answer, I allowed the participant to clarify. As the interviews would be typed in MAXQDA 11.1, the process of participant reviewing saved time later during coding and analyzing. I followed the identical concept of a long table approach; the actual scissors, colored marking pens, and long table were replaced with MAXQDA 11.1 software where I had access to unlimited space, cut/copy/paste functions, and text highlight and font colors of similar themes of behaviors, beliefs, thoughts, and perceptions.

I provided a master copy of each group's transcripts by their designated group color code. The MAXQDA 11.1 software allowed me to arrange transcriptions in a reasonable order by groups, i.e. students, parents, school officials, religious leaders, local

policy leaders, and health advocates. The master copy helped heighten my awareness to changes that occurred from one group to the other (Krueger, 1998, p. 58). Also, the coloring of groups was helpful for tracking different categories. I used MAXQDA 11.1 to code the data in the following ways:

1. I identified all possible themes.
2. I identified phrases that could be associated with the themes. Each theme had a separate file.
3. I used the *search* function to insert the phrase that was developed. Once MAXQDA 11.1 identified the phrase, I copied, pasted, and inserted the entire sentence as it appeared under the theme. This process took place for each phrase that was developed.

I arranged all responses by question or theme for each particular group. For instance, question one may have had all responses for the youths group color-coded purple, parents color-coded red, religious leaders color-coded black, school officials color-coded green, health advocates color-coded blue, and local policy leaders color-coded orange in one document. After participant responses were categorized, I began the analysis of specific themes or questions. Once transcripts and quotes were coded and grouped, I analyzed the document for similarities and differences and wrote an executive summary, as recommended by Krueger (1998).

Issues of Trustworthiness

I indicated ways in which validity, reliability, and objectivity took place as supported by noted researchers. Qualitative researchers judge the credibility of their work

by its transparency, consistency-coherence, and communicability. Below, I describe how I addressed the issues of the trustworthiness of this research study.

Credibility (Internal Validity)

I accomplished internal validity through the use of three strategies—triangulation, member checking, and peer review. Triangulation took place when I matched the participants' interview results to their audio transcription to validate that I accurately captured what the participant intended to communicate. Member checking took place when participants had the opportunity to review and verify the answers to their interview for accuracy and review tentative interpretations at the end of the interview. Merriam (2009) described this step as essential in the internal validity process of qualitative research. A clear chain of evidence allows the readers to track derivation of the data through the development of the research questions, a conceptual framework, documentation investigation, and interviews to the eventual study conclusions (Yin, 2011).

Transferability (External Validity)

External validity can be established by ascertaining if the findings of one study can be applied and generalized to another study (Yin, 2011). Yin (2011) maintains that case studies do not rely on statistical generalizability. Yin (2011) recommends conducting research as if someone were always monitoring the process. As a result, I provided very rich, specific descriptions to convey the findings of the study. Utilization of rich, in-depth descriptions from participants incorporated and highlighted the truly lived experience of each participant, providing vivid details of that participant's

perception at that moment in time. I achieved transferability by establishing a clear protocol developed for this study that listed the steps taken to conduct the study so that another researcher could replicate it. I developed a formal database so that other researchers can review findings without having to rely on a written report as described by Yin (2011). The reader of the study should be able to trace findings in either direction from the initial research questions to a conclusion and back (Yin, 2011). Reliably, the procedural and questioning methods were linked to the case study protocol where I provided transparency throughout the study.

Dependability (The Qualitative Counterpart to Reliability)

Dependability was established with an audit trail, which involved maintaining and preserving all transcripts, notes, and audiotapes associated with this study. I created audit trails throughout the process by recording field notes and documentation during the semistructured interview sessions.

Confirmability (The Qualitative Counterpart to Objectivity)

Confirmability was established by linking the data to their sources. I reported each participant's experience in a neutral context that was not shaped by reflexivity or by my own bias, motivation, or interest. Individual participants had the opportunity to review their choice of wording to verify that what they said portrayed the meaning they intended in the form of member checking.

Ethical Procedures

To promote the ethical rights of participants in this study, the methods I used to conduct research was reviewed and approved by the Walden University Institutional

Review Board prior to any contact with possible participants. The superintendent of the designated school system granted me permission on October 17, 2012 to conduct a study with high school students.

Research in which human subjects are consulted or data pertaining to human subjects is collected raises ethical and policy concerns (Creswell, 2009). Information from the school district can be released for research purposes as long as participants are not put at undue risk of exposure. The information obtained from the study has the potential to expose the school district and its students to a negative backlash; anonymity was established. The names were shared only with the dissertation committee. The collection of data involving children entailed special consideration in regards to the protection of individual data. The Family Educational Rights and Privacy Act of 1974 (updated in 1977) states that directory information such as a student's name, address, telephone number, email address, and gender are not considered harmful or an invasion of privacy if disclosed. I took all necessary precautions to protect the identity of the students. The nature of the questions that were asked of the students posed minimal risk, meaning I did not ask questions about sexual preferences, sexual identity, or the state of their sexually transmitted disease report, which are all considered personal, private, and an invasion of privacy. However, if parents request to see the document after it is published and are able identify their child's interview responses, the responses would not be damaging or incriminating. In any case, anonymity was achieved by using pseudonyms in place of actual names on all interviewing documents.

Early withdrawal from the study was the ethical concern that could alter the collection of data. Through the informed consent and assent forms, I explained that participation in the current study was voluntary. Participants could have withdrawn from the study. In such case, any information obtained would not been used in the study and all pertinent documents would be shredded. If the number of participants fell below the number of identified participants, I would initiate re-recruitment, which I did.

Research data will be kept in a locked, fireproof file cabinet in my home for a minimal time frame. Data removal from the secure location for data entry occurred only after data collection was completed. The data will be preserved for seven years or five years post-publication, whichever comes first. At the end of the appropriate time frame, the data will be burned. The data was separated by format—audiotapes, written notes, transcriptions—and filed by pseudonym. Electronic data was de-identified such that it is not possible to link a specific case to a child name, adult name, or address. The information linking real names to pseudonyms is kept in a separately locked file with a code title to which only this researcher has access.

Summary

Chapter three laid out a plan I followed to delve into the perceptions African Americans have towards the phenomenon of teen pregnancy and sexually transmitted diseases in their communities and schools. A case study research design was chosen primarily because my goal was to understand in great detail specific instances of individuals who live day in and day out with the issue so that the information provided might be used to develop better policies and curricula to address the problem. The

methods used to collect such pertinent data were face-to-face interviews and audio recordings, which were transcribed. MAXQDA 11.1 was used to analyze the data for thematic purposes.

Chapter 4: Results

Introduction

The purpose of this study was to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education in their district. This study also explored the participants' general understanding of sexual health. The results of the study include information that will allow school administrators to tailor sex education curriculums to collectively address the multifaceted needs of all students, while also being sensitive to the particular needs of African American students and complying with the state of Georgia's sex education policy. These findings are of use for helping educators, parents, and stakeholders become better informed about the impact of a sex education curriculum on these students and aid in the effort to reduce the rates of teen pregnancy and sexually transmitted infections among youths.

There were three overarching research questions in this study:

1. What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education in XYZ County?
2. Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?
3. What knowledge**,** beliefs, and/or attitudes do the target audiences have regarding the offerings of abstinence-only versus comprehensive sex education?

This chapter is organized into seven sections: (a) setting, (b) demographics, (c) data collection, (d) data analysis, (e) evidence of trustworthiness, (f) results, and (g) summary.

Setting

The southwest Georgia school district in XYZ county where the study was conducted, consisted of two elementary schools (grades K-5), one middle school (grades 6-8), and one high school (grades 9-12). I collected data from students who were in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates on their consent, assent, demographic, and selection criteria. Prior to this study, the school district was under the leadership of a different superintendent who enforced an abstinence-only (AO) curriculum from 2004-2011, which drove research question 2. There was no personal or organizational condition that influenced the participants or their experience at the time of the study that may influence the interpretation of the study results.

Demographics

This study evaluated the perceptions of 9th-grade students, their parents, school officials, religious leaders, policymakers, and health advocates regarding teen pregnancy/sexually transmitted disease prevention and the implementation of a culturally defined comprehensive sex education curriculum. Three African American students were included in the study, two of whom were men (MS11A and MS21C) and one woman (FS21B). There were five African American parents, which consisted of three married women (FP11D, FP31A, and FP41C), one single woman (FP21B), and one married man

(MP51F). Five school officials were included in the study: one Caucasian man who was a member (MS1) of the school board and four African American women: a teacher, a counselor, an administrator, and a principal. Three African American religious leaders were included in the study, one woman and two men, all married. Policymakers in the study included four African Americans: one male city councilman, one male county commissioner, a former female mayor, and a female commissioner. The health advocates in the study included four people: two Caucasian female nurses, one African American female nurse, and one African American male doctor (see Table 2).

Table 2

Demographic Characteristics of Participants

Gender	Quantity
Male	9
Female	15
Ethnicity	
African American	21
Caucasian	3
Age	
Under 18	3
26-30	1
31-35	6
36-45	3
46-55	1
Over 55	10
Marital Status	
Married	16
Single	5

This study targeted six different groups with diverse backgrounds to provide richer data. I interviewed men, women, and individuals from diverse backgrounds

(single, married, African American, Caucasian), and different ages who provided varied responses regarding their perceptions and knowledge of teen pregnancy and sexually transmitted disease prevention. Centered on Bronfenbrenner's ecological systems theory, the various groups represented social environments that influenced children's knowledge and behaviors regarding sexual health (See Table 3).

Table 3

Group Demographic Characteristics of Participants

Participant	Sex	Age	Ethnicity	Marital Status
Student				
MS11A	Male	<18	African American	Unmarried
FS21B	Female	<18	African American	Unmarried
MS21C	Male	<18	African American	Unmarried
Parents				
FP11D	Female	26-30	African American	Married
FP21B	Female	31-35	African American	Single
FP31A	Female	31-35	African American	Married
FP41C	Female	46-55	African American	Married
MP51F	Male	31-35	African American	Married
School Officials				
MS1	Male	Over 55	Caucasian	Married
FS2	Female	Over 55	African American	Single
FS3	Female	36-45	African American	Married
FS4	Female	31-35	African American	Married
FS5	Female	Over 55	African American	Married
Policymakers				
MP1	Male	Over 55	African American	Married
FP2	Female	Over 55	African American	Single
FP3	Female	36-45	African American	Married
MP4	Male	46-55	African American	Married
Religious Leaders				
FR1	Female	46-55	African American	Married
MR2	Male	Over 55	African American	Married
MR3	Male	Over 55	African American	Married
Health Advocates				
FH1	Female	36-45	Caucasian	Married
FH2	Female	31-35	Caucasian	Married
FH3	Female	31-35	African American	Single
MH4	Male	31-35	African American	Single

Data Collection

Students-Parents

I collected the Youth Assent (Appendix C) and Parent Consent (Appendix B) for eight weeks until a diverse population of participants was recruited. Three of those weeks included the extended deadline due to a lack of prior participation during the first five weeks. The extended date allowed time for me to collect rich data. I followed the procedures for recruitment and data collection, except for a deviation in the plan for the participant selection. Unfortunately, there were 100 informational packets distributed to African American students in the 9th grade Academy; 20 students returned completed forms. There were 10 parents who were screened and met the criteria as stated on the criteria list. Though the goal of this recruitment effort was to find a minimum of 6 boy/girl student participants and a minimum of 6 male/female married/single parent participants, the end result was three students (2 boys, 1 girl) and 5 parents (4 women, 1 man).

The final pool of participants deviated from the initial plan because two parents who initially granted permission for their children to participate later rescinded that permission and requested that their children's information not be included in the study. However, these parents still participated in the study. As a result, only three students participated in this study, instead of the projected five students.

I followed the Student Interview Protocol to interview students and the Parent Interview Protocol to interview parents. Fifteen open-ended questions were posed to student participants in a one-on-one format. No two students were present at the same

time. I scheduled and conducted face-to-face student interviews on alternating dates and times. Interviews were not re-occurring. Each participant had one time for a face-to-face interview but was allowed to review the transcripts for accuracy purposes. I coordinated the student participants' face-to-face interview times with their parent/guardian; for the sake of privacy, interviews took place at the ABC location where only the interviewee and I were present.

To maintain privacy, each parent's face-to-face interview took place at the parent's home where only the interviewee and I were present. The remaining parents' interviews took place via telephone. The length of student interviews was between 20-45 minutes. Parents' interviews lasted up to 60 minutes. An audio recorder was also used to capture the interviewees' responses for the purpose of accuracy in transcribing the interview. I used hand-written notes to capture all other nonverbal language that took place as the participants answered questions.

School Official-Community Members

School officials (5), policymakers (4), religious leaders (3), and health advocates (4) in this study were screened and met the criteria. The data collection period for the interviews lasted 12 weeks. The duration was different than what was originally proposed in Chapter 3 due to a lack of response from members of the community to phone calls/emails and to others simply declining to participate after receiving the Appendix M Recruitment Flyer along with the appropriate consent form describing the study and its duration in detail. During a phone conversation, a city official indicated his lack of

interest in participating in the study and lack of knowledge on the importance policymaking has on sex education. He stated,

> I would love to help you, but I don't see how teen pregnancy affects what we do in the "City". I mean, all of my workers are over 18 and I hope they've had some form of sex education.

The groups had options for face-to-face, over-the-phone, or email interviews. One school official and one policymaker participated in face-to-face interviews for which dates/times were provided and interviews were audio recorded. Face-to-face interviews lasted up to 60 minutes each. All other community member interviews were conducted in single-round exchanges via email. Policymakers, religious leaders, and health advocates were asked 11 questions (see Appendix H).

I initially proposed 12 questions for the school community, for which I relied on the School Official Interview Protocol for proper inquiry of all school officials. However, after collecting preliminary data during the other 4 groups' interviews, I realized that a question on cultural differences was needed and added it as a probing question. School officials were the last to be interviewed, which prevented me from adding a cultural question for the other 4 groups' interview protocols. The question was not used for the other four groups. I was unable to derive a fair assessment of the community's perception of cultural in regards to sex education. However, some participants included cultural considerations in their answers.

Data Analysis from Interviews

Data analysis involved several phases (categorizing, transcribing, reviewing, comparing, consolidating, and coding) with the use of MAXQDA 11.1 to ensure my objectivity. The following groups categorized all interviews: students, parents, school officials, religious leaders, policymakers, and health advocates. Once all interviews were grouped accordingly, they were independently color-coded. Following the collection of all interviews, the research assistant transcribed the audio recordings. The research assistant and I reviewed handwritten notes taken during the interviews simultaneously to ensure information was interpreted in the same manner. Though my handwritten notes taken during the interviews were transcribed and interpreted synchronously, all other data analysis and coding was performed separately and independently. Open coding was encouraged to facilitate emerging patterns, which would become the basis of this study's thematic analysis. Data from each group was compared, consolidated, coded, and then compiled at the end to confirm the consistency and accuracy of the data interpretation. There were no instrumentation changes or alterations or modifications to data strategies.

This study included a majority of open-ended questions. The first three questions for each of the six groups addressed the participants' awareness of the school district's sex education policy, the type of sex education offered, its frequency, and the party responsible for disseminating this information to youths. Those opening questions set the tone for the remaining interview questions.

The emergent themes were identified regardless of the participants' differing age, gender, and group association. Table 4 contains the various themes that emerged from the

data, including a description of those themes.

Table 4

Emergent Themes
**Students Only*

Theme	Description
Type of Sex Education	No policy, health course , comprehensive sex education, uncertain
Curriculum Content	Abstinence, having sex and using protection, sexually transmitted disease, safe touch, not detailed, Biology, uncertain
Duration of Course	Daily, every 2-3 months, once a year, uncertain
Awareness of STDs	*HIV/AIDS, Chlamydia, Gonorrhea, Trichomoniasis, and Herpes
Motives for Prevention	Health, age, lazy, messes up life, unfulfilled goals
Motives for Abstinence Education	Religion, Fear, Funding, Non-Complex, Trend
Abstinence Not Supported	Not real, Not effective, No
Differences in Abstinence and Comprehensive Education	*Abs*—No sex, not have sex, abstaining, Parents-limited educational information, close-minded, ignored reality, biblical principles, forces reality to try sex, taught by lay person, Not sure *Comp*—Protection with sex, teaching on the body, recognized reality, taught by skilled person, contraceptive, keeping it real, all inclusive, uncertain
Comprehensive Sex Ed Preferred	Age appropriate, protection, kids want to have sex, fully aware, uncomfortable topics
Responsibility of Information Dissemination	School (teachers/counselors), adults, parents, community, church, medical providers
Teen Pregnancy Widespread	Very present, very high, 12- to 13-year-olds pregnant, middle/ high school pregnant

General Response Coding

Type of sex education. I asked all groups the first three questions about the existence of the school's sex education curriculum and coded the responses separately. In MAXQDA the codes associated with the responses included *uncertainty*, *no policy*, *health course*, and *comprehensive curriculum*. Participants were inconsistent in their responses to whether or not a sex education curriculum policy existed. Participants who responded with *unsure* or *I don't know* where coded as uncertain. These themes were a result of students stating that while they do have a sex education curriculum that takes place during health class, there are no books for this course. The parents stated that they were unsure if there was a policy in place. One female parent FP21B declared, "If there is an 'active' curriculum, no consents have been issued…but they go over some things in health class, [sic] the depth is unknown." Of this group of school officials surveyed (which included a counselor, a principal, a member of the school board, a school administrator, and a teacher), only the member of the school board adamantly said, "Yes!" there is a sex education curriculum policy. Health Advocates strongly stated that there was no sex education policy in place through the district. Policymakers and religious leaders were unsure.

Curriculum content. The codes used to depict the type of sex education and what was covered in the curriculum varied. Those interviews were coded as *Abstinence*, *STD*, *Safe Touch*, *Nothing*, and *Unsure*. The theme was *Incoherence*. Student MS11A explained that "It [the sex education curriculum] covers…using abstinence, one having sex and using protection." Male student MS21C disclosed that "It [health course] covers

some stuff about STDs, but the class doesn't go into detail about prevention and other types of diseases." According to MS1, a school board member, some basic topics like safe touch are covered at the elementary level. Safe Touch is a program that concentrates on how children and adolescents can protect themselves from any type of abusive or unwanted touch. At the middle school level, biology is the more dominant approach, possibly because they talk about reproduction, and high school students get a comprehensive sex education. Four out of five parents were unsure about what was included in the curriculum. All other groups did not provide responses as they agreed there is not a defined curriculum in the district or they were unsure if a curriculum existed.

Duration of course. Groups' responses varied when asked how frequently students navigate through the sex education course. The codes associated with their responses were inconsistent and the groups lacked knowledge about the duration of the course. Some participants did not know and were coded *uncertain*. Themes were derived based on the cohesiveness of thoughts per group. The 9th-grade students gave a variety of responses including *every day*, *2-3 months*, and *unsure*. A school official said students matriculate through the course yearly, while other school officials were unsure. Parents' responses varied from "I don't know" to "I think...yearly" to "unsure". The other groups' responses were marked *Not Applicable* based on their initial knowledge of the school's nonexistent sex education curriculum.

Students

Awareness of sexually transmitted disease/infection (STDS). Only students were asked to define and provide examples of sexually transmitted diseases and infections. The definitions of sexually transmitted diseases and infections were consistent among students. The group was themed *aware* based on their similar responses. A male student described STDs/STI's, stating it is "…[w]hen you having sex with another person that has that disease and you are liable to get that disease." Students were asked to identify types of STDs/STIs. On the whole, they identified AIDS, Chlamydia, Gonorrhea, Trichomoniasis, Herpes and HIV as types of STDs/STIs. According to the students, their understanding of these diseases was derived from conversations they had with family and friends.

Motives for prevention. I asked students if they believed that the prevention of teen pregnancy and STDs/STIs is important and to identify prevention methods that they were taught. The group's responses were coded as *lazy*, *age*, *messes up life*, and *health*. The theme that derived from the coding was based on students' reasons for not becoming teen parents or contracting a STD/STI. One student, MS11A, indicated that "Students my age should not be trying to have a baby because they don't have jobs and they are only trying to sit at home and expect their parents to do everything." Both FS21B and MS21C believed prevention is important because "students having babies at a young age mess [sic] up your life." One student, MS21C, explained that prevention of STDs/STIs is important because if someone gets a disease, "[t]hey may not live to see their goals

fulfilled." Students individually identified condoms and abstinence as separate forms of prevention.

All Groups (Except Students)

Motives for abstinence education. Parents, school officials, policymakers, religious leaders, and health advocates were asked to speculate on why the school system teaches AO education over comprehensive sex education. Each groups' responses differed. Parents were individually unsure. Two Parents were coded with *risk factors*, another with *sexually active teens*. The codes that were captured from school officials included *uncomplicated teaching*, *parental permission*, and *nonawareness of peer pressure*. Policymakers' responses were coded as *parents' responsibility*, *teaching sex condones sexual activity*, and *morals*. MP1 stated, "I think they teach abstinence to go along with the trend of what everyone in different communities have [sic] done...." Health advocates and religious leaders shared similar codes: *fear*, *religion*, and *teaching sex condones sexual activity*. One health advocate mentioned funding. FH1 stated, "I believe schools teach AO over comprehensive sex education due to funding. Overall, social acceptance and numbers drive dollars. Therefore, we have not funded the comprehensive sex education in Public schools."

Teen pregnancy widespread. Parents, school officials, policymakers, religious leaders, and health advocates were asked how prevalent teen pregnancies were. The codes associated with the question from each group were *very high*, *very present*, or *present*. Overall, the prevalence of teen pregnancies was themed *widespread*.

Abstinence-only is supported for elementary students. Codes associated with the groups' acceptance of an AO curriculum were *no* across the board for middle and high schools, including several *yes* responses for elementary schools. A female teacher (FS3) elaborated that AO could work for students who have not been "exposed to anything sexually." In other words, AO education could work for students who have not encountered explicit information about sex or sexual health from any source, including the media. A female parent, FP31A, replied, "No, because it's [AO education] not real." All religious leaders were coded as *no*. Religious Leader MR2 answered, "…It's not effective enough to keep our kids from doing it. Our statistics are so high in Southwest Georgia that obviously it's not working as well."

Abstinence effectiveness depends on variables. Parents', school officials', policymakers', religious leaders', and health advocates' codes were consistent. The overall consensus of all groups was coded with *no, abstinence is not effective*. Three participants out of the groups separately added that if abstinence alone is the curriculum, it is not effective if students have been exposed to sexual imagery or messages in the media or participated in or observed activities. One person said if that child chooses to remain 100% abstinent, abstinence will be effective.

Differences in abstinence-only and comprehensive education. Groups were coded according to their definition of the difference between abstinence-only and comprehensive education. Generally, the overall consensus was that most members could distinguish between AO education and comprehensive sex education. The student participants' definition of AO was coded as *no sex* and comprehensive as *protection*. Two

students and a parent were coded as *not sure*. Parents' responses were coded as *not have sex, limited educational information,* and *abstaining* for their response to the definition of AO. Conversely, comprehensive sex education was coded as *prevention, all-inclusive responses,* and *keeping it real*. School officials' codes for abstinence included *character building, no sex,* and *not reality*. Identical to the parents' group, the school officials' comprehensive codes included *inclusive* and *contraceptive*. FS3 stated, "Abstinence–Only sex education consists of character building to try and 'guilt' children into not having sex." In addition, the religious groups' coding mirrored other groups with *no sex*; a member of the group called abstinence teachings close-minded. Their [religious leaders] comprehensive codes included *teachings about bodies* and *protection*. Policymakers' responses for abstinence were coded as *ignored reality, biblical principles, refraining from sex,* and *force the reality to try sex*. Comprehensive sex education was coded as *recognized reality* and *prevention*. FP2 answered,

> The difference is that the former [AO] ignores human realities such as peer pressure, youthful curiosity, and plain old hormonal swings that spark biological urges. The latter [comprehensive] recognizes these realities and tries to compensate for them via developing the curriculum to deal with the realities.

Health advocates' codes were *AO can be taught by a layperson, teaching excludes prevention* and *sex*. Comprehensive education for this group meant there was a *skilled person to teach the information* and *inclusive teachings* (sex, protection, abstaining).

Comprehensive sex education preferred. Having defined the difference between abstinence-only and comprehensive sex education, all groups were asked which

they preferred, followed by *please explain.* The codes associated with student groups were both [*Abstinence-Only and comprehensive sex education*] and *knowledge*. MS11A stated, "I would choose both because when you get a certain age, I think everyone should have sex. But when you're young, you should be abstinent." All other groups were coded with *comprehensive* as their preference. Policymaker MP4 responded,

> Absolutely, comprehensive sex education. We're fooling ourselves if we think we can teach abstinence only and have the same impact as comprehensive sex education. For the greater good, comprehensive sex education is best.

Comprehensive education is most accepted amongst all groups despite participants' inability to fully articulate the definition of comprehensive sex education.

Sexually active students can benefit from sex education. Parents and Students were asked if they believed sex education is beneficial to already sexually active students. The students' code included *yes*. Parents' codes included *yes* and *it depends*. MS21C replied, "Yes, because they could be doing something wrong like not using protection and a sex education course can help them to start using protection." Male parent MP51F said,

> [For] information purposes, yes. [As a] preventative, no. [In terms of] informational purposes, [the course can teach] about what can happen during sex, but [as a] preventative I would say no, because when you speak on information most kids, I would believe, they have the knowledge already; they can enhance their knowledge, but they make the decision to become sexually active even with the knowledge.

Responsibility of information dissemination. All groups were coded on whom they believe should be responsible for teaching students about sex. All groups believed parents are ultimately responsible. Codes were repeated in each group. Students were coded with *teachers*, *adults*, and *parents*, teachers being identified as the most responsible. Parents were coded with *parents*, *schools (teachers and counselors)*, and *experienced people*. FP41C said, "Parents are primarily responsible, but teen pregnancy affects our community, so I believe that it should be a partnership with parents, school, and community."

MP5IF replied,

> Initially the parent or guardian then schools. I think AA students in our district should have a different curriculum than any other race...[due to]…poverty… [sic]. And with poverty, sometimes it contributes to a lack of education academically as well as sexual [sic] education amongst other things. I think that the language barrier will be the most important thing to enhance sexual [sic] education in our area.

School officials were coded with *health/physical education teachers*, *nurses*, *church*, but they emphasized the responsibility was primarily the parents'. FS4 explained, "I feel like it should be a community effort, which includes parents, teachers, and knowledgeable people in the community." Policymakers were coded with *parents*, *church*, *community*, and *school*. Religious leaders were coded with *parents*, *school*, and *community*. Health advocates were coded with *parents* (primarily responsible), *medical providers*, and *school*. Health advocates FH1 said, "Ultimately, it should lie within the

home according to my beliefs. However, medical providers are a good source to provide good sound education. Again, we already overtax our schools with responsibilities that should occur in the homes."

Discrepant Cases

Some interview questions were the same in nature but posed differently in order to capture a greater understanding of the participants' knowledge. Groups were asked three different questions: what is abstinence (students only); what is the difference between AO curriculum and a comprehensive sex education curriculum; and which do you prefer and why. Participants in the students, parents, and school officials groups provided conflicting responses. Their responses were factored into the analysis by taking everything else the participants were saying in context, even though they were not familiar with the terminology *comprehensive sex education*. These cases were factored into the analysis to discern the participants' lack of knowledge.

Evidence of Trustworthiness

Reliability is an examination of the consistency of participant responses. Establishing and maintaining the authenticity of the participants' responses in a qualitative research design strengthens the credibility of the results. Each face-to-face or over-the-phone interview was audio recorded to increase trustworthiness. As this research consists of content analysis, each participant reviewed the transcript of the interview, which was transcribed by a Research Assistant. The participants reported no changes in their interviews. Merriam (2009) described this step as essential to the internal validity process of qualitative research

Yin (2011) asserted that transferability can be established by ascertaining if the findings of one study can be applied and generalized to another study. A researcher looking to yield the same results should therefore be able to trace findings in either direction from the initial research questions to a conclusion and back when running the same categories of raw data in MAXQDA.

Dependability is the degree to which the research findings are consistent and could be repeated in another study. The duration of the study and the content quality contribute to dependable results. It is likely that if this study were repeated following the protocol without deviations, it would yield the same results.

Confirmability arises from collaboration with others in interpreting the results of the study. To confirm the results of the study, the research assistant evaluated the transcripts and notes and analyzed the raw data to verify what participants said. Member checking took place during the interview process and at the conclusion of the study where participants reviewed their transcriptions to increase the study's credibility.

Results

The school district where this study was conducted is required to follow the State of Georgia's Education policy O.C.G.A. 20-2-143 Sex education and AIDS prevention instruction, implementation, and student exemption (Appendix O). The state of Georgia does not dictate whether the schools should provide AO or comprehensive sex education. The Georgia Board of Education has the responsibility of enforcing the most suitable sex education curriculum for its individual districts.

The results of this study are grouped by interview questions corresponding to the study's research questions and categorized by each groups' relationships. Passages below contain quotations that have been taken word-for-word as the participant spoke them, so some passages might be less polished in terms of clarity and grammatical correctness.

RQ1: What is the Relationship Between Knowledge About the Prevention of Teen Pregnancy and STDs/STIs and Sex Education in XYZ County?

All groups. ***Does your school have a sex education course/curriculum?*** All students and 2 out of 4 school officials agreed that they do have a form of sex education course/curriculum. All parents agreed that either there is no sex education course/curriculum or they were unsure. FP31A further expressed that "if there is an 'active' curriculum, no consents have been issued…but they go over some things in health class, the depth is unknown. I think for the younger grades they have a program for one week for the year discussing good touch/bad touch."

Educating students about the importance of sexual health takes place during health class according to a student and a teacher. Religious leaders and policymakers were unsure; their uncertainty is derived from their disassociation with the school's policies. Policymaker FP2 said there is no "full" curriculum. FP3 explained, "To be clear, the state of Georgia does have an active sex education curriculum but not all counties within the state of Georgia have a sex education policy. XYZ County is one of the ones that does not have a sex education policy."

Health advocates adamantly declared there is no active sex education curriculum at the schools. Their steadfast positions are the result of the health department nurses'

visit to a class to educate high school students about safe sex and prevention. FH3 stated that "[t]he only active sex curriculum is the health department and I don't think that they truly educate until one has to come in for an exam or testing. It would be nice to see them go out into the community and educate [youths] on sex and STD's."

All groups. ***What does it cover?*** There was consensus on what the school district's sex education curriculum covered among the students and one of the five school officials who acknowledged the existence of a curriculum. The consensus among religious leaders, policymakers, health advocates, and some parents was a general uncertainty about the content and existence of a curriculum.

According to MS1, a school board member, some basic topics regarding safe touch are covered at the elementary level. The middle school curriculum covers more about biology such as explaining the differences in male and female body parts. MS1 described the basic goals, stating,

> In high school it is a continuation of that [Biology]. Middle and high [school students] both get… the fear factor of sexually transmitted disease. But bottom line, we can play around if we want to, but our kids are going to be sexually active at an early age.

Student MS11A similarly stated,

> It covers…using abstinence, one having sex and using protection. For instance, our health teacher tells us [boys] to use two condoms instead of one, because if one breaks, then you will have one to back you up. We did not have books or nothing. It was on a screen [promethean board] by Glencoe.

The female student FS21B shared that the sex education they got during health class depicted what could happen if students engaged in early sex and discussed types of sexually transmitted diseases. Male student MS21C said, "It [health course] covers some stuff about STDs but the class doesn't go into detail about prevention and other types of diseases."

Though the students explained what they were taught in health class, three out of five parents were unsure what their child was taught in health class regarding sexual health. FP11D said, "I heard her [daughter interviewed but results not included] talk about some type of sex education course that takes place in the health class." According to FP31A, the health teacher covered some sex education along with other health topics such as the reproductive system (e.g., having babies and the placenta).

The uncertainty in the responses of the religious leaders, some parents, and some policymakers regarding the type of sex education being taught at the school correlates to their previous responses that they were not sure if there was a defined curriculum. Similarly, the health advocates, some parents and some policymakers previously stated there was not a defined curriculum in the school district so they could not comment on the type of sex education curriculum.

All groups. ***How frequent is the course?*** Students' knowledge of the frequency of the course varied. One male student, MS11A, answered, "We at least stay on this course 2-3 months." FS21B said they covered sexual health "[e]very day in health class." MS21C replied, "Not sure because the heath class talks about other health things not just sexual health."

All parents were unsure of the frequency. FP11D said, “To my knowledge, they [students] have to take it every year.”

All other members of the School Officials group were unsure of the frequency except for one member (MS1) who stated that sex education in high school happens once a year and it is a required course for freshmen. He affirmed,

> You will get in some of the aspects of it [sex education] in some of your Sciences. But as far as the “true” sex ed. it will be once a year. Middle school will re-occur through the exploratory classes every 9-12 weeks. Elementary, I am not sure.

All policymakers, religious leaders, and health advocates were unsure of the frequency because they were unaware of a curriculum and or stated that one did not exist.

Students only. *What is a sexually transmitted disease*? The students’ consensus on the definition was that a sexually transmitted disease is acquired from sex. MS11 said, “Everyone does not use protection when they have sex. STD is when you having sex with another person that has that disease and you’re liable to get that disease.” In other words, not everyone uses protection when they have sex, which increases the chance of acquiring STDs. Both female FS21B and male MS21C students stated an STD is a disease that is passed along through sex.

What is a sexually transmitted infection? Students have similar understandings of a sexually transmitted infection. MS11A stated, “I’m thinking you can get rid of an infection (since it’s a sexually transmitted infection) quicker than you can get rid of a disease.” Similarly, FS21B said “…He [the teacher] told us it wasn’t like the disease, but

you can get infected in the area; with the disease it's like AIDS." MS21C simply stated that a sexually transmitted infection is "[w]hen you get infected having sex."

What are some types of STDs/STIs? **S**tudents were asked to identify types of STDs/STIs. Independently, they identified AIDS, Chlamydia, Gonorrhea, Trichomoniasis, Herpes and HIV as types of STDs/STIs. According to the students, they learned of these widely known STD/STIs from family and friends. The only new terms that were mentioned in health class were *trichomoniasis* and *venereal disease*. When students were asked if they knew what a venereal disease was, they could not define such a term.

Do you think the prevention of pregnancy is important? Explain. All students identified age as a determinant for the importance of pregnancy prevention. MS11A said, "Students my age [16] should not be trying to have a baby because they don't have jobs and they are only trying to sit at home and expect their parents to do everything." Both FS21B and MS21C believed that prevention is important because "students having babies at a young age mess[es] up your life."

Do you think the prevention of STD/STI is important? Explain. Students think the prevention of STD/STI is important because it will help students avoid "catching" a disease or infection. MS11A argued that "…either with or without a condom people can become infected, so you have to be careful whom you have sex with." FS21B believed that an STD/STI can affect a student's learning abilities because the symptoms could be serious enough to cause the student to miss school. MS21C expressed the importance of

prevention because acquiring an STD/STI will affect a student's overall goal attainment because he/she may not live to see those goals fulfilled.

Can you provide any examples of methods of prevention? Male students MS11A and MS21C cited using condoms and abstaining from sex as methods of prevention. MS11A further expressed his belief in using two condoms versus one "just in case one breaks." The only female student, FS21B, argued that the surest way to prevent pregnancy and sexually transmitted diseases and infections is abstinence.

RQ2: Why are XYZ County Schools Continuing to Disseminate Abstinence-Only Curricula in Light of New Policies and Evidence of the Effectiveness of Comprehensive Approaches?

Group: Parents. ***Why do you think the school system should teach*** AO ***education over comprehensive sex education?*** *A* majority of the parents were unsure if a curriculum existed. They responded with "I don't know; I really cannot say." FP31A said, "[I'm] not sure if a curriculum is taught because my son never received a permission slip from the school to discuss sex. As an educator in the elementary school, kids in pre-kindergarten are taught good touch/bad touch with [their] parents' permission." FP41C said, "I am in favor of a comprehensive sex education class since we already see the magnitude of teen pregnancy and the rise of sexually transmitted diseases. Parents should give consent after being given a curriculum outline." MP51F added, "To eliminate all risk factors."

Group: School officials. One school official, MS1, adamantly expressed that the schools do not teach AO. Other female officials believed the school would choose an AO

curriculum because of its simple teachings. FS3 stated that she thinks there would be a hindrance in getting parental permission to discuss sex education at a deeper level. She explained that many parents will say they will be the ones to talk to their child/children about sex at home. FS4 believed that the state educational leaders are not aware of the effects of peer pressure and the media influences on children's decisions about sex.

Conversely, School Official FS5 believed that the number of teen pregnancies and sexually transmitted diseases would force the schools to teach abstinence in hopes of curtailing students' desire to engage sexually yet allow students the opportunity to focus on finishing their education, and when they are older, they will be able to make wiser decisions about sex.

Group: Religious leaders. Religious leaders had different perspectives on why the school district would teach abstinence-only over a comprehensive curriculum. FR1 stated, "The children are ultimately going to make their own decision to have sex or not. We have to educate the children and hope they make the right decision on their own." MR2 said,

> I think because the mere fact so many young kids think that having sex is the thing to do. So they [would] rather teach abstinence in the full curriculum on sex education because they feel students are going to do what they want to do anyway.

MR3 stated, "I believe it is out of fear and perhaps religious beliefs."

Group: Policymakers. Policymakers also suggested that religious beliefs play a part in an AO curriculum. Use of the term "Bible-belt" was recorded in various

responses. Policymakers proposed that an AO curriculum serves as a deterrent to sexual activity and essentially aims to prevent teenage pregnancy. The idea that sex education was the parents' responsibility was also proposed; thus, school systems do not see a comprehensive curriculum as a priority because the youth are receiving that information at home. MP1 stated that abstinence is taught to go along with the trend.

Group: Health advocates. The health advocate group provided several reasons for a preferred Abstinence- Only curriculum: 1) lack of appropriate funding for comprehensive programs; 2) lack of community support for comprehensive programs because people believe that it will promote sexual activity in youth; 3) religious beliefs of the community dictate that abstinence is the only form of education.

FH1 said, "I believe schools teach abstinence-only over comprehensive sex education due to funding. Overall, social acceptance and numbers drive dollars. Therefore, we have not funded the comprehensive sex education in public schools." Similarly, FH2 stated,

> A lot of the times, the school is not permitted to teach comprehensive [sex education] because some people think it is telling the students it is ok to have sex because they give condoms and teach them [the students] about birth control, but really it is not.

FH3 said, "Personally, I don't know because the kids are still having premarital sex, having babies, and contracting various STD's. The education to me as a nurse is outdated and needs to be revamped." According to male Health Advocate MH4,

> We are a part of the bible and everything is based on religion. I believe that only abstinence is taught because that's the way of the bible and "good Christian children" should not be having sex. It's a SIN [respondent's emphasis added]. Furthermore, underage and premarital [sex] is still taboo throughout the Bible. People avoid the conversation rather than tackle [this issue].

How present are teen pregnancies in the XYZ County school system?

Group: Parents. Teen pregnancies are widespread according to female parents. Female parents identified an increased number of early pregnancies among students 12 years of age or middle school age.

Group: School officials. According to MS1 and FS2, there are far fewer pregnant students enrolled this year than in previous years. School Official MS1 said,

> As far as prevalence, it is happening. Sex is happening. As adults, we can turn the blind eye and take data to read the way we want it to. Our students are more aware and conscious of birth control methods; they are more aware than they [students] were 20-30 years ago.
>
> …I'm not going to say our teaching contributed to the decline, but I think teaching it [comprehensive sex education] and making students and young people aware that they have choices and becoming sexually active is a choice.

FS3, FS4, and FS5 confirmed that teen pregnancies are present; students are becoming pregnant as early as 12-13 years of age and in high school.

Group: Policymakers. Policymakers agreed upon the prevalence of teen pregnancies. MP1 explained, "It's very present. I wouldn't know the ratio, but it's very

present. Some ladies can't even make it out of the twelfth grade let alone the tenth [without getting pregnant]." Similarly, FP2 said, "I don't know the ratio or frequency, but I have seen many pregnant students on campuses." FP3 also described teen pregnancy as "Very present." MP4 stated, "Now, I do review the data from Family Connections and it seems that it [teen pregnancy] is on the decline. I think it has to do with education on abstinence and on protection."

Group: Religious leaders. Religious leaders (2/3) state that teen pregnancies are present. One leader was unsure. MR2 responded, "Very, because I've seen it in our church." MR3 stated, "I believe it is present; however, I am not sure of the rate."

Group: Health leaders. Health advocates agreed that the number of teen pregnancies is high in the school district and community. FH1 elaborated,

> Teen pregnancies are high in the school district but on a decline. We have a high rate of teen pregnancies. Although statistics show our rates are down, we still have a high number. According to the Annie Cassie Foundation, in 2008 we had 32 pregnancies and in 2012 we only had 13; 13 is still a relatively high number if you look at the percentage of 34.

FH2 responded, "I would say teen pregnancy is at a very high rate. As far as a percentage I cannot tell you that." FH3 simply replied, "VERY" [respondent's emphasis added]. MH4 specified that "[t]een pregnancy is very prevalent in our school system. I remember when I was a teacher in the system. I saw several pregnant students. I had at least 4 or 5 of my own pupils who were pregnant."

Do you support an Abstinence-Only curriculum? ***Group: Parents.*** The majority of parents do not support an abstinence-only curriculum alone because it does not provide students with the necessary knowledge and skills to protect themselves as well as an understanding of the potential consequences of their actions.

FP11D said, "Yes. Nowadays it's [AO] the best, because people aren't going to tell you if they have a disease or an STD even if they are gay or not. So it's just best not to have sex at all." FP21B disagreed, "I would support comprehensive [sex education] because I'm for kids abstaining, themselves, but I am also for them protecting themselves, letting them know how to protect themselves and the consequences for not abstaining or protecting themselves."

FP31A said, "No, because it's [AO] not real. As an educator, some kids don't know the lack of knowledge of parents. It takes a whole village to raise a child. Teachers complain about what they already have [to do] and that [the students] should be taught at home. Some kids are raising kids that are not theirs."

FP41C answered, "No. Because some teens are not going to choose abstinence and I would like for teens to be familiar with methods of prevention." MP51F said, "I think it [AO] should be available, but it shouldn't be the only option."

Group: School officials. School officials provided several arguments in their support of an abstinence-only curriculum. Three out of five officials did not support AO education for students in grades higher than the elementary level. MS1 contended that each grade level should tailor their teachings to a particular level. He said,

> No. You're going to have to tailor what you're teaching to each grade level, no doubt about it. I taught sex education [different location]. What I would teach at a middle and high school I would not teach at an elementary level. It wouldn't even be close. At an elementary level, you have to focus on knowing the body, differences between male and female. I don't think you would get into the [topic of] intercourse and sexual components at that early of an age. Now, as they get to 4th and 5th grade, you might can [sic] allude to it. In 5th grade, I know some of ours [students] are knowledgeable but I don't think an abstinence-only curriculum would work at an early age. I don't think it's a topic you would consider. I think it's more of "Biology" than sex education.

Two female officials, FS2 and FS5, support AO. According to FS5, "Even if students are already sexually active, he/she [sic] can begin again."

Group: Religious leaders. None of the religious leaders support an AO curriculum. They each suggested that the sex education policy needs to be appropriate for the community in which the youth live where sex and disease are widespread and rampant. They also indicated that a more comprehensive program would equip the students with more knowledge and allow the youth to make more educated decisions. MR3 stated, "…the more educated one becomes, the more safe and protected one will be." FR1 said,

> No. We live in a society that is driven by sex and money. The more money you have, the happier you will be. The more [women] you have, the happier you will be. Children are presented with these images as early as 4 and 5 years old. Boys

> are asked at age 10, "How many girlfriends do you have?" as if to say, that remaining a virgin or being in a monogamous relationship is "weird" or "crazy". Teaching AO is a fallacy; it is not the reality our children live in today.

MR2 specified, “No. I would rather them teach a full sex education program. If you just teach abstinence, you’re just saying that it is ok to engage.” Also, MR3 stated, “I do not support AO curricula because I believe the more educated one becomes, especially on this topic, the more safe and protected one will be,”

Group: Policymakers. Policymakers agreed that a comprehensive sexual education curriculum was more effective for youth, though they also supported the idea that abstinence should be stressed in this curriculum. One suggestion was that schools should offer a comprehensive program and provide parents with the option of enrolling their children (or not) at their discretion. This group also supported the notion that more knowledge may lead to a more informed decision regarding risky sexual behavior in youth.

MP1 responded, “No. I think you should know the consequences of abstinence as well as the consequences if you have sex and what the future [holds] and what lies ahead for having sex [sic]. I think both ways should be explained.” FP2 also stated, “No, I prefer a comprehensive, reality-based program that stresses abstinence but acknowledges the probability that some young people will yield to the temptation to indulge in sexual activity.” Similarly, FP4 replied, “I believe that a comprehensive sex education program should be put in place and parents should have the option of enrolling their children at their own discretion.” MP4’s reply was adamant:

> Absolutely not! The reality is that if we only teach abstinence, then we, in my opinion, were not really paying attention to…the reality around us because when we look around, we see all these views and stuff of young kids with babies and having babies and I would say probably every person you know, including me, know[s] of a youth who at some point had a baby in their teens. So I don't know if you're going to ever be able to teach an AO curriculum….I wish we could (laughter), but…conventional wisdom will have us to believe that we can, but in a reality we can't. We live in a different world than that.

Group: Health advocates. Health advocates on the whole did not support an AO curriculum. Every member of this group reported that adolescents are sexually active and require a curriculum that addresses their decision making directly. This group believed that educating the youth was the only way to prevent pregnancy and STI's. FH1 stated, "While the concept is good and if practiced would be excellent, kids today do not practice abstinence only. Where it used to be the norm for young people to practice abstinence, sexual activity is the norm in today's society. So, I do not support and AO curriculum."

FH2 said, "I do support abstinence because that is the only way that you will not have teenage pregnancy or STD's, but in reality not all students are going to be abstinent even when you talk at length to them about [it]." FH3 simply said, "No, because they are having premarital sex, having babies, and contracting various diseases." MH4 replied,

> No, I don't support an abstinence-based curriculum because the truth is children are having sex. It's a topic that no longer needs to be taboo. I think that we have to deal with the reality of the situation rather than continue to wear our rose-

colored glasses. With this generation of children, they are being taught about [sex] from various sources: TV, social media, the Internet, etc. Therefore, I do believe that our responsibility to our children is to provide them with this education so if they choose to participate, they will at least be informed. Abstinence is the best decision. However, it's not reality.

Do you think it is effective? Explain**.** ***Group: Parents.*** *C*ompared to their answers to previous questions, parents provided mixed messages when asked if they think AO is effective. Sixty percent of parents contended that AO education is effective.

Female Parent FP11D simply said, "Yes." FP21B disagreed: "No. I wouldn't say it is effective. If it was effective, I guess it would be geared towards one sex [boy or girl] to abstain. I think the goal is for all to abstain, not just girls or boys." FP31A also said, "AO is effective [from] child birth [to] middle [school]." FP41C replied, "Yes, if chosen it is 100% effective." MP51F responded with "not as the only option."

Group: School officials. In general, school officials stated that the effectiveness of AO sex education has to do with what sort of sexual contexts students are exposed to earlier. School official FS believes that one reason abstinence is not effective is that students lack the conviction or discipline to abstain until marriage. MS1 simply stated, "No." Female School official FS2 replied, "I think abstinence is effective with students in fifth grade, not middle and high schools." According to FS3, "I think it is effective for students who are not 'exposed' to a lot of sexual connotations." School Teacher FS4 answered,

> No, I don't think it is effective because too many teens and, sadly to say it but our young youths, are becoming pregnant and contracting STDs at an early age…too many of our children are not being persuaded to stay abstinent until they become married. I see it before my own eyes that the word *abstinence* is not sticking with our kids very long.

Group: Religious leaders. The entire group of three agreed that an AO curriculum is not effective. One member lamented that the proof of the inefficiency could be observed by looking at the statistics for southwest Georgia. MR3 commented further, "I do not think it is effective. It is not effective enough to keep our kids from doing it. Our statistics are so high in southwest Georgia that obviously it's not working as well."

Group: Policymakers. While the vast majority of the policymakers believed that an AO curriculum was ineffective (based on the increase in the teenage pregnancy and teenage STD transmission rates), one group member proposed that the effectiveness depends on the individual. MP1 responded, "I don't think abstinence is effective at any stage of education." Female policymaker FP2 said, "The fact that we have sexually transmitted diseases and teen pregnancies speaks to the ineffectiveness of an AO based curriculum." FP3 explained, "The rate of teen pregnancy is on the rise in many communities that foster AO programs. This is very obvious in certain communities, namely rural and impoverished [communities]." MP4 replied,

> Abstinence? I think it's effective when you consider additional variables and constructs. When you look at a person, for instance my daughter, abstinence could be effective for her because we teach biblical principles at home. I'm not saying

> I'm better than anyone else, but I teach that. But at the same time, she may be vulnerable to having sexual relationships with a boy. It depends on the youth as well. But I think in can be effective. It's just not going to be effective for everybody.

Group: Health advocates. Health advocates agreed that an AO curriculum is ineffective but not because youth are "planning" to have sex. One member suggested that sexual interaction occurs in the "heat of the moment" while another member said that sexual intercourse may be a result of peer pressure. For this reason, they suggested that a more comprehensive course of study be presented to youth. FH2 responded, "No. I think you should teach all aspects of sex and diseases. You can't teach just one aspect of sex and forget about the rest. You are not equipping them with all that they need to make a proper conclusion."

RQ3. What Knowledge, Beliefs, and Attitudes do the Target Audiences Have Regarding the Offerings of Abstinence-Only Versus Comprehensive Sex Education?

What is abstinence? *Group: Student.* The students' definition of abstinence varied. MS11A stated, "It's thinking before you do something, making sure that you're going to be safe and can you prevent it." FS21B described it as "Refusal skills." MS21C simply defined it as "Not having sex."

What is the difference between Abstinence-Only sex education and comprehensive sex education? *Group: Student.* FS21B said that she had heard the terms but did not know what they meant. Two students were unable to distinguish the

difference between AO and comprehensive sex education even though they identified that the health teacher covered sex education topics.

Group: Parent. One female and one male parent described abstinence as not having sex at all or until an age of responsibility. The female parent was not sure of the definition of comprehensive sex education but added that it involved some type of prevention. FP21B did not know the difference between the two methods. FP31A contended that "*AO* means to stay away from sex until you are married and financially stable. *Comprehensive* is keeping it real, knowing students will try to have sex …and teach them about protection." FP41C stated that AO sex education may limit educational information on preventive methods that are available to teens. She, too, was not sure what comprehensive sex education entailed.

Male parent MP1F contended that AO is more of means of distributing information about sex, STDs, and pregnancies and comprehensive sex education would be all inclusive, taking into account what goes on around students daily, including their personal risk factors and those of the community. FP11D explained, "Abstinence is not having sex at all. Don't have an idea about comprehensive, involves some type of prevention." FP21B said, "I don't know. What's the difference?" According to FP31A, "AO means to stay away from sex until you're married and financially stable. Comprehensive [is] keeping it real, knowing they [students] will try sex, is straightforward about what's going on, and teach[es] them about protection." FP41C said, "AO sex education may limit educational information on other preventive methods that are available to teens. However, I'm not sure." MP51F stated,

> From my perspective, *abstinence* is abstaining from all sexual activity at all cost. Sex education is more of an information perspective of passing out information about sex and STD and pregnancies and different things of that nature. *Comprehensive* would be all inclusive of what's actually going on all around them amongst them, including their risk factors and community risk factors as well.

Group: School official. One school official, FS3, defined AO sex education as a character building exercise to try to "guilt" children into not having sex. The majority of school officials defined comprehensive sex education as a method of teaching students about protection and contraceptives. Female school official FS5 added, "Comprehensive does educate, but I do not know if it helps to eliminate."

MS1 stated,

> AO sounds good and looks good on paper, which makes it easier for the board to digest, but it is not reality. So if we truly care about the young people, then let us be honest with them and ourselves and give them [students] information that will help. Don't blow smoke up their rear end because they will know it from the start...kids out there are telling me stuff about sex that I didn't know. They're smarter than we think and what we give them credit for….So let's equip these young adults with the tools they need to be safe.

Female Administrator FS2 simply stated, "I don't know. I'm not sure." FS3 responded, "Abstinence –only sex education consists of character building to try and guilt children into not having sex. Comprehensive sex education *discusses* diseases, different types of contraceptives, pregnancy, and everything attached to each of these topics." Similarly,

FS4 responded, “AO sex education just teach[es] and encourage[s] students not to have sex until they become married. Comprehensive sex education teach[es] students about abstinence and different contraceptives students can use if they are going to have sex.” School executive FS5 stated,

> To me, the difference will be *abstinence* means you do not have sex until an age of responsibility. *Comprehensive* means you’re given the knowledge of what happens if you have unprotected sex, [like] you can get STDs.

Group: Religious leaders. The responses were consistent within and between all three groups. Each group defined *AO* as teaching students to refrain from sexual activity and comprehensive sex education as providing information on disease and pregnancy prevention.

FR1 said that “AO emphasizes the importance of not having sex. Sex education is a comprehensive approach to teaching students (children) about their bodies.” MR2 stated, “I think AO [sex education] teaches them to try to say *no* versus comprehensive [sex education], which teaches if you are going to do it, protect yourself.” MR3 described the relationship a little differently: “I think the differences are that AO is a more ‘closed-mind[ed]’ approach to a growing problem and a comprehensive sex education could not only address the problem but curtail many of the problems associated with sexual activities among youth.

Group: Policymaker. Policymakers agreed on the defined differences between the two curricula. During his or her interviews, without hesitation, each member defined

abstinence-only education as teaching that abstinence is not having sex and comprehensive sex education teaches about protection. MP1 stated,

> If you continue to teach abstinence, at some point in time the child may want to try to see if your abstinence equals up to the comprehensive side of sex instead of teaching them both [and] telling them what will happen. Some of them will like to experiment to try and see if they're right or if you're right or who is wrong about it.

FP2 further described the difference:

> The difference is that the former [AO] ignores human realities such as peer pressure, youthful curiosity, and plain old hormonal swings that spark biological urges. The latter [comprehensive] recognizes these realities and tries to compensate for them via developing the curriculum to deal with the realities.

FP3 believed that an "AO curriculum emphasizes refraining from sex whereas a comprehensive sex education curriculum will present abstinence as a viable option but also includes other forms of birth control and disease prevention." MP4 honed in on the moral aspect of this question by stating,

> AO is generally based on biblical principles. I can't think of any other reason you will tell someone to abstain until you get married. Think about it. Any reason you think of will be tied to a biblical principal, in my opinion. The combination sex education is "I'm talking to you about abstinence at the benefit of abstaining [sic], saving oneself for marriage, but also teaching you about if you decide to have sex, this is what can happen."

Group: Health advocates. Health advocates' responses were precise and similar as expected. FH3 defined the two as "AO teaches no sex, but comprehensive [sex education] will open up more avenues to educate more." Female nurse FH1 said, "AO education can be taught by any layperson. Comprehensive sex education needs to be taught by someone with a specific skill set to teach the chemistry [and] functional, physical, and emotional aspects of sex education." FH1's colleague, FH2, elaborated,

> AO sex education is educating the students on abstinence from sexual activity, and most of the time they do not educate them on any type of pregnancy prevention, which includes birth control and condom use for protection [against] STD's. Comprehensive sex education is when the students are being educated at an age-appropriate level, not just on sex in general, as well as sexual development. It includes safe sex practices like condom use and education on birth control. It gives the student a chance to ask questions that he or she may or may not want to ask a parent or they may not get to ask if they were only in an AO sex education class. I think that abstinence and comprehensive should be taught together. Not this or that.

Which do you prefer and why? ***Group: Student.*** All students chose a comprehensive sex education curriculum. One student in particular, MS11A, believed that abstinence should be taught when children are young. MS21C prefers a method that teaches students that if they do make that decision to engage sexually, they are prepared.

Group: Parents. Parents agreed that comprehensive sex education is the preferred method. Their consensus was that youth need to be taught about sex and to stay away

from sex at the same time. FP21B stated, “I would prefer comprehensive, especially for middle and high school students because they are exposed to the same thing. That way, it will give them dangers and ways they can kind of protect themselves.” FP31A chose comprehensive “because kids are at a place where they want to have sex and it is parents’ duties to be honest with our kids about the dangers of early sex.” FP41C said,

> I would prefer a comprehensive sex education with parental consent [regarding] the topics that would be discussed. I would like to see preventive methods of pregnancy taught in the curriculum (with abstinence as a method that is 100% effective) along with sexually transmitted diseases.

MP51F explained,

> I have two answers. For my child, comprehensive. I prefer that because at the end of the day, I would like my child fully aware of any[thing] and everything that can happen. As a parent, I know parents that are somewhat uncomfortable with their children being exposed to certain types of conversations. So, I think a mixture of all two depending on the kid.

Group: School officials. School officials’ responses were similar except for one. The outlier preferred abstinence teaching because she believed AO expected more from the students. Male official MS1 chose Comprehensive. FS2 explained,

> I would prefer at my level (elementary) for students to be taught abstinence. I don’t have any proof, but I think some of my fifth grade girls have been sexually active and just trying to get them to understand that sex can wait especially for

> fifth grade girls and boys [sic]. I think boys need to be talked to just as much as the girls.

FS3 said,

> I would prefer comprehensive sex education. Even if parents do a good job discussing this issue at home, I don't think it will hurt to reinforce this at school. Teaching sex education at school may catch loopholes and make sure students understand the importance of abstaining. A school program will also give correct science/medical meaning.

Like MS1 and FS3, F4 preferred the comprehensive approach "because the more students know about sex, they will be [able to] demonstrate knowledge through conversation and action about the decision to have sex. They will also feel more comfortable talking to responsible adults and their partners about their sex decisions and concerns."

FS5 was the only official to support an AO curriculum:

> I prefer abstinence teaching. If you set the bar high, you may get to comprehensive. If you set the bar high, you may have those students who may think about it twice. I think what's missing with our students is they may be given the information, but no one seems to care whether or not they are having sex. They are given information because it's a mandate of some sort. If the mentors, teen centers, Boys & Girls Club, Sunday school classes, and pastors were all saying the same thing, they will get it. It would mean more to them. I don't think it means as much because it (sex talk) is put out there and it's left up to them to make a decision about it.

Group: Religious leaders. All religious leaders selected comprehensive sex education programs mostly because they are more informative and can help reduce teen pregnancy and disease transmission. Interestingly, many supported the idea of abstinence but reported that it is unlikely that youth would not engage in sexual activity. The concept of sex education is used interchangeably with comprehensive sex education by this group. FR1 explained:

> I prefer sex education. Some parents and adults believe that if you teach sex education, you are giving the children a ticket to go out and have sex. News Flash...they are having sex anyway! Not talking about it only continues the ignorance that plagues our community when it comes to sexually transmitted diseases, pregnancy, HIV/AIDS, and etc.

MR2 replied,

> Comprehensive sex education. I like to be able to help the kids see the reality…so when you bring someone in that they can sort of identify with, I think it has a greater effect. At some point, you have to help kids to see they have to break the cycle of pregnancy and sexually transmitted diseases. How do you do that? You do that by talking directly with kids…saying "listen, young girls, take my word [that] boys only want one thing." They understand that language better than sugarcoating stuff.

Do you believe the sex education curriculum provides beneficial information to help you understand the topic? ***Group: Students*****.** Students believed the sex education they are taught in health provides beneficial information. One student

explained that “kids are going to do things.” He knew about sex but didn’t know condoms would prevent pregnancy. MS11A stated, “Yes, I do. I’m a kid. A kid is going to do things. I knew about sex. I just didn’t know you can use a condom to prevent having a baby.” FS21B said, “Yes, if they stop doing what they [were] doing before and just start following it [sex education curriculum].”

Do you believe the sex education curriculum is helpful to sexually active students? Why? ***Group: Students.*** Students agreed that sex education is helpful to those students who are sexually active. One student argued that a sex education curriculum could perhaps enlighten sexually active students to “stop it” [having sex] until they are mature. Another student referenced sexually active students not practicing safe sex and said that the sex education curriculum could provide information about protection. According to MS11A, “Yes, [the sex education curriculum is helpful] because it may make a difference in their life. They may stop it until they get [to] a certain age.” Similarly, FS21B said, “Yes, because they could be doing something wrong like not using protection and a sex education course can help them to start using protection.”

Group: Parents. Four out of five parents agreed that although some students are already sexually active, a sex education curriculum is beneficial because it can provide them with information about prevention and consequences and perhaps make them take heed. One male parent provided a two-part response. According to MP51F,

> Information purposes, yes. Preventative, no. Information purposes about what can happen during sex, but preventative I would say no. Because when you speak on information, most kids, I would believe,…have the knowledge already; they can

enhance their knowledge, but they make the decision to become sexually active even with the knowledge.

Whom do you believe should be responsible for talking to you about sex (including teen pregnancy and sexually transmitted diseases/infections)? ***Group: Students.*** Unanimously, students believed teachers should be responsible for discussing sex education topics. Parents and other adults such as preachers should also be responsible. One student believed those who have suffered from sexually transmitted diseases/infections and/or who were teen parents should be responsible for bringing that reality to students.

Group: Parents. Parents had similar views to those of the school officials; they, too, agreed that parents should take the lead in teaching students about sex, then schools, then community stakeholders. One parent agreed with the students that teachings should come from health teachers because of their knowledge of health education. Other parents contended that students should learn from teen mothers, people they can actually see and hear from regarding their personal stories.

FP11D said that the health teacher and the child's counselor should be responsible for talking to students about sexual health. Without hesitation, FP21B said, "Of course parents, then health teachers because they are knowledgeable of the topic. I think the children will be responsive to church leaders speaking on general topics about sex education." FP41C stated that youths should hear from "people that's [sic] been there (i.e. teen mothers). People they can actually see and hear their stories about their lives

that they can see. Color doesn't make a difference when it comes down to teaching as long as the person cares."

FP41C believed that "Parents are primarily responsible, but teen pregnancy affects our community, so I believe that is should be a partnership with parents, school, and community."

Group: School officials. In general, the school officials did not think an individual is responsible for teaching students about sex because students meet many people, by way of technology, including other students and adults. FS5 argued that parents are the first teachers; then the responsibility should branch to the "village" because it takes a village to raise a child. MS1 stated he did not think the government [local, federal or state] should be responsible because the government does not care. He thought the responsibility should fall on the community, church, schools, parents, and social agencies. He (MS1) believed that maybe the public school should take the prominent role because of how many children can be reached at one time.

One female official, FS2, said that the responsibility should rest with health/physical education teachers. Female official FS3 believed parents should take the lead and schools should have an effective program to reinforce the knowledge. FS4 stated, "I feel like sex education is just as important as students demonstrating knowledge of skills and concepts in all subject areas. In order for our children to be successful in school and become productive citizens, we need the parents, teachers, and stakeholders to work together." This approach applies to sex education.

Group: Religious leaders. Religious leaders believed that there should be a holistic approach to teaching students about sex and that everyone should be involved, from community leaders to religious leaders to parents to school administrators. FR1 argued that "EVERYONE [participant's emphasis] should be responsible. This includes parents, the schools, the church, doctors, the community." Similarly, MR2 said,

> Parents, schools, church, and everybody in between. Some pastors think you are supposed to teach spiritual things and that is it. They do not understand you have to deal with the whole man emotionally, physically, economically. I think some pastors only deal with issues that are spiritual and it has nothing to do with the Bible belt.

In a similar vein, MR3 said, "I believe that all education should begin with the home. However, I further believe that there is a need for a strong/wholesome curriculum in our schools to support the home and the community."

Group: Policymakers. Policymakers had similar views on who should be responsible for talking to students about sex (including teen pregnancy and sexually transmitted diseases/infections). 25% of Policymakers stated that parents are primarily responsible, 50% said schools should be responsible, and 25% said everyone is responsibility.

FP2 stated, "I think the curriculum should be adapted by grade levels. The 'tone' with which one addresses a sixth grader would be different than the tone used to address a high school student." FP3 said, "I think a full description of the human anatomy should be provided at every level of school. Pregnancy prevention and disease prevention should

be started in middle school and continue throughout high school." MP4 laughed and asked,

> Is that a trick question? It's a community responsibility. Do you want me to triage? It's the parent. The church, the community. The school. It's everyone's responsibility. It's the parent's responsibility because you got them first. You begin. You have them at home to teach them everything. The church because you got them and their parents, so you're teaching both. You have a dual impact. The community because they live and exist with you; you see them on a regular basis. And the school, the school because you have them during the day, teaching them [the] educational part, and they interact with kids in your place of business. The parents are a part of the community, the church and the school. The parents are the trick but the rest of these components are supplemental support to that teaching.

Group: Health advocates. Health advocates all agreed that teaching should begin at home with parents. FHI stated that "[u]ltimately, it should lie within the home, according to my beliefs. However, medical providers are a good source to provide good sound education. Again, we already overtax our schools with responsibilities that should occur in the homes." FH2 said,

> Yes! I do believe we [health experts], teachers, and parents or guardians should be responsible for educating students about sex. A lot of times the students' parents or guardian are not open on the subject of sex education or they are just not

> educated themselves on the matter either. So everyone should be involved in the responsibility of sex education.

FH3 simply argued that "All teaching starts at HOME!" [participant's emphasis added]. Also, male health advocate MH4 said,

> The primary responsibility should be the parent. However, we do know that every child isn't getting what he or she needs at home. I think that then it becomes the responsibility of the school system to, at the minimum, educate.

What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? ***Group: Parents.*** Parents across the board believed something needs to take place to protect students against the plague of teen pregnancies, diseases, and infections. FP11D said,

> I feel they should do a class to speak to them about abstinence, to talk and guide them. Nowadays, you have kids starting to have sex in middle school, so I will say to teach abstinence classes from 5th grade and up because girls are getting pregnant in middle school. I say that because a lot of girls can't really talk to their parents about sex. So, I think the schools should [give]the girls and boys someone they trust as well.

Another female parent, FP21B, answered, "They can probably have some type of sex ed across the board or all grades teaching on both abstaining and protecting." FP41C said, "I think that the school can partner with the community and parents to provide education resources." Male Parent, MP51F suggested that students need a "more realistic

dialogue regarding sex education…From a language barrier perspective versus technical jargon." FP31A stated,

> There's a lot of denial from the schools and community regarding sex. Let's face it; sex is here and happening with teenagers. It's a part of life. The question [that] should be asked [is] what can we do to help prevent (pregnancies, diseases, and infections). A community center is needed, something that will get them interested with music/technology. The community needs to work hand-and-hand, provide different programs that address teens and their knowledge on sex education in a safe environment. The community center must have people on [the] students' level, meaning folks they connect with, folks students trust, adults who care and love kids. Children love attention to be shown. Also, some kids can't talk to their parents, so kids are raising themselves with no guidance….It's not about being friends with your kids. You have to have an open door policy.

Group: School officials. School officials had similar opinions on educating students in an effort to help protect students against the epidemics of teen pregnancies and sexually transmitted diseases/infections. MS1 replied,

> I think we got to stay diligent. I think it's good to get the information, but we are going to have to tailor our instruction to meet those cultural differences and those normalities by culture that occur. Because there is a vast difference in the black community, a young girl getting pregnant doesn't have the stigma that it had a few years ago and doesn't have the stigma that it has in the white race. And if

> we're going to teach them, we have to get on their level (*pounds desk with palm of hand*). I'm sorry!

Female school official FS2 said,

> They [the school board] may need to look closely at getting or considering having [the] sex education talk or have someone come in to the elementary school to start speaking to the fifth grade girls and boys. I think whatever is put in place needs to be included with the elementary and not wait until middle or high school.

FS3 also stated,

> As long as the parents agree, I think more can be discussed at school. If I'm not mistaken, they talk more about comprehensive sex education at the middle school level. I'm not sure if it's just one grade or multiple grades.

FS5 responded,

> Of course, you know knowledge is key….I think if everybody was saying the same thing, if we would all reiterate to our students [on the dangers of unprotected sex]…it helps the children to know that that's the right decision.

Group: Religious leaders. Religious leaders suggested a more comprehensive plan of study buttressed by at-home teachings of a similar nature by parents or legal guardians. MR3 simply summed up a need "[t]o educate them with a wholesome sex education curriculum. FR1 stated,

> Knowledge is not power. It is *potential power*. A person can have knowledge and do nothing with it. That is why it is only *potential power*. We have to teach

> everything, the good and the bad about sex. Not talking about it only perpetuates the disease of ignorance.

Similarly, MR2 stated,

> I think for me, we cannot just rely on the schools to do it. I think it has to start at homes, churches, our school programs as well. Everywhere a child goes, they have to hear that. In our church, when bible study starts back up, there will be a[n] all-teen girls class and all-teen boys class where we address those issues. We will be teaching comprehensive sex education.

Group: Policymakers. Policymakers had parallel views of education and collaboration on what the school system and community can do to aid in the prevention of early pregnancies and sexually transmitted diseases and infections. The responses resulted in 50% stating that the community and the school system should come together to further develop programs that will better educate the youth on teen pregnancies and STI transmission. The other 50% believed that a more comprehensive sex education program would benefit the community at large.

FP3 emphatically argued (with hand gestures) the need to "[e]ducate them more thoroughly." MP4 agreed, stating,

> There are a couple of things. The primary thing we can do is to mandate education. I think if you mandate education on sexual diseases, you got half of the battle done. Abstinence should be taught the minute a child recognizes any sexual sensation whether ten or fifteen. Kids mature at different level[s]. For girls, when they get their menstrual cycle, it may be too late then, but as soon as possible and

> as often as possible. It's more uncomfortable for us than it is them. So if you start talking about it now, [it] won't leave a black hole. I'm ok with people talking to them about abstinence now not sex. Fortunately, I have a wife who talks to my girls because it's uncomfortable for me.

Male policymaker MP1 stated,

> The community and the school system can work together to educate the community about sex without marriage and try to teach more about abstinence as well as the consequences if they have sex of what lies ahead of unwed mothers and fathers that have children.

FP2 offered another point of view:

> I think that there should be a reality-based partnership program that starts by targeting middle school parents [and] middle school students. Community groups such as churches and resources such as health departments would be vital partners. First, parents would be educated about how to approach their children and about what resources are available for the young people. This partnership would work together to develop an aggressive curriculum that might include such bold steps as providing birth control, disease testing and screening, positive peer partnering to replace peer pressure, abstinence incentives, etc.

Group: Health advocates. Health advocates tended to agree that education is the key to prevention. FH3 insisted, "Educate! Educate! Educate!" [emphasis added]. FH1 argued that "[e]ducation is the key to prevention. Not sure that this falls completely on

the school system. We already overtax our schools with responsibilities that should lie within the home." FH2 replied,

> No, I don't think the school does all they can do to help protect the students. I know that even though we educate, there are going to be some students that get pregnant or get an STD, but I think that the school system can do better. As the health department, we educate our patients every chance we get on prevention of pregnancy and STD's.

MH4 said,

> I think the community and the school system need to be realistic about what's going on in the community. I think that there needs to be sex education starting at the middle school level. I think there needs to be open dialogues about sex education, sexually transmitted infections, and teenage pregnancy. I think there needs to be parenting classes on the high school level in which pupils have to rear [a] child throughout the course of the 6 weeks. This class should address the issues that come with child rearing such as feeding, diapers, clothes, daycare, etc.

Summary

The purpose of this study was to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education in their district. This study explored participants' general understanding of sexual health in their community. The results of the study have the potential to provide useful information that will allow school administrators to tailor a sex education policy/curriculum that collectively addresses the

multifaceted needs of all students, but is sensitive to the needs of African American students while complying with the state of Georgia's sex education policy.

Research Question 1 asked participants to describe the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education in XYZ County. The relationship between what each participant group knew about the methods of prevention of teen pregnancy and STDs and their understanding of what each type of sex education entailed seemed contradictory, and more importantly, the participants did not recognize their ability to enforce change. I found that overall, the six groups had knowledge of the prevalence teen pregnancies in the XYZ County School District. There was limited knowledge and awareness of the multitude of sexually transmitted diseases that are possibly acquired through unprotected sex, yet there was an awareness of unplanned pregnancies because of their physical visibility as pregnant teens made their way through school hallways and participated in class each day. I will not assume that a lack of testing for STDs equals the lack of STD awareness. This research protected participants' privacy; therefore, questions concerning STD status were not asked.

Research Question 2 asked for the reason XYZ County schools continue to disseminate AO curricula in light of new policies and evidence of the effectiveness of comprehensive approaches. Participants believed that an AO curriculum is disseminated to the rural district of XYZ County because of religious beliefs, fear, lack of funding, and because it is noncombative. The interview questions revealed that students and one school official identified that there was a sex education curriculum taught during the

health course. However, the type of curriculum and publishing company was unknown. All other groups, especially parents and other school officials, denied the existence of a truly defined curriculum. As a result, the disparity in these responses showed a lack of knowledge, awareness, and cohesiveness of what is prescribed as a curriculum. The participants' inability to identify a consistent time frame for instruction on sex education led me to believe that instruction on sex education does not take place as often as it needs to consider the number of teen parents in the middle and high schools.

Research Question 3 asked for the knowledge, beliefs, and/attitudes the target audiences had regarding the offerings of AO versus comprehensive sex education. Unwaveringly, all six groups agreed that comprehensive sex education was the preferred method of teaching; however, the type of sex education should be distributed according to the age or maturity of the student as there is no one-size-fits-all solution.

In Chapter 5, I review the findings of the study in terms of positive social change implications and approaches that may be possible if problems in policy implementation arise. I revisit Bronfenbrenner's (1979) social ecological theory of perception and how it affects the community's interpretation and implementation of a defined sex education policy for all grades. I also address the significance of disparities in the school's policy implementation and will suggest further research to implement a cultural sex education policy more successfully. I conclude with a discussion of how a deficit in cultural policy implementation may help to explain why teen pregnancies and sexually transmitted diseases and infections remain prevalent in rural communities.

Chapter 5: Discussion, Recommendations, and Conclusions

Introduction

The dearth of literature that prompted the inception of this research on 9th-grade rural African American students' knowledge and understanding of abstinence-only sexual education is two-fold. First, published information regarding the internal factors (knowledge) of teen pregnancies and sexually transmitted diseases and infections in the United States was virtually nonexistent. This means that the perceptions and knowledge of sex education and curriculum of rural African American students, their parents, school officials, policymakers, church leaders, and health advocates were not collectively captured and reported prior to this study. Second, there was very little data resulting from a collection of African American students' first-hand knowledge of the phenomenon, generally speaking, which is even more profound when one aims to investigate the *why* behind adolescent decision making. This study was designed to address this two-fold gap in the literature and provides empirical data to support the need for a culturally sensitive sex education curriculum.

This study also explored the participants' general understanding of sexual health. It generated useful information that will allow school administrators to tailor sex education curricula to collectively address the multifaceted needs of all students while also being sensitive to the particular needs of African American students and complying with the state of Georgia's sex education policy. By gathering perceptions of different groups in this investigation, I documented the needs of African American youths in a rural southwest Georgia community. I also collected and analyzed information that will

help educators, parents, and stakeholders become better informed about the impact of different sex education curricula in reducing teen pregnancy and sexually transmitted infection rates among youths.

The nature of this exploratory study involved a qualitative approach and case study design that garnered information regarding the convoluted sense of dissonance between Georgia's state sex education policy, a district's sex education curriculum, and the perceptions that African American 9th graders and their parents, school officials, religious leaders, policymakers, and health advocates have towards sexual health curricula.

In the realm of public policy, this study substantiates the need for strong community support in influencing policy development on a local or community level toward a collective social action with the capability to exert influence on changes in policy, such as sex education. In addition to filling a gap in the literature, this study's results showed that no one entity guided the politics and policies under investigation, and that restructuring sex education is a multifaceted process.

Sex education policy is a controversial topic that has received little attention in rural areas despite its direct relevance to students and its effect on the global community. Schools are the chief entity that prepares students scholastically; they are also dynamic contributors in helping young people take responsibility for their health. The issues regarding sex education in public school systems are vast and widespread. Two of the more significant points I identified are the rates of teen pregnancy and sexually transmitted infections, and the accuracy and appropriateness of the information

disseminated through the current sex education pedagogy, both of which are essential in assessing the efficacy of policies related to sex education.

The following research questions were used to provide an understanding of the community's perception of XYZ School District's sexual health education program and implementation of curriculum:

1. What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education in XYZ County?
2. Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?
3. What knowledge**,** beliefs, and attitudes do the target audiences have regarding the offerings of abstinence-only versus comprehensive sex education?

The present study examined XYZ School District, a predominately African American community in southwest Georgia where unplanned teen pregnancy rates are the highest in the state, resulting in communities that suffer increased poverty, crime, and dropout rates. Key findings potentially explain why high rates of teen pregnancy and sexually transmitted disease are still so widespread among African American teens in rural schools:

- the environment is deficient in resources and opportunities;
- parents and community stakeholders are disconnected from the school;
- the community overall prefers a comprehensive sex education curriculum;
- African American students need cultural reassurance;

- the responsibility for sex education falls first on the parents and then the school and then the community (policymakers, church leaders, and health advocates);
- a lack of knowledge of who is responsible for the type of sexual health curriculum;
- a lack of communication; and
- no defined curriculum.

Interpretation of Findings from Interviews

Theoretical Framework

This study was conducted in an attempt to illuminate the perceptions of rural African American students, their parents, and their local community regarding the implementation and knowledge of a sex education curriculum. Bronfenbrenner's ecological systems theory of 1979 was the theoretical framework. Previous research has explored specific elements of similar teens' environment (church, culture, communication, sexual behavior, human rights/effective sexual health programs, school-based curricula) as the external foundations of teen pregnancy and sexually transmitted disease in the African American community. However, this previous research failed to address specifically the general perceptions and knowledge of any existing sex education and its curriculum among rural African American students and their parents, school officials, policymakers, church leaders, and health advocates. These studies' researchers also did not gather or explore first-hand knowledge of the phenomenon among African American students.

This study applied Bronfenbrenner's (1979) ecological systems theory, which focuses on both behavior and its individual and environmental determinants. The sexual health model emphasizes that intrapersonal factors, interpersonal processes, institutional factors, community factors, and public policy determine sexual behavior, which ultimately sums up Bronfenbrenner's systems. Studies in the literature review mainly addressed the micro- and mesosystems when addressing the sources of teen pregnancy and sexually transmitted diseases/infections.

Microsystem. The microsystem consists of one's immediate environment: church, self, family, and school. Church leaders, parents, and school officials were asked for their perceptions of sexual health curricula and why they thought AO was the preferred method for sex education. Overall, participants perceived a comprehensive sex education curriculum to be ideal for students in middle and high schools where teen pregnancies are evident and on the rise. As stated previously, past research did not address such intrapersonal factors as perceptions and knowledge. The themes generated from the literature review for this system were *environment* and *church*.

Nunn et al. (2012) identified two primary challenges from the perspectives of African American church leaders in addressing HIV/AIDS: 1) not knowing how to address human sexuality broadly from a biblical context and 2) having fear that tithing and offerings would come to a halt if they [church leaders] discussed condom use, risk behaviors, and human sexuality considering that discussions of sex are still taboo in the African American church.

Church leaders face challenges in addressing the real issues of their congregation. However, their perspectives and guidance are still expected and respected in the African American community. African Americans' social, spiritual, and personal development reflect the ideals and morals of the church they attend. The church is the rightful place for sexually active youth to engage in comprehensive sex education due to the protective role the church plays in the lives of African American and Hispanic youth (Sherr & Dyer, 2010). Church leaders in the current study described the taboo of sex in their perspective churches. Despite that, they [church leaders] supported a comprehensive sex education and they were not afraid to teach a broader sexual health curriculum to students in general and to the general members of their congregation because the reality of the world we live in is that teens are drawn to the notion that money, power, and sex rule. Their teachings would cover HIV/AIDs, sexual health, and protection.

The findings in this study agreed with past studies that sex talk is still taboo in church as presented by church leaders, parents, school officials, policymakers, and health advocates. However, the finding that church leaders were not afraid to discuss these sensitive issues seems to negate past research findings that church leaders worried that if they were to discuss HIV/AIDS, they would be perceived to be homosexual. Church leaders in this study believed that education is key and did not use religion as an excuse for not addressing reality.

Little, Henderson, Pedersen, and Stonecipher (2010) examined the perceptions of 22 Caucasian and one Mexican pregnant or parenting students in Oregon, where the rates of teen pregnancy were high. Their study found that nearly half of the students were

disadvantaged and their perceptions of teenage pregnancy revealed four major themes. First, the number of teenage pregnancies was increasing and becoming a growing concern. Second, teenage pregnancy posed harm to the teen parents' education and finances. Third, teenage girls wanted babies as a status symbol while boys only wanted sex. Finally, teenage pregnancy happened by chance or was the consequence of having careless sex, even though students were aware of contraception methods through their peers, the media, and family members. Themes one, two, and four were confirmed by my study.

All participants in this study confirmed theme one, the rise in teen pregnancies. Participants identified that teen pregnancies have become normal for middle schoolers. When participants were questioned about the cause of the increased rates in teen pregnancies, the common theme was "kids have nothing to do and they lack resources." The CDC (2010) stated social structures are needed to maintain and improve health; the lack of opportunity or resources connected to these social determinants places a person at a health disadvantage.

My study found that the community lacks resources to aid students in achieving good health and prosperity, which is a focus mandated by the school policies. The current findings confirmed theme two, teenage pregnancy posed harm to a youth's education and finances, and theme four, students were aware of contraception methods through their peers, the media, and family members. Theme three, teenage females wanted babies as a status symbol while males only wanted sex, was not confirmed by the present study. Students in the present study were not parents, unlike the participants of past studies, but

they shared a sense of the importance of pregnancy and disease prevention, the understanding that they are just kids, and that early pregnancy and diseases restrict goal attainment. Students in this study revealed they would prefer their health teacher, parents and/or religious leaders discuss contraceptives and prevention because they trust those individuals. Students, who were the core of the theory, perceived information from trustworthy sources to be more beneficial and caring than that gained from friends and media. Students in the present study were knowledgeable about sex with/without condoms and abstinence through their health course unlike the students in Little et al.'s (2010) study on *Perceptions of Teen Pregnancy Among High School Students In Sweet Home, Oregon,* who participated in a 3-year minimum AO education program and still were unsure about how to use condoms and whether they should have sex with/without condoms and abstinence.

Mesosystem. The mesosystem encompasses the interaction and collaboration of everyone in the community working together for the growth and development of the child. This study found communication deficiencies between the school, parents, and students. Parents were not confident in what their children had learned in sex education. A past study by Royer et al. (2009) stated that sex education programs should be designed based on youths' perceptions, where a level of trust and openness may develop between providers and adolescents. Students in the present study confirmed that their parents, teachers, and church leaders should be the primary influence in matters of sex education. This study's findings have provided evidence that the community does not

have collaborative efforts in place; the community is a critical and important part of the ecological system.

Exosystem. This third system consists of other people and places in the community with whom the child seldom interacts with, such as community members, peers, and family members. The child in this system is defined by how he or she socializes and behaves. The participants in this study believed students need more than education. Students could be taught about protection and prevention and still choose to have unprotected sex, as church leaders and parents explained. Past studies showed that sources other than parents, such as medical doctors, peers, and the media, influence teenagers' decisions about sex and sexual views. Findings from past studies reaffirm that students need consistent and constant reminders and information on the dangers of unprotected sex over a longer period than a year in high school as described by the National Campaign to Prevent Teen Pregnancy (2013).

Macrosystem. The macrosystem includes cultural, economic, and political variables, like policies, curricula, and funding, that influence the individual. The ecological theory is important in building linkages. In past research, rural educators declared that social and political communities decided what type of sex education students received (Blinn-Pike, 2008). As Schmid and Kretzschmar (2012) pointed out, it is more complex than the environment; it is what takes place in the environment that puts a group more at risk than others. My study found the school board to be responsible for XYZ County's sex education curriculum, though the community was uninformed of their own role in advocating for a comprehensive sex education curriculum, which they

preferred according to my research. All participants identified a prevalence in teen pregnancy in the schools and community amongst girls as young as 12. None of the participants identified or acknowledged males as teen parents in general.

A past study found that rural educators' ineffectiveness or inability to reach or control students' sexual behavior was due to the existing political and religious constraints (Blinn-Pike, 2008). The present study at hand extended the knowledge that students, parents, policymakers, church leaders, and health advocates rely heavily on parents and schools to educate students at different grade levels appropriately on the dangers of unprotected sex. It is not enough for students to be educated. It is necessary for them to trust the information that is presented and act accordingly when no one is looking. The inexistence of a mandated, defined curriculum in XYZ County poses a barrier to proper sex education.

Economic. This study found a lack of opportunity or resources, which confirmed an aspect of the literature review that social determinants are economic systems and social structures that are needed to maintain and improve health; the lack of opportunity or resources regarding these social determinants places a person at a health disadvantage (CDC, 2010). Participants in the present study shared that the community does not offer a safe and fun-filled place for students like bowling, youth centers, or extracurricular programs aside from the school's basketball, football, and cheerleading programs, which may result in students engaging in early sexual activity. Because there are not enough extra-curricular activities, teens are left alone more and might chose to have sex to entertain themselves.

Cultural. As several studies have revealed, there has to be sensitivity to the cultural needs of a group of people (Romer et al., 2009; Winters & Winters, 2012; Wyatt, 2009) because a one-size-fits-all approach is not effective in preventing sexually transmitted infections. Musa, Schulz, Harris, Silverman, and Thomas (2009) stated that within minority populations, increasing the cultural sensitivity of medical professionals and institutions can build trust. This study confirms this aspect of the previous studies. In this study, a school administrator stated that sex education instruction has to be tailored to mitigate the cultural barrier that affects African Americans. One parent added that the curriculum should focus on more realistic dialogue to break down potential language barriers. The parent believed that African American students would take the curriculum more seriously and find it more believable if the material were written in the language/vernacular that African American students understand in the context of their own culture. For example, the curriculum could use terms that the students use with each other as well as the proper terminology.

The present study confirmed past research studies that found that females are held to higher moral standards than males when it comes to sex. A male policymaker revealed that the culture expects males to have multiple women while women should remain monogamous. One religious leader expressed how notable it was in the African American community that for a man, more money and women equate to happiness, and money attracts the women. In addition, at an early age, boys goad and taunt each other into stating the number of girlfriends they have. Past studies found that it is less acceptable for females to have multiple sex partners (Reed et al., 2012; Tobey et al., 2011).

Political. As stated in the literature review, the critical role of policy making and analysis is to provide the general public and target populations with policy options and promote public input in the policy making process even regarding a matter as focused as a local school sex education policy and curriculum. Policy development, policy advocacy, and policy analysis all play an important role in health promotion as described by McLeroy et al. (1988). The present study is linked to public policy in the formation of public programs (as well as the initial stages of policymaking) and getting information on the topic of sex education from those affected by it as well as other stakeholders, which is very important and the basis for the program's success.

One policymaker advocated that people in the field of writing and executing policies provide funding to help educate the community on the issues surrounding sex education. The present study revealed a lack of participation from school board members as well as city and county council members. I asked policymakers, after the lack of participation, what policymakers could do to aid in the prevention of teen pregnancy and sexually transmitted diseases/infections. Policymakers suggested that either their colleagues did not want to address the issue and make it their problem or that they refused to look around and see how STI transmission is affecting their community. If they did not know about it, it did not exist.

Based on the findings from the study, it was obvious the school's sex education policy was not based on consumer information. There is a good chance that if it had been formed with the consumers' concerns in mind, the outcome would have been more positive.

Chronosystem. The final system, chronosystem, can be viewed as a person's entire personal experience over the span of a lifetime in the context of this study. The changes that take place in this system could affect the way a person develops mentally. Teen parents were not targeted for this study, and as a result, this system was not applicable to the current study.

Limitations of the Study

There were minimal limitations to this study, but we still need to consider them in order to understand each perspective that was brought forth during the study. One limitation arose after the student interviews when two parents requested that their children's interviews not be included in the present study. These parents had originally consented for their students to participate, but when asked why they wanted to recant the interviews, one parent explained that she did not trust the information would remain confidential and the other parent stated she simply did not want her child to participate further in light of the interview taking place. Both parents were willing to participate in the present study, themselves, and were allowed to continue.

Also, there were moments during the interviews when participants were not familiar with the academic term *comprehensive sex education*. Their facial expressions showed their discomfort with the questions; nevertheless, participants provided lengthy responses to the interview questions. In some instances, I had to direct participants back to the original question, explaining more of what I was asking without providing my personal biases.

The number of participants in the present study fell short of what was originally proposed. City council members did not respond to phone and email communications regarding this study. The premise of this study was to ascertain the perceptions of African American students in 9th grade, their parents, and church leaders and to gather perceptions of Caucasian community members. Participants' varied knowledge, demographics, and personal views provided substantial data that has the potential to influence decision making on the local level for those who are not familiar with policy changes.

Recommendations for Future Research

Sex education has been a topic of national debate for decades and will continue to be such as unwavering statistics of teen pregnancies and sexually transmitted diseases/infections persist. Unless there are drastic policy changes put in place, there will be no positive affect on the rates of teen pregnancies and sexually transmitted infections. Teen Pregnancies and sexually transmitted diseases remain prevalent amongst middle and high school students, although policies and interventions are in place to curtail students' sexual behaviors. The goals of this study were to gather the perceptions of members of the ecological system regarding sex education and to evaluate their knowledge of the school district's implementation of a sex education curriculum. Members of the community where unaware that policies on local, state, and federal levels determine the types of programs school districts implement.

There is a need for empirical data on schools' sex education policies as they parallel with their state's policy. It is unknown if schools' inability to implement

mandated sex education programs is due to funding, the attitudes of elected school administrators, or the communities' perceptions of sex education.

Another recommendation is for future researchers to compare sex education policies among several rural schools. There is no specific evidence that rural students in particular suffer because of issues with sex education policies or curriculum, but comparing or contrasting rural schools' sex education policies could provide a plethora of knowledge regarding the various boards of education's knowledge, perception, and implementation of sex education curricula in their schools.

Future researchers should explore pregnancy and sexually transmitted disease rates in urban, rural, and suburban areas and compare policy implementation at the various schools that may help to identify other similarities and differences regarding the students' and administrators' perceptions. These similarities could be compared to find common themes on how sexual health is viewed at the different schools and how the administration implements a particular type of sex education policy for each school.

Future researchers should also conduct analyses of the implementation of schools' sex education curriculum and policy in rural areas. Evidence-based curricula are needed to accurately identify if a curriculum is effective. Due to a lack of tracking, there is little and outdated data on the effectiveness of sex education curricula in rural areas. It is unknown if implementation of curricula has reduced the rates of teen pregnancy and sexually transmitted diseases.

The final recommendation is for future researchers to further investigate the cultural perceptions African Americans, as well as other races, have towards sexual

health and knowledge. As culture plays a very important role in the development of individuals.

Implications for Social Change

Georgia's sex education policy general requirements mandate the inclusion of discussions of STIs but do not require curricula to be age or culturally appropriate. Policy, as it stands, would restrict funding for comprehensive sex education resources, which becomes a direct excuse for school boards to administer fly-by-night curricula on sexual health without the proper education and training needed to execute it [policy].

Social change is a critical component of this doctoral study wherein information may be disseminated to community stakeholders so that they better understand the students', their parents', school officials', church leaders', policymakers', and health advocates' perceptions of sexual health and the implementation of a sex education curriculum. The implications of social change within this chapter provide a method by which to improve the implementation of a defined curriculum and provide ways in which members of the ecological systems can become a united front in the fight against teenage pregnancies and sexually transmitted diseases and infections.

Teen pregnancy and sexually transmitted diseases are a problem that must be resolved using a holistic approach. Addressing these problems from an ecological perspective allows the school administration to consider the culture and perspective of the students, their parents, policymakers, church leaders, and health advocates. Using the holistic approach to combat teen pregnancy and sexually transmitted diseases/infections will likely have a social impact on the school and community environment by increasing

awareness. A community properly educated on the effects of poor sexual health can produce overall healthy individuals with the potential to live prosperous lives. The holistic approach is ideal in getting everyone involved and sending the same message regarding preventive methods.

Findings

The findings of the case study suggested that the community needs to become more involved in creating education policy in the XYZ School District. Stakeholders need to know there is a problem, and they should be supplied with the available research that will allow them to make fully informed sex education policy decisions and to dispel the myth that the community supports AO education.

Schools must be able to implement effective sex education policies/curricula that correspond to the cultural, social, and economic conditions of their students and communities. This responsibility is placed with parents, policymakers, church leaders, and health advocates. I recommend the implementation of an evidence-based, culturally sensitive, comprehensive curriculum as a part of the school's standardized course of study. This curriculum will allow school administrators to document its effectiveness empirically. The curriculum should include both males and females throughout the same curriculum sessions because students are not isolated in their day-to-day interactions. There are not many culturally sensitive curricula for African American youth; however, I recommend *Focus on Youth: An HIV Prevention Program*. A list of evidence-based programs that are recognized by the new Teen Pregnancy Prevention Initiative under President Obama's Administration is located in Appendix P.

Also, this study revealed that participants were adamant that people who resemble the members of their community provide training and bring awareness. Moreover, this study exposed an indecisiveness in defining terms and preferences for a specific type of sex education curriculum. Possibly, with this extended knowledge, the community/school could provide educational material and training to the community as well as students apart from that provided by the health department. As several studies expressed, African Americans often have trust issues with people who do not look like them. They find it difficult to put their faith in people in the medical field who historically have not cared about their well-being (Parrill & Kennedy, 2011; Plowden, James, & Miller, 2000; Thomas et al., 2012). The materials and training should be culturally sensitive to the African American community.

This qualitative study is the first of its type to explore the perceptions of sexual health and implementation of sex education from every aspect of society in a rural community in southwest Georgia. This research study can be used in practice to study further the implementation of sex education policies in rural areas in terms of the proven social ecological theory of Bronfenbrenner where rural communities are often overlooked.

The results can be published as well as shared with the administration in the XYZ School District to create immediate social change through community level collaboration. This study depicted the level of disconnection between each member of the ecological system regarding how they could benefit from each other in making changes. The community lacks resources and information because its members do not communicate for

the common good of the students and community. I suggest that the community form a coalition to advocate for such policy changes regarding issues of teen pregnancy and STDs/STIs in their community. Each member of the ecological system influences students. If members work together to provide consistent, transparent messages concerning prevention and protection, then possibly the messages will register with youth.

For immediate social change, XYZ School District could adopt or define a sex education policy specifically for their district and openly advocate to the community the district's position for comprehensive sex education and explain the types of evidence-based curricula the district is looking to adopt and their level of execution. The key is to be transparent and direct so that the community cares about the well-being, growth and development of all students.

Conclusion

Sexual health knowledge is an essential component of affirming a strong health education curriculum in schools and providing skills needed for adolescents to remain healthy. The disadvantaged communities and at-risk behaviors of African Americans have been widely studied. Generally, communities enact policies to evade negative effects that have been identified or to seek some positive benefits. AO programs arose in an era when teen pregnancy rates were constantly rising, mainly in low-income, disadvantaged African American communities, and those schools and communities received earmarked Title V funds to *fix* the problem by declaring teen pregnancy the result of children without two-parent families and a lack of moral beliefs.

Over the years, evidence has shown that abstinence-only sex education is not an evidence-based approach to reducing the rates of teen pregnancy and sexually transmitted diseases. Yet in XYZ, a low-income and disadvantaged community where the rates of both are still high for such a small population, an AO curriculum was considered the best method for years. The results of this study show that the community supports a comprehensive sex education curriculum in the absence of a known or titled sex education curriculum. The nonexistence of a sex education curriculum sheds light on why teen pregnancies and sexually transmitted diseases might remain prevalent if they are not addressed through the implementation of a clear sex education policy and curriculum.

More empirical research is needed to understand the relationship between the rates of teen pregnancy and sexually transmitted diseases in a rural community and the implementation of a mandated sex education policy. Also, empirical research is further needed in rural communities to understand the members' perceptions and knowledge of sexual health. There were inconsistencies in what participants knew about the implementation of the school's sex education policy and curriculum, which shed light on the community's lack of knowledge. The school administrator was the only person who was aware and able to describe precisely the district's execution of sex education. We cannot say that the school district's lack of a defined curriculum caused an increase in the rates of teen pregnancies and possible sexually transmitted diseases/infections. It is justifiable, however, to say that with the current high rates, the community needs to do more to reduce these rates.

The school district needs to implement a clearly defined sex education policy. Random discussions of topics are an injustice to students if an evidence-based curriculum does not guide the instruction. Implementation of sex education programs is often inadequately considered or not considered at all in planning, developing, and evaluating pregnancy prevention and sexually transmitted disease interventions.

In this chapter, I summarized the results of this study, presented the findings and provided an interpretation of the data. I also discussed the implications that inform educational policy, the limitations of the study, and recommendations for further research. This research contributes to the field of education and public health and provides school boards and administrators with a broader knowledge of the best practices surrounding culturally sensitive policy implementation. This study enhances the ability of the school board, parents, policymakers, church leaders, and health advocates to find a unified way to work together towards reducing teen pregnancies and sexually transmitted diseases amongst rural African American students.

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Appendix A: District Permission to Conduct Research

October 5, 2012

I am writing to request permission to conduct a qualitative study involving the 9th Grade Academy in this school district. The purpose of this study is to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education health curricula in their district. This will be a qualitative case study that will include 36-60 students, their parents, administrator, religious leaders, policymakers and health advocates. The researcher will collect data through an interview guide.

It is important to note the researcher will protect the identity of the district, its employees, parents and children throughout the process by use of pseudonyms. Furthermore, all participants will be informed that they may withdraw from the study at any time during the process without written notification. The study will take approximately three months to complete.

The results of the study will contribute to the scholarly literature on the phenomenon of pregnancy and STD's prevention as well as provide data that might prove useful to the organization. Specifically, the study will provide insight into a phenomenon that has been rarely studied in this capacity but is becoming a greater problem within the educational community.

If you have any questions regarding the proposed study, please contact me via email at felecity.burns@gmail.com or call me at [redacted]. Thank you for considering my request.

Sincerely,

Felecity N. Burns
Doctoral Student, Walden University
Public Policy & Administration

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 valid as long as both parties have agreed to conduct the transaction electronically.

✓ Consent has been granted.

Vic Hill, Superintendent

_____ Consent has been denied.

3.31.15

Date

Appendix B: Parent/Guardian Consent Form

Youth are being asked to participate in the research study, which will assist with Felecity Burns' doctoral research. You child was selected as a possible participant because you are a parent/guardian of a 9th Grade student at XYZ County High and you are over 18. Please read this form and ask any questions you may have before accepting this invitation to participate in this study. Felecity Burns, a doctoral candidate at Walden University, will conduct this study.

Background Information:
The purpose of this interview is to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education health curricula in their district. This study will also explore the participant's general understanding of sexual health.

This includes questions in regards to their knowledge of ways to prevent pregnancy and sexually transmitted infections. The results of the study have the potential to provide useful information that will allow school administrators to tailor a sex education curriculum that collectively addresses the multifaceted needs of all students, but is sensitive to the needs of African American students while complying with the state of Georgia's sex education policy.

Please understand your child's sexual history will not be questioned or obtained at any time during this study.

It is in my best interest to create an environment in which adolescents feel comfortable and safe in answering questions. I will do her best to ensure adolescents answer questions honestly. In some situations it's important for parent to be present or to give their consent for an interview with a minor, this gives the adult opportunities to help protect the minor's rights. However, in other situations the interview is apt to be more effective if the adult is not present. Many adolescents are hesitant to reveal sensitive information in the presence of their parents.

For this reason, I wants to interview the adolescent alone in an effort to garner the most honest response. This will allow me to assess the adolescent's perceptions more accurately. It's not the intention of I to gather information about the adolescent's private and personal encounters or experiences, at any time the participant illicit personal stories or experiences, I will steer the focus back on the questions on the interview protocol. In order for parents to feel comfortable without being present during minors' interviews, the full set of student interview questions (Appendix E) are attached to this packet.

Procedures:
If you agree for your child's participation in this study, you and your child are invited to complete all forms and for your child to return all forms to one of the four ballot boxes on the 9th grade academy. Submission of the consent and assent forms does not guarantee automatic inclusion in the study. In the case of participation in the study, it is possible that the data collected may not be used in the final publication and that the inclusion and exclusion of data is at the sole discretion of me conducting the study. If child/parent are not selected that does not mean parent(s) did not grant permission it only means the parent/child were not selected to participate.

If selected, your child will be interviewed in person, alone, with me. You will be contacted via phone to schedule an interview appointment time and place (either the library or a secluded room in a restaurant) that is convenient and approved by you. Your child will be asked a series of open-ended questions lasting no more than 60 minutes. Parents will not be allowed in the interviewing session.

Interview data will be published collectively. No individual input will be determined in the research report, as your child's name and responses will not be connected or identifiable.

Voluntary Nature of the Study:
Your child can only participate if you agree to participate. Your and your child's participation in this study is strictly voluntary. You and your child have the right to refuse the interview recording and skip any question.

Risks and Benefits of Being in the Study:
There are minimal risks associated with participating in this study. For instance you will be invited to transport your child to a location. Please note interviews must be done outside instructional time which will impact your time. The only benefits are the opportunity to state your perspectives and know that you are positively contributing to the research, which will improve services for youth in this community. If the research procedures reveal or create an acute psychological state, it will be recommended for student and parent participants to seek the school counselor or health care practitioner advice and or counseling.

In the instance of disclosure of criminal or illegal activity from any participant, local authority will be contacted immediately; at that point the interview will be terminated.

Compensation:
There will be no monetary compensation provided for you or your child's participation; there will be individual vouchers provided to Pizza Hut or local restaurant.

Confidentiality:
The signed consent/assent forms will be coded and kept in a separate locked file where only I have access. If this study is published, I will not include any information that will make it possible to identify you or your child. The code will be transferred to interview responses with no other identifying information. The recording will be destroyed upon completion of the study and only used for accurate recording/transcribing.

Contacts and Questions:
The student conducting this study is Felecity Burns. The student's Chairman is Dr. Hilda Shepeard, who may be reached by email at hilda.shepeard@waldenu.edu. You may ask any questions you have now. If you have questions later, you may contact Felecity Burns at felecity.burns@waldenu.edu. If you would like to ask my university a question, you can call Dr. Leilani Endicott. Her phone number is 612-312-1210. You will receive a copy of this form from me.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent for my child to participate in Felecity Burns' sex education research.

Printed Name of Participant _____
Participant Signature _____
Email Address/Phone Number _____

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 valid as long as both parties have agreed to conduct the transaction electronically.

Printed Name of Doctoral Student	Felecity N. Burns
Signature of Doctoral Student	Felecity N. Burns
Email Address of Doctoral Student	felecity.burns@waldenu.edu

Appendix C: Youth Assent Form

Hello, my name is Felecity N. Burns and I am doing a research project to learn about how people in this school district feel about a sex education curriculum to prevent teen pregnancy and sexually transmitted diseases/infections.

Your community has many teens who are pregnant and or have sexually transmitted diseases. I am inviting African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates to share their knowledge of a sex education health curricula in their district. I want you to learn about the project before you decide if you want to be in it.

Please understand your sexual history will not be questioned or obtained at any time during this study.

WHO I AM:
I am a student at Walden University. I am working on my doctoral degree. I am a graduate of the XYZ County School System.

ABOUT THE PROJECT:
If you agree to participate, your parent will not ever know what you said in the interview unless you share the information. Only I will know your identity. Your name or any information about you will not be used in this study.

If selected, you will participate in a one on one interview. The interview will last approximately 60 minutes. You will be asked 17 questions on the sex education curriculum in your school, knowledge of different types of STDs/STIs, your knowledge, attitude, and beliefs about the importance of sexual health, and what you know about the prevention of pregnancy and prevention of STDs/STIs. The interview will take place in a private environment.

Here are some sample questions:
What type of sex education does your school provide?
What is a type of sexually transmitted disease?
How can teen pregnancy be prevented?

IT'S YOUR CHOICE:
You don't have to participate in this research study if you don't want to. If you decide now that you want to join the project, you can still change your mind later. You can stop the interview anytime and skip any question you do not want to answer.

I am hoping this project help others by providing ways students can prevent teen pregnancy and diseases for themselves.

If you decide to participate, you will receive a certificate for a personal pan pizza that is valid at Pizza Hut once the interview is over.

PRIVACY:

Everything you tell me during this project will be kept private. That means that no one else will know your name or what answers you give. Your interview will be coded or grouped with other interviews that share your thoughts as a whole. So your responses, to each question will not be put in the study as is, I will summarize what you say. This method will make it impossible for anyone to identify who you are. The only time I have to tell someone is if I learn about something that could hurt you or someone else.

If the research procedures reveal or create an acute psychological state, it will be recommended for student and parent participants to seek the school counselor or health care practitioner.

ASKING QUESTIONS:
You can ask me any questions about the study now. If you think of a question later, you or your parents can reach me at [redacted] or felecity.burns@waldenu.edu. If you or your parents would like to ask my university a question, you can call Dr. Leilani Endicott. Her phone number is 612-312-1210.

I will give you a copy of this form.

Please print and sign your name below if you want to join this research study. Return Parent/Guardian Consent (Appendix B) and Youth Assent (Appendix C) to one of the four ballot boxes on the 9th grade academy.

Printed Name of Child _____

Child Signature _____

Date _____

Researcher Signature Felecity N. Burns

Appendix D: Adult Consent Form

You have been invited to participate in a research study, which will assist with Felecity Burns' doctoral research. You were selected as a possible participant because you reside or work in the XYZ County School District as a parent, school official, religious leader, policymaker, or health advocate. Please read this form and ask any questions you may have before accepting this invitation to participate in this study.

Background Information:
The purpose of this interview is to explore the perceptions of rural African American students in 9th grade, their parents, school officials, religious leaders, policymakers, and health advocates regarding sex education health curricula in their district. This study will also explore the participant's general understanding of sexual health.

This includes questions in regards to your knowledge of ways to prevent pregnancy and sexually transmitted infections. The results of the study have the potential to provide useful information that will allow school administrators to tailor a sex education curriculum that collectively addresses the multifaceted needs of all students, but is sensitive to the needs of African American students while complying with the state of Georgia's sex education policy.

Procedures:
If you agree to participate, you will be invited to complete and return this form. Submission of the informed consent form does not guarantee automatic inclusion in the study. In the case of participation in the study, it is possible that the data collected may not be used in the final publication and that the inclusion and exclusion of data is at the sole discretion of me conducting the study.

You have a choice to be interviewed in person or over the phone. You will be contacted via phone to schedule an interview appointment time and place that is convenient and approved by you. You will be asked a series of open-ended questions lasting no more than 60 minutes. The interview will be audiotaped if you prefer to be interviewed in person.

Voluntary Nature of the Study:
Your participation in this study is strictly voluntary. You have the right to refuse the interview recording.

Risks and Benefits of Being in the Study:
There are minimal risks, such as uncomfortableness answering questions, associated with participating in this study. The only benefits are the opportunity to state your perspectives and know that you are positively contributing to the research, which will improve services for youth in this community. If the research procedures reveal or create an acute psychological state, it will be recommended for adult participants to seek a health care practitioner advice and or counseling.

In the instance of disclosure of criminal or illegal activity from any participant, local authority will be contacted immediately; at that point the interview will be terminated.

Compensation:
There will be no monetary compensation provided for your participation; there will be a voucher provided to Pizza Hut or a local restaurant.

Confidentiality:
The signed consent form will be coded and kept in a separate locked file where only I have access. If this study is published, I will not include any information that will make it possible to identify you. The code will be transferred to interview responses with no other identifying information. The recording will be destroyed upon completion of the study and only used for accurate recording/transcribing.

Contacts and Questions:
The student conducting this study is Felecity Burns. The student's Chairman is Dr. Hilda Shepeard, who may be reached by email at hilda.shepeard@waldenu.edu. You may ask any questions you have now. If you have questions later, you may contact Felecity Burns at felecity.burns@waldenu.edu. If you would like to ask my university a question, you can call Dr. Leilani Endicott. Her phone number is 612-312-1210. You will receive a copy of this form from me.

Statement of Consent:
I have read the above information. I have asked questions and received answers. I consent to participate in Felecity Burns' sex education research. Please print and sign your name below if you want to join this project and return via the self-addressed envelope or email it to felecity.burns@waldenu.edu.

Printed Name of Participant _____
Participant Signature _____
Email Address/Phone Number _____

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 valid as long as both parties have agreed to conduct the transaction electronically.

Printed Name of Doctoral Student	Felecity N. Burns
Signature of Doctoral Student	Felecity N. Burns
Email Address of Doctoral Student	felecity.burns@waldenu.edu

Appendix E: Student Interview Protocol

Hello. My name is Felecity and I am a Doctoral Candidate at Walden University. I am conducting a dissertation research on the perceptions the community has on sexual education in the school system. This case study will examine what you think about sexual health in your school and community. I am glad that you are willing to talk to me about teen pregnancy and sexually transmitted infections prevention. Please understand your sexual history will not be questioned or obtained at any time during this study.

The interview process will take about 60 minutes. There are no wrong answers to the questions. You make skip a question at any time you feel uncomfortable answering. I want you to be candid. It is hoped that the findings will contribute useful information to address issues identified in the information you provide. The comments you provide are confidential; I won't use your name in any description or summary that I write. I will also record the conversation today to help me make sure my notes are accurate. Your parent will not hear or see your interview responses. Only the transcriber and I are involved with this effort and will hear these recordings; the recordings will be destroyed after five years, the required time that the dissertation data must be maintained. Do I have your permission to record? Do you have any questions before we start?

Knowledge

1. Does your school have a sex education course/curriculum?
2. What does it cover?
3. How frequent is the course?
4. What is a sexually transmitted disease?
5. What is a sexually transmitted infection?

6. What are some types of STDs/STIs?
7. Do you think prevention of pregnancy is important? Explain
8. Do you think the prevention of STD/STI is important? Explain
9. Can you provide any examples of methods of prevention?
10. What is abstinence?

Attitudes

11. What is the difference between abstinence-only sex education and comprehensive sex education?
12. Which do you prefer and why?

Beliefs

13. Do you believe the sex education curriculum provide beneficial information to help you understand the topic?
14. Do you believe the sex education curriculum is helpful to sexually active students? Why
15. Who do you believe should be responsible for talking to you about sex (including teen pregnancy and sexually transmitted diseases/infections?

Appendix F: Parents Officials Interview Protocol

Hello. My name is Felecity and I am a Doctoral Candidate at Walden University. I am conducting a dissertation research on the perceptions the community has on sexual education in the school system. This case study will examine what you think/know about sexual health in your school and community. I am glad that you are willing to talk to me about teen pregnancy and sexually transmitted infections prevention.

The interview process will take about 60 minutes. There are no wrong answers to the questions. You may skip a question any time you feel uncomfortable answering. I want you to be candid. It is hoped that the findings will contribute useful information to address issues identified in the information you provide. The comments you provide are confidential; I won't use your name in any description or summary that I write. I will also record the conversation today to help me make sure my notes are accurate. Only the transcriber and I are involved with this effort and will hear these recordings; the recordings will be destroyed after five years, the required time that the dissertation data must be maintained. Do I have your permission to record? Do you have any questions before we start?

Knowledge

1. Does XYZ County have an active sex education curricula?
2. What type of sex education curricula is at your child's school?
3. How frequent is the course?
4. Do you know who is responsible for determining sex education in your child's school?
5. Why do you think the school system teach abstinence only education over comprehensive sex education?
6. How present are teen pregnancies in the XYZ County school system?

Attitudes

7. What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections?
8. What is the difference between abstinence-only sex education and comprehensive sex education?
9. Which do you prefer and why?

Beliefs

10. Do you support an abstinence only curricula? Explain
11. Do you think it is effective? Explain.
12. Do you believe the sex education curriculum is helpful to sexually active students?
13. Who do you believe should be responsible for teaching students about sex?

Appendix G: School Officials Interview Protocol

Hello. My name is Felecity and I am a Doctoral Candidate at Walden University. I am conducting a dissertation research on the perceptions the community has on sexual education in the school system. This case study will examine what you think/know about sexual health in your school and community. I am glad that you are willing to talk to me about teen pregnancy and sexually transmitted infections prevention.

The interview process will take about 60 minutes. There are no wrong answers to the questions. You may skip a question any time you feel uncomfortable answering. I want you to be candid. It is hoped that the findings will contribute useful information to address issues identified in the information you provide. The comments you provide are confidential; I won't use your name in any description or summary that I write. I will also record the conversation today to help me make sure my notes are accurate. Only the transcriber and I are involved with this effort and will hear these recordings; the recordings will be destroyed after five years, the required time that the dissertation data must be maintained. Do I have your permission to record? Do you have any questions before we start?

Knowledge

1. Does XYZ County have an active sex education curricula?
2. What type of sex education curricula is at your child's school?
3. How frequent is the course?
4. Who determines the type of sex education for the school?
5. Why do you think the school system teach abstinence only education over comprehensive sex education?
6. How present are teen pregnancies in the XYZ County school system?

Attitudes

7. What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections?
8. What is the difference between abstinence-only sex education and comprehensive sex education?
9. Which do you prefer and why?

Beliefs

10. Do you support an abstinence only curricula? Explain
11. Do you think it is effective? Explain.
12. Who do you believe should be responsible for teaching students about sex?

Appendix H: Community Member Interview Protocol

Hello. My name is Felecity and I am a Doctoral Candidate at Walden University. I am conducting a dissertation research on the perceptions the community has on sexual education in the school system. This case study will examine what you about sexual health in your school and community. I am glad that you are willing to talk to me about teen pregnancy and sexually transmitted infections prevention.

The interview process will take about 60 minutes. There are no wrong answers to the questions. You may skip a question any time you feel uncomfortable answering. I want you to be candid. It is hoped that the findings will contribute useful information to address issues identified in the information you provide. The comments you provide are confidential; I won't use your name in any description or summary that I write. I will also record the conversation today to help me make sure my notes are accurate. Only the transcriber and I are involved with this effort and will hear these recordings; the recordings will be destroyed after five years, the required time that the dissertation data must be maintained. Do I have your permission to record? Do you have any questions before we start?

Knowledge

1. Does XYZ County have an active sex education curriculum?
2. What type of sex education curricula is at the schools?
3. How frequent is the course?
4. Why do you think the school system teach abstinence only education over comprehensive sex education?
5. Do you support an abstinence only curricula? Explain
6. Do you think it is effective? Explain.
7. How present are teen pregnancies in the XYZ County School System?

Attitudes

8. What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections?
9. What is the difference between abstinence-only sex education and comprehensive sex education?
10. Which do you prefer and why?

Beliefs

11. Who do you believe should be responsible for teaching students about sex?

Appendix I: Screener

Hi I'm Felecity Burns, a Ph.D. Candidate at Walden University. I will ask you a few simple questions to see if you qualify as a participant for this research study. You have the right to refuse to answer any of the questions; however in not answering, you will be unable to be considered a participant. You can qualify for more than one position, but expected to answer questions based on how you would like to be identified.

ALL

1. Are you a student, parent, school official, religious leader, policymaker or health advocate?
2. How do you self-identify: African American, White, Hispanic, Asian, or Other?
3. Are you Male or Female?
4. How old are you? Under 18? 18-25? 26-30? 31-35? 36-45? 46-55? Over 55?

ADULTS ONLY

5. Are you married? Single?

STUDENTS

6. Do you reside at home with your parent/guardian?

PARENTS

7. Are you a school official, religious leader, policymaker or health advocate?

SCHOOL OFFICIALS

8. Are you a principal, teacher, or a school board member?

RELIGIOUS LEADERS

9. Are you currently serving in a pastoral role in the XYZ County school district?

POLICYMAKERS

10. Are you a City councilman? County Commissioner? District Representative? Mayor? City Manager?

HEALTH ADVOCATE

11. Are you a Clinician? Nurse? Physician Assistant?

Appendix J: Confidentiality Agreement

Name of Signer:

During the course of my activity for this research: "A Community's Perception of Pregnancy, Sexually Transmitted Infections and Prevention Programs" 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:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. 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.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. 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 K: Letter of Cooperation

Felecity N. Burns
felecity.burns@waldenu.edu
[redacted]

March 26, 2015

Dear Ms. Burns,

Based on my review of your research proposal, I give permission for you to conduct interviews for the study entitled **A Community's Perception of Teen Pregnancy, Sexually Transmitted Infections and Prevention Programs** at City Walk Sports Cube. I am aware that individuals' transportation to the site will be at their own discretion.

I understand that my organization's responsibilities include: Providing full access to [redacted], including a functioning break room and restroom. You are responsible for providing participants beverages. I will be responsible for providing access to the site at least an hour before interviews. In complying with the study's confidentiality, my staff nor I will be present during individual interviews. Once interviews are over for the day, I will return to secure the building.

I confirm that I am authorized to approve research in this setting and that this plan complies with [redacted] policies. In compliance with your study, I will sign a confidentiality agreement.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

[redacted]..

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying

marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix L: Data Collection Coordination Request

March 26, 2015

Dear [redacted],

I have obtained Superintendent [redacted] support to collect data for my research project entitled A Community's Perception of Teen Pregnancy, Sexually Transmitted Infections and Prevention Programs within the 9th grade Academy.

I am requesting your cooperation in introducing this study to your students. I propose to collect data before FY 14-15 school year ends.

As you've agreed to be part of this research project, there are specific activities that are expected. My goal is to minimize disruption to your teachers' instructional activities as much as possible while maintaining the confidentiality of the student.

I would ask that during an assembly you introduce the study and me to your students, where literature will be provided on criteria, confidentiality, permission forms, and the length of the study. After the assembly, I would like to distribute a research packet to the students that includes a flyer about the study, consent forms, and an assent form, student interview questions.

I am also requesting four nontransparent locked ballot boxes (which I will provide) to be stored on the back walls of the two instructional halls/wings, bus entrance and the cafeteria. I will collect documents at the end of each school week.

Data collection may take up to eight weeks depending on students returning documents.

If circumstances change, please contact me via felecity.burns@waldenu.edu or [redacted]. Thank you for your consideration. I would be pleased to share the results of this study with you if you are interested.

I am requesting that you reply to this email with "I agree" to document that I have cleared this data collection with you.

Printed Name of 9th Grade Academy Instructional Leader	[redacted]
Date	_____
Teacher'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 M: Recruitment Flyer

You are Cordially Invited to...

WHAT IS THIS?

A Teen Pregnancy and Sexually Transmitted Disease Prevention Study

FOR WHOM?

[redacted] *Georgia Community*

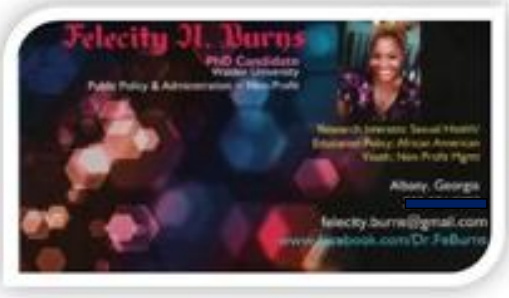
WHY SHOULD YOU BE CONCERNED?

- ✓ Georgia has the 8th highest teen pregnancy rate in the nation.
- ✓ Also one of the highest AIDS rates in the African American community.
- ✓ There are over 152,000 sexually active teens in Georgia.
- ✓ Public school systems have Abstinence-Only Education or no sexual education curricula

If you are interested in participating, please contact Felecity Burns at the email address or phone number below **by January 10, 2015.**

Best regards,

Felecity Burns. PhD. Candidate



Who can participate in the study?

- ✓ African American students in 9th grade Academy
- ✓ African American parents of 9th grade students
- ✓ School officials
- ✓ Policy leaders
- ✓ Church leaders
- ✓ Health advocates in [redacted] GA

Criteria for Parents:

- ✓ Must Be African American
- ✓ Have a child in the 9th Grade Academy in the [redacted] County schools

Criteria for Teachers, School Officials, Health Advocates, Church Leaders, and Community Leaders:

Must live/work in [redacted] GA

Appendix N: Research/Interview Question Matrix

	RQ1 **What is the relationship between knowledge about the prevention of teen pregnancy and STDs/STIs and sex education curricula in XYZ County?**	**RQ2** **Why are XYZ County schools continuing to disseminate abstinence-only curricula in light of new policies and evidence of the effectiveness of comprehensive approaches?**	**RQ3** **What are the knowledge, beliefs, and/attitudes of the target audiences regarding the offerings of Abstinence-Only versus comprehensive sex education?**
STUDENTS	Does your school have a sex education course/curriculum? What does it cover? How frequent is the course? What is a sexually transmitted disease? What is a sexually transmitted infection? Do you think prevention of pregnancy is important? Explain Do you think the prevention of STD/STI is important? Explain Can you provide any examples of prevention of STD? What are some types of STDs/STIs?		What is abstinence? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why? Do you believe the sex education curriculum provide beneficial information to help you understand the topic? Do you believe the sex education curriculum is helpful to sexually active students? Why Who do you believe should be responsible for talking to you about sex (including teen pregnancy and sexually transmitted diseases/infections??
PARENTS	Does XYZ County have an active sex education curricula? What type of sex education curricula is at your child's school? How frequent is the course?	Do you know who is responsible for determining sex education in your child's school? Why do you think the school system teach abstinence only education over comprehensive sex education?? Do you support an abstinence only curricula? Explain Do you think it is effective? Explain. How present are teen pregnancies in the XYZ County school system?	What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why? Who do you think should be responsible for teaching your child about sex? If you speak to your child about sex what is your overall message? Teen Pregnancies?

			Sexually Transmitted Diseases and Infections?
SCHOOL OFFICIAL	Does XYZ County have an active sex education curriculum? What type of sex education curricula is at your child's school? How frequent is the course?	How present are teen pregnancies in the XYZ County school system? Why do you think the school system teach abstinence only education over comprehensive sex education? Do you support an abstinence only curricula? Explain Who determines the type of sex education for the school? Do you think it is effective? Explain	What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why? Who do you think should be responsible for teaching students about sex?
RELIGIOUS LEADER		Why do you think the school system teach abstinence only education over comprehensive sex education?? Do you support an abstinence only curricula? Explain Do you think it is effective? Explain. How present are teen pregnancies in the XYZ County school system?	What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why? Who do you think should be responsible for teaching students about sex?
POLICYMAKER	Does XYZ County have an active sex education curriculum? What type of sex education curricula is at your child's school? How frequent is the course?	Why do you think the school system teach abstinence only education over comprehensive sex education?? Do you support an abstinence only curricula? Explain Do you think it is effective? Explain.	What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? What is the difference between abstinence-only sex education and comprehensive sex education?

		How present are teen pregnancies in the XYZ County school system?	Which do you prefer and why? Who do you think should be responsible for teaching students about sex?
HEALTH ADVOCATE	Does XYZ County have an active sex education curriculum? What type of sex education curricula is at your child's school? How frequent is the course?	Why do you think the school system teach abstinence only education over comprehensive sex education?? Do you support an abstinence only curricula? Explain Do you think it is effective? Explain. How present are teen pregnancies in the XYZ County school system?	What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections? What is the difference between abstinence-only sex education and comprehensive sex education? Which do you prefer and why? Who do you think should be responsible for teaching students about sex?

Appendix O: Students, Parents and School Officials Members Transcriptions

	STUDENTS		**PARENTS**	**SCHOOL OFICIALS**
	MS11A FS21B MS21C		FP11D FP21B FP31A FP41C MP51F	MS1 FS2 FS3 FS4 FS5
5. What is a sexually transmitted infection?	MS11A: I'm thinking you can get rid of an infection (since it's a sexually transmitted infection quicker than you can get rid of a disease. FS21B: Well he told us it wasn't like the disease, but you can get infected in the area; with the disease it's like AIDS. MS21C: When you get infected having sex.	5. Why do you think the school system teach abstinence only education over comprehensive sex education?	FP11D: I don't know. FP21B: I really can't say. FP31A: Not sure if a curriculum is taught because son never received a permission slip from the school to discuss sex. As an educator in the elementary school, kids in pre-kindergarten are taught Good touch Bad touch with parent's permission. FP41C: I am in favor of a comprehensive sex education class since we already see the magnitude of teen pregnancy and the rise of sexually transmitted diseases. Parents should give consent after being given a curriculum outline. MP51F: To eliminate all risk factors	MS1: We do not teach abstinence only. I think they would choose FS2: Abstinence only because it may be not as complex to teach and its part of the curriculum. FS3: I think it is "easier" for a school system to teach abstinence only. This way they don't have to go deep into the different types of contraceptives and their usages. They also don't have to talk about diseases. I think another hindrance would be parental permission to discuss sex education at a deeper level. Many say they will talk to their child/children about that at home. FS4: I think the school system teach abstinence only education over comprehensive sex education because the state educational leaders are not aware of the effect of peer pressure, how the media (tv's shows and movies, commercials, music, social media, etc) persuade a lot of children decision about sex. FS5: I would think the school would teach abstinence because of the numbers of teen pregnancies and stds. That allows students the opportunities to get finish with their education, where they are older and can make wiser decisions.

6. What are some types of STDs/STIs?	MS11A: AIDS, Chlamydia, Gonorrhea, Trich, you have VD [Venereal Disease] FS21B: Gonorrhea, Herpes, AIDS, and Trich. MS21C: Gonorrhea, Chlamydia, HIV, and that's about it.	6. How present are teen pregnancies in the XYZ County school system?	FP11D: Likely, I see a lot of kids pregnant. Around ages 12 to 17. FP21B: Very, Very. That's all I can say. These pregnancies are with middle school students' 7-8 grades and high school students 9-12. FP31A: Has increased since she became a teen parent 16 years ago. Kids are getting pregnant more early. FP41C: I don't know. The statistics but I see many teen pregnancies in the community and school. MPF1F: Not extremely prevalent but more than often than they should be. I think the community rate is higher than the school rate.	MS1: Are you asking how "prevalent"? This past year, high school, I think we had three girls, two girls in high school and one shortly after she graduated. Which my heart broke for her she and the sweetest child you ever met. I know this [pregnancy] would slow her down because I knew her family's background. So as far as prevalence, it's happening. Sex is happening. As adults we can turn the blind eye and take data to read the way we it to. It talking to our students they are more aware and conscious of birth control methods, they are more aware than they were 20-30 years ago. Back then, and I'll be blunt, you found condom machines in men's' bathrooms at local gas stations. Now it's more common and obvious, I'm not going to say our teaching contributed to the decline, but I think teaching it and making students and young people are that they have CHOICES and becoming sexually active is a choice. If a child or young person make that choice, I want them to understand that it doesn't have to be a choice that ruins your life and they're are precautions you can take and the wise young adults will take precautions. I know it sounds like I condone them to go out and having sex. But that's not the case. But I don't want some child, two children, a male and a female to experiment and want to experiment have to pay for it in some bad way the rest of their lives by making a choice. So, I think it [teaching comprehensive] has helped in some way by giving young people knowledge of birth control and choices that they can make in helping them protect their lives. FS2: I think it's not as prevalent as it has been in the past years, I'm not sure maybe parents are talking more to their children at home and family members. There's the millennium (alternative school off campus) where young students who get pregnant

				while in high school don't have to attend regular school. They have an alternative place to learn. FS3: Over the past 2-3 years I have known/seen 5-6 pregnant teenagers. I am not familiar with the area. FS4: Teen pregnancies is very present in XYZ County School System. I believe it has increase since I was in school. I see too many of our teens in our community at the middle school age and high school pregnant and they are happy about it. FS5: Very. The age ranges as early as middle school, which could be 13, I know there are several during the school year at the high school from grades 9-12 or ages 14-89 at the high school level.
7. Do you think prevention of pregnancy is important? Explain	MS11A: It depends on your age. Say for instance if you're my age [16] it ain't no question about it you shouldn't be trying to have a baby. Because most kids around here ain't got no job and they're trying to sit at home and expect their parents to do everything. FS21B: I don't think teenagers should get pregnant at a young age because they can't take care of no baby. I think if students gets babies in school it messes them up because they have to stay up all night, no sleep, sleeping in classing and missing out on a lot of stuff. MS21C: Yes (laughs) I mean you don't want to have no baby and no young age. Because it messes up your life.	7. What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections?	FP11D: I feel they should do a class to speak to them about abstinence to talk and guide them. Nowadays, you have kids starting to have sex in middle school, so I will say to teach abstinence classes from 5th grade and up because girls are getting pregnant in middle school. I say that because a lot of girls can't really talk to their parents about sex. So, I think the schools should have the girls and boys someone they trust as well. FP21B: Well, the can probably have some type of sex ed across the board or all grades teaching on both abstaining and protecting. FP31A: There's a lot of denial from the schools and community regarding sex. Let's face it, sex is here and happening with teenagers, it's a part of life. The questions should be asked what can we do to help prevent. A community center is needed, something that	MS1: I think we got to stay diligent. I think it's good to get the information. But we are going to have tailor our instruction to meet those cultural difference and those normalities by culture that occur. Because there is a vast difference in the black community a young girl getting pregnant doesn't have the stigma that it had a few years ago and doesn't have the stigma that it has in the white race. And if we're going to teach them we have to get on their level (pounds desk with palm of hand). I'm sorry! FS2: They may need to look closely at getting or considering having sex education talk or have someone come in to the elementary school to start speaking to the fifth grade girls and boys. I think whatever is put in place needs to be included with the elementary and not wait until middle or high school. FS3: As long as the parents agree, I think more can be discussed at school. If I'm not mistaken, they talk more about comprehensive sex education at the middle school level.

			will get them interested with music/technology. The community needs to work hand and hand; provide different programs that address teens and their knowledge on sex education in a safe environment. The community center must have people on students' level, meaning folks they connect with, folks students trust, adults who care and love kids. Children love attention to be shown. Also, some kids can't talk to their parents, so kids are raising themselves with no guidance. Show them that you love them and care for they will feel comfortable to discuss issues with them. It's not about being friends with your kids, you have to have an open door policy. FP41C: I think that the school can partner with the community and parents to provide education resources. MP51F: More realistic dialogue regarding sex education as more understood. From a language barrier perspective versus technical jargon.	FS4: I'm not sure if it's just one grade or multiple grades. FS5: Of course you know knowledge is key; to anything. I think if everybody was saying the same thing, if we would all reiterate to our students we may not have the children that do not get a chance to attend the teen center, but maybe some of the same students that is in my Sunday school class that if the church is say it, the school is saying it, and teen center, then it makes it a little easier for the parents to say it. Because a lot of children doesn't want to hear their parents anyway because they think they don't have any senses. So if we are all saying the same thing it helps the children to know that that's the right decision.
8. Do you think the prevention of STD/STI is important? Explain	MS11A: Yes, because nobody should want a disease. You can get a disease with or without a condom, so basically have to be careful who you have sex with. FS21B: So you want catch it; just to prevent you from catching it. If students have a std/sti it may stop them from learning. Because it may be too serious and you will have to stay out of school. MS21CAh yeah that's important. Like some of that stuff [stds/stis] you can't cure. I think having a std or sti will affect you obtaining your goals because you may not live to see it.	8. What is the difference between abstinence-only sex education and comprehensive sex education?	FP11D: Abstinence is not having sex at all. Doesn't have an idea about Comprehensive, involves some type of prevention. FP21B: I don't know. What's the difference? FP31A: Abstinence-Only means to stay away from sex until you're married and financially stable. Comprehensive- keeping it real, knowing they will try sex, is straightforward about what's going on and teach them about protection. FP41C: Abstinence only sex education may limit educational information on other preventive methods that are available to teens, However I'm not sure.	MS1: AO it's like the ostrich burying his head in the sand. It sounds good and looks good on paper very well. It's easy for board to digest, but it's not reality. If we truly care about children and the young people then let's be honest with ourselves and be honest with them and give then information that will help them. Don't blow smoke up their rear end, because they will know it from the start. So aye, kids out there are telling me stuff about sex that I didn't know. They're smarter than we think and what we give them credit for. If we're wearing rose colored glasses and thinking they are not going to be sexually active then we are kidding ourselves. So let's equip these young adults with the tools they need to be safe.

			MP51F: From my prospective, abstinence is abstaining from all sexual activity at all cost. Sexual education is more of an information perspective of passing out information about sex and STD and pregnancies and different things of that nature. Comprehensive would be all inclusive of what's actually going on all around them amongst them, including their risk factors and community risk factors as well.	FS2: I don't know. I'm not sure. FS3: Abstinence –only sex education consists of character building to try and "guilt" children into not having sex. Comprehensive sex education *discusses* diseases, different types of contraceptives, pregnancy and everything attached to each of these topics. FS4: Abstinence only sex education they just teach and encourage students not to have sex until they become married. Comprehensive sex education teach students about abstinence and different contraceptives students can use if they are going to have sex. FS5: To me, the difference will be Abstinence means you do not have sex until an age of responsibility. Comprehensive means you're given the knowledge of what happens if you have unprotected sex you can get stds. Comprehensive does educate but I don't know if it helps to eliminate.
9. Can you provide any examples of methods of prevention?	MS11A: Like I said before, using two condoms instead of one, using abstinence. FS21B: Waiting until marriage, protection. Boys should be responsible for the protection, girls should be responsible too but they shouldn't do it at this age [15]. MS21C: Using condoms and not having sex.	9. Which do you prefer and why?	FP11D: Prefer both of them. They need to be taught about sex and to stay away from sex. FP21B: I would prefer comprehensive especially for middle and high schools students because they are exposed to the same thing. That way, it will give them dangers and ways they can kind of protect themselves. FP31A: Comprehensive because kids are at a place where they want to have sex and its parents duties to be honest with our kids about the of early sex. FP41C: I would prefer a comprehensive sex education with parental consent of the topics that would be discussed. I would like to see preventive methods of pregnancy taught in the curriculum (with abstinence as a method that is 100% effective) along with sexually transmitted diseases. MP51F: I have to answers. For my child comprehensive. I prefer	MS1: Comprehensive see question 8. FS2: I would prefer at my level (elementary) for students to be taught abstinence, I don't have any proof but I think some of my fifth grade girls have been sexually active and just trying to get them to understand that sex can wait especially for fifth grade girls and boys. I think boys need to be talked to just as much as the girls. FS3: I would prefer comprehensive sex education. Even if parents do a good job discussing this issue at home, I don't think it will hurt to reinforce this at school. Teaching sex education at school may catch loop holes and make sure students understand the importance of abstaining. A school program will also give correct science/medical meaning. FS4: I prefer comprehensive sex education because the more students know about sex they will be demonstrate knowledge through conversation and action about the decision to have sex. They will also feel more comfortable talking to

			that because at the endo of the day I would like my child fully aware of aware or any and everything that can happen. As a parent, I know parents that are somewhat uncomfortable with their children being exposed to certain types of conversations. So, I think a mixture of all two depending on the kid.	responsible adults and their partners about their sex decisions and concerns. FS5: I prefer abstinence teaching. If you set the bar high you may get to comprehensive. If you set the bar high you may have those students who may think about it twice. I think what's missing with our students is, they may be given the information but no one seems to care whether or not they are having sex. They are given information because it's a mandate of some sort. If the mentors, teen centers, boys & girls club, Sunday school classes, and pastors were all saying the same thing they will get it. It would mean more to them. I don't think it means as much because it (sex talk) is put out there and it's left up to them to make a decision about it.

10. What is abstinence?	MS11A: You [student] thinking before you do something, you want to make sure that you're going to be safe and can you prevent it. FS21B: Refusal skills. He really didn't talk much about it in Health class. MS21C: Not having sex.	10. Do you support an abstinence only curricula?	FP11D Yes. Nowadays it's the best. Because people aren't going to tell you if they have a disease or an std even if they are gay or not. So it's just best not to have sex at all. FP21B: I would support comprehensive because I'm for kids abstaining themselves, but I am also for them protecting themselves, letting them know how to protect themselves and the consequences for not abstaining or protecting self. FP31A: No, because it's not real. As an educator. Some kids don't know the lack of knowledge of parents. It takes a whole village to raise a child. Teachers complain about what they already have and	MS1: No. You're going to have to tailor what you're teaching to each grade level no doubt about it. I taught sex Ed [different location]. What I would teach at a middle and high school I would not teach at an elementary level, it wouldn't even be close. At an elementary level you have to focus on knowing the body, differences between male and female. I don't think you would get into the intercourse at sexual components at that early of an age. Now as they get to 4th and 5th grade you might can allude to it. In 5th grade I know some of ours [students] are knowledgeable but I don't think an abstinence only curriculum would work an early age. I don't think it's a topic you would consider. I think it's more of "Biology" than sex Ed. FS2: At my level for fifth grade.

			that they should be taught at home. Some kids are raising kids that are not theirs. FP41C: No. Because some teens are not going to choose abstinence and I would like for teens to be familiar with methods of prevention. MP51F: I think it should be available, but it shouldn't be the only option..	FS3: I guess any little bit helps. But this curricula should start in maybe 5th grade, but by 7th or 8th grade the knowledge needs to be deepened. I'm sure the vocabulary would be different from 5th to 8th grade. FS4: No because I feel that the more you educate our children about having sex the more they are aware of the risk of having unprotected sex. Students will be more open to ask questions and discuss concerns about sex issues they are faced with. FS5: I do even if students are already sexually active, you can begin again. If you have not contracted a disease or gotten pregnant, boy or girl, if they were educated on what parenting involves at that age. It not only includes STD, but what about when the baby comes and everything else that's involved with a child. I just think if abstinence was preached until they are out of high school, you make your decision; you know if you're in college you make your own decisions (maybe not freshman year) they will be a little wiser teaching abstinence at that far along in their schooling will help them make wiser decisions.

11. What is the difference between abstinence-only sex education and comprehensive sex education?	MS11A: Abstinence says you should try to prevent from having sex. Just not having it. Comprehensive teaches you to protect yourself and abstinence teaches you not to have sex. FS21B: I've heard the names but I really don't know what they mean. MS21C: I don't know.	11. Do you think it is effective? Explain.	FP11D: Yes. FP21B: No. I wouldn't say it's effective. If it was effective, I guess it would be geared towards on sex to abstain. I think the goal is for all to abstain not just girls or boys. FP31A: Abstinence only is effective child birth middle (when hormones not raging). Because parents aren't with kids 24/7. FP143: Yes, if chosen it is 100% effective. MP51F: Not as the only option.	MS1: No. See previous question. FS2: I think abstinence is effective with students in fifth grade not middle and high schools FS3: I think it is effective for students are not "exposed" to a lot of sexual connotations. FS4: No, I don't think it is effective because to many teens and sadly to say it but our young youths are becoming pregnant and contracting STDs at an early age. It too many of our children are not being persuade to stay abstinence until they become married. I see it before my own eyes that the word abstinence is not sticking with our kids very long..
12. Which do you prefer ad why?	MS11A: I would choose both because when you get a certain age I think everyone should have sex. But when you're young you should be abstinent. I think you should. FS21B: Yes. Because it tells you what to do, when to do it and the diseases you can catch when you do it. MS21C: A method that teaches us that if you do make that decision [to have sex] you know what to do.	12. Do you believe the sex education curriculum is helpful to sexually active students?	FP11D: Risk of sex and diseases that can be contracted. Health class can be helpful if students are comfortable with it being taught in Health class. FP21B: I do. Because it still will give them preventive ways and show consequences. So, even if they haven't ran across problems, who is to say they won't run into these problems on the future. So, it [sex ed curriculum] may wake them up. They [sexually active students] should be taught comprehensive surely. FP31A: Yes. They are doing "it" {having sex} but not knowing what they're doing so they need educating.	

			FP143: Yes, it can shape future decisions and prevent a future pregnancy. MP51F: Information purposes yes. Preventative no. Information purposes about what can happen during sex but preventative I would say no. Because when you speak on information most kids I would believe, they have the knowledge already; they can enhance their knowledge but they make the decision to become sexually active even with the knowledge.	
13. Do you believe the sex education curriculum provide beneficial information to help you understand the topic?	MS11A: Yes, I do. I'm a kid. A kid is going to do things. I knew about sex, I just didn't know you can use a condom to prevent from having a baby. FS21B: Yes, if they stop doing what they doing before and just start following it. MS21C: Yes.		13. From a cultural perspective, do you think African American student should be taught about sex education from a different curriculum than other races? Please Explain	MS1: Without a doubt. I rehearsed this question in my mind. There's a cultural difference by far. There's a difference in what white kids and black kids are taught, there's a difference in the way they are received, the options they feel they have, there's a difference in acceptance that's cultural. It's good to discuss, look at, and research sex education, sexual prominence, sexually transmitted diseases that's all fine and dandy. To make a true difference were going to have to look at that one particular topic cultural difference because there's a great divide out there. In our community we are facing generation poverty. We have a high minority student population. It is 94% minority, within that 94 %, we have a 90- 90-90 school which means over 90% are minority over 90% are on free and reduce lunch and over

				90% live below poverty level. Our children that are walking the halls their mothers and grandmothers have a rocking chair on their front porch. Our children have an imaginary rocking chair waiting for them. Our job is to fight that idea and let them know they have additional options. To fight the generation poverty that they've grown up in and break that cycle. Our responsibility as educators is not only to break that cycle of generation poverty but it goes back to what was stated earlier. If were truly going to make a difference in the area of unwanted pregnancy, safe sex, and reducing sexually transmitted disease because kids are going to experiment. I don't like the term promiscuous, because it carries with it a slutty or trashy connotation. And that's not it. We have great kids. You walk through our halls they are going to look at you and say yes ma'am no ma'am and they're going to be as god of a kid as you've ever met. Does that mean they're not going to experiment sexually elsewhere? No. But do they have to pay for the rest of their lives through disease, through bad luck that might occur no. So, along with fighting generation poverty, our instruction (although it's the same method of birth control since the 40s and 50s) we got to talk on their levels and teach them. Any unwanted pregnancy is too much. So we have to fight that culture and change that culture. So if

				they make that decision; they make them with a little more understanding that there are things they can do to prevent the negative consequences that occur. And hopefully change the culture that it's not ok to be pregnant and let the government take care of you. That goes along with fighting that generation of poverty mentality and we got kids that are winning and are being successful. It doesn't happen overnight, we work at it every day and will continue to work at it. But, I think the difference is the teaching has to meet the needs of the child in a specific community or in a specific culture. Not, this program is going to work I don't care where you are because it's not. You got to talk to the kids and get on their level and listen to the kids and find out what their knowledge is and expand and make them want to learn more. FS2: I don't think race should play a part on how it (sex education) is taught. FS3: I don't think so because sex is sex no matter the race, creed, or color. Culture is different from race to race and even from household to household. Maybe the person/people delivering the information is more important than what the racial make-up is of a group. FS5: The church should make it apart of their message and ministry because the world has changed and children have access to more information about sex

				both the good and bad side. The good side is they know where babies come from you don't' have to be taboo. The bad side a lot of our young students starts with porn at an early age. So, if it was talked about we wouldn't act like it's an elephant in the room when it is discussed, children will be more open. The student's will talk to you if you talk to them.
14. Do you believe the sex education curriculum is helpful to sexually active students? Why?	MS11A: Yes because it may make a difference in their live they may stop it until they get a certain age. FS21B: Yes, because they could be doing something wrong like not using protection and a sex ed course can help them to start using protection.			
15. Who do you believe should be responsible for talking to you about sex (including teen pregnancy and sexually transmitted diseases	MS11A: Both parents and people who do have a disease. FS21B: Adults. The school administrators and parents. My preacher talked to us about waiting until we are married. MS21C: Parents, siblings, and a teacher.	13. Who do you believe should be responsible for teaching students about sex?	FP11D: Of course, teachers because they are knowledgeable of the topic. I think the children will be responsive to church leaders speaking on general topics about sex education. FP21B: People that's been there i.e. Teen Mothers. People they can actually see and hear their stories about their lives that they can see. Color doesn't make a difference when it comes down to teaching as long as the person cares. FP31A: Parents are primarily responsible, but teen pregnancy affects our community so I believe that is should be a partnership with parents, school, and community.	MS1: I don't think it's any one person. They are going to hear and see things at home, some good, some not good. They're are going to come in contact with other students in school, this thing right here [hold up cell phone], I mean they're going to come in contact at an early age because of the technology age we live in with probably thing you and I weren't exposed to at an early age. Kids are curious. So to put it on any one person I don't know if there is one. I think all of us has to work together in all aspects. I think it goes back to the data you're getting for the doctoral program. What comes out of that goes back to teaching cultural difference, it goes back to churches. I'm not one to pin everything on the parents, I don't think

			FP143: Initially the parent or guardian. Then schools. I think AA students in our district should have a different curriculum than any other race, with the addition to income levels and the amount of poverty we have. And with poverty, sometimes in contributes to a lack of education academically as well as sexual education amongst other things. I think that language barrier will be the most important thing to enhance sexual education in our area.	government should be responsible because I think they don't care. I don't mean that negatively it's just a fact. I think it falls on the community, the church, the schools, the parents, the social agencies any aspect we can. Because they're going to be learning on their own. My father is a preacher and I don't remember have the sex talk" with him but I'm a father now. So, I thinks it's going to take us all. Do schools have to take the prominent role? Probably, because in public schools you reach the masses but I don't think it's any one person or any one group main responsibility. I think it's a part of life and as part of life we just have to kind of incorporate it wherever we can to teach lessons and teach options. FS2: If this is not going to be a part of the curriculum I would say health or physical ed teachers, (follow up) with much restraint in the rural community I believe that it could be taken care of in a health and physical education class and make it part of their curriculum, and it would not hurt to have guest speakers or nurse practitioners or someone in the medical field, social work area to come in to speak with the students from time to time. FS3: I think it is very important for parents to take the majority of the lead and schools should have a good program to reinforce the knowledge. FS4: I feel like it should be a community effort which includes parents,

				teachers, and knowledgeable people in the community. I feel like sex education is just as important as students demonstrating knowledge of skills and concepts in all subject areas. In order for our children to be successful in school and become productive citizen we need the parents, teachers, and stakeholders to work together. I feel the same way about sex education also. FS5: Parents are the first teachers. The responsibility lies within us all. I think that conversation should come up in the home and then I'm still that village kind of person. It takes a village to raise a child. So this includes the school, churches, mentors, B&G club, any club or any people that can give their testimony that have had to deal with this type of issue.

	RELIGIOUS	**POLICYMAKERS**	**HEALTH ADVOCATES**
	FR1 MR2 MR3	MP1 FP2 FP3 MP4	FH1 FH2 FH3 MH4
4. Why do you think the school system teach abstinence only education over comprehensive sex education?	FR1: The children are ultimately going to make their own decision to have sex or not. We have to educate the children and hope they make the right decision on their own. MR2: I think because the mere fact so many young kids think that having sex is the thing to do. So they rather teach abstinence in the full curriculum on sex ed because they feel students are going to do what they want to do anyway. MR3: I believe it's out of fear and perhaps religious beliefs.	MP1: I think they teach abstinence to go along with the trend of what everyone in different communities have done. And teach abstinence in hoping they don't get pregnant and still are telling them the facts about sex and sex lives and what could happen in the future if they misuse sex at an early age. FP2: The system probably would be resultant for two reasons; first, because they think that teaching sex education is the responsibility of the home and second because they think that teaching sex education would, in some way, condone sexual activity. FP3: I believe these decisions are based more on the moral/ethical code of the policymakers than it is on empirical data related to sexually transmitted diseases and pregnancy. When you talk about abstinence, generally it's tied to some religious belief. Therefore southwest GA, where some consider the bible belt it is not likely that you will see, any time soon in my view somebody start to teaching sex education it terms of how to protect yourself through sex versus abstinence. Abstinence is something that's generally done in a community such as ours as part as there are a lot of angelica Christians from what I can tell. I haven't seen in data on it, but I'm sure it goes back to that.	FH1: I believe schools teach abstinence only over comprehensive sex education due to funding. Overall, social acceptance and numbers drive dollars. Therefore, we have not funded the comprehensive sex ed in Public schools. FH2: A lot of the times the school is not permitted to teach comprehensive because some people think it is telling the students it is ok to have sex because they give condoms and teaching them about birth control out but really it is not. FH3: Personally, I don't know because the kids are still having premarital sex, having babies, and contracting various STD's. The education to me as a nurse is outdated and need to be revamped. MH4: Well, we are a part of the bible and everything is based on religion. I believe that only abstinence is taught because that's the way of the bible and "good Christian children" should not be having sex it's a SIN. Furthermore, underage and premarital is still taboo throughout the Bible. People avoid the conservation rather than tackle
5. Do you support an abstinence only curricula? Explain	FR1: No. We live in a society that is driven by sex and money. The more money you have the happier your will be. The more women (hoes) you have the happier you will be. Children are presented with these images as early as 4 and 5 years old. Boys are asked at age 10, "How many girlfriends do you have?" As to say, that remaining a virgin or being in a monogamous relationship is "weird" or "crazy". Teaching abstinence only is a fallacy; it is not the reality our children live in today. MR2: No. I would rather them teach a full sex education program. If you just teach abstinence you're just saying that it's ok to engage.	MP1: No. I think you should know the consequences of abstinences as well as the consequences if you have sex and what the future and what lays ahead for having sex. I think both ways should be explained. FP2: No, I prefer a comprehensive reality based program that stresses abstinence but acknowledges the probability that some young people will yield to the temptation to indulge in sexual activity. FP3: I believe that a comprehensive sex ed program should be put in place and parents should have the option of enrolling their children at their own discretion. MPH: Absolutely not. The reality is that if we only teach abstinence, then we in my opinion were not really paying attention to what the reality around us. Because when we look around, we see all these views and stuff of young kids	FH1: While the concept is good and if practiced would be excellent. Kids today do not practice abstinence only. Where it used to be the norm for young people to practice abstinence, sexual activity is the norm in today's society. So, I do not support and abstinence only curricula. FH2: I do support abstinence because that is the only way that you will not have teenage pregnancy or STD's, but in reality not all students are going to be abstinence even when you talk at length to them about. FH3: No, because they are having premarital sex, having babies, and contracting various diseases.

	MR3: I do not support abstinence only curricula, because I believe the more educated one becomes, especially in this topic, the more safe and protected one will be.	with babies and having babes and I would say probably every person you know, including me, knows of a youth who and some point had a baby in their teens. So I don't know if you're going to ever be able to teach an abstinence only curriculum. I don't see that. I wish we could (laughter) But in a conventional wisdom will have used to believe that we can, but in a reality we cant. We live in a different world than that.	MH4: No, I don't support abstinence base curricula because the truth is children are having sex. It's a topic that no longer needs to be taboo. I think that we have to deal with the reality of situation rather than continue to wear our rose colored glasses. With this generation of children, they are being taught about from various sources: TV, social media, the internet, etc. Therefore, I do believe that our responsibility to our children is to provide them with this education so if they choose to participate; they will at least be informed. Abstinence is the best decision. However, it's not reality
6. Do you think it is effective? Explain.	FR1: No. See above explanation. MR2: I don't think it's effective. It's not effective enough to keep our kids from doing it. Our statistics are so high in Southwest Georgia that obviously it's not working as well. MR3: I don't believe an abstinence only curricula is effective.	MP1: I don't think abstinence is effective at any stage of education. FP2: The fact that we have sexually transmitted diseases and teen pregnancies, speak to the ineffectiveness of an abstinence only based curriculum. FP3: The rate of teen pregnancy is on the rise in many communities that foster abstinence only programs. This is very obvious in certain communities, namely rural and impoverished. MPH: Abstinence? I think its effective when you consider additional variables constructs. When you look at a person who, for instance my daughter, abstinence could be effective for her because we teach biblical principals at home. I'm not saying I'm better than anyone else but I teach that. But at the same time, she may be vulnerable to having sexual relationships with a boy. It depends on the youth as well. But I think in can be effective it's just not going to be effective on everybody. Obviously, you know, you have to look at (I'm being honest with you) how attractive somebody is, you have to look at how outgoing they are; their personality, the interest that boys have in them and all these type of things before you can really decide what group this will be effective in. Now of course it will be all demographics in every different groups, but the reality is that some youth will have more temptation than others. While abstinence should be effective, it has to be combined with teaching at home, school, and church it's a whole combination of things, I think, that will make something like this effective. Some of it is just, using a condom or whatever, but that's not necessarily the biggest risk in my opinion, for a youth who engage in sexual activity. Because a condom, you know, does not prevent	FH1: No abstinence only is not an effective means of education or birth control. Sexual Activity happens in the heat of the moment, not usually planned, so therefore, preplanning for the method is the best choice. FH2: In some cases yes I do think that it is effective but not all the time. I think that some students have all the intentions of being abstinent but peer pressure plays a big part during that time during their life. FH3: No. I think you should teach all aspects of sex and diseases. You can't teach just one aspect of sex and forget about the rest. You are not equipping them with all that they need to make a proper conclusion. MH4: N/A

		100% of the sexually transmitted diseases so abstinence is by far the best choice, but the reality is that it's going to take combination. I think some parts are effective and some education on protecting yourself is effective as well.	
7. How present are teen pregnancies in the XYZ County School System and Community?	FR1: Unknown MR2: Very. Because I've seen it in our church. MR3: I believe it is present; however, I am not sure of the rate.	MP1: It's very present. I wouldn't know the ratio but it's very present some ladies can't even make it out of the twelve grade let alone the tenth. FP2: I don't know the ratio or frequency; but I have seen many pregnant students on campuses. FP3: Very present. MPH: Now, I do review the data from Family Connections and it seems that it's on the decline. I think it has to do with education on abstinence and on protection.	FH1: We have a high rate of teen pregnancies. Although statistics show our rates are down, we still have a high number. According to the Annie Cassie Foundation, in 2008 we had 32 pregnancies and in 2012 we only had 13. 13 is still a relatively high number if you look at the percentage of 34. FH2: I would say teen pregnancy is at a very high rate. As far as a percentage I cannot tell you that. FH3: VERY. MH4: Teen pregnancy is very prevalent in our school system. I remember when I was a teacher in the system, I saw several students pregnant. I had at least 4-5 of my own pupils who were pregnant.
8. What do you think the school system or community can do to help protect students against pregnancies, diseases, and infections?	FR1: Knowledge is not power. It is "potential power." A person can have knowledge and do nothing with it. That is why it is only "potential power." We have to teach everything, the good and the bad about sex. Not talking about it only perpetuates the disease of ignorance. MR2: I think for me, we cannot just rely on the schools to do it. I think it has to start at homes, churches, our school programs as well. Everywhere a child goes they have to hear that. In our church, when bible study starts back up there will be a all teen girls class and all teen boys class where we address those issues. We will be teaching comprehensive sex education. MR3: To educate them with a wholesome sex education curriculum.	MP1: The community and the school system can work together to educate the community about sex without marriage and try to teach more about abstinence; as well as the consequences if they have sex of what lies ahead of unwed mothers and fathers that have children, you know its love today and hate tomorrow and just a child didn't ask to come. Just like a love child left in the community. FP2: I think that there should be a reality based partnership program that starts by targeting middle school parents, middle school students. Community groups, such as churches and resources, such as health departments would be vital partners. First, parents would be educated about how to approach their children and about what resources are available for the young people. This partnership would work together to develop an aggressive curriculum that might include such bold steps as providing birth control, disease testing and screening, positive peer partnering to replace peer pressure, abstinence incentives, etc. FP3: Educate them more thoroughly. MP4: There are a couple of things. The primary thing we can do is to mandate education. I think if you mandate education on sexual diseases you got half of the battle done. Abstinence should be taught the minute a child recognizes any sexual sensation whether ten or 15. Kids mature at different level. For girls when they get	FH1: Education is the key to prevention. Not sure that this falls completely on the school system. We already overtax our schools with responsibilities that should lie within the home. FH2: No I don't think the school does all they can do to help protect the students. I know that ever though we educate there are going to be some students that get pregnant or get an STD but I think that the school system can do better. As the health department we educate or patients every chance we get on prevention of pregnancy and STD's. FH3: Educate! Educate! Educate!! MH4: I think the community and the school system needs to be realistic about what's going in the community. I think that there needs to be sex education starting at the middle school level. I think there needs to be open dialogues about sex education, sexually transmitted infections, and teenage pregnancy. I think there needs to be parenting classes on the high school level in which pupils have to rear child throughout the course of the 6 weeks. This class should address the issues that come with child rearing such as

		their menstrual cycle, it may be too late then but as soon as possible and as often as possible. It's more uncomfortable for us than it is them. So if you start talking about it know won't leave a black whole. I'm ok with people talking to them about Abstinence now not sex. Fortunately, I have a wife who talks to my girls, because it's uncomfortable for me.	feeding, diapers, clothes, daycare, etc.
9. What is the difference between abstinence-only sex education and comprehensive sex education?	FR1: Abstinence only emphasizes the importance of not having sex. Sex education is a comprehensive approach to teaching student (children) about their bodies. MR2: I think abstinence only teaches them to try to say no versus a comprehensive teaches if you're going to do it protect yourself. MR3: I think the difference are the abstinence-only is a more "closed mind" approach to a growing problem and a comprehensive sex education could, not only address the problem, but curtail many of the problems associated with sexual activities among youth	MP1: If you continue to teach abstinence at some point in time the child may want to try to see if your abstinence equal up to the comprehensive side of sex instead of teaching them both telling them what will happen. Some of them will like to experiment to try and see if they're right or if you're right or who is wrong about it. FP2: The difference is that the former ignores human realities such as peer pressure, youthful curiosity and plain old hormonal swings that spark biological urges. The latter recognizes these realities and tries to compensate for them via developing the curriculum to deal with the realities. FP3: Abstinence only curricula emphasizes refraining from sex where comprehensive sex ed curricula will present abstinence as a viable option but also includes other forms of birth control and disease prevention. MPH Abstinence only is generally based on biblical principles. I can't think of any other reason you will tell someone to abstain until you get married. Think about it, any reason you think of will be tied to a biblical principal; in my opinion. The combination sex education is I'm talking to you about abstinence at the benefit of abstaining, saving oneself to marriage, but also teaching you about if you decide to have sex, this is what can happen.	FH1: Abstinence only education can be taught by any lay person. Comprehensive sex education needs to be taught by someone with a specific skill set to teach the chemistry, functional, physical and emotional aspects of sex education. FH2: Abstinence –only sex education is educating the students on abstinence from sexual activity and most of the time they do not educate on them on any type of pregnancy prevention which includes birth control and condom use for protection of STD's. Comprehensive sex education is when the students are being educated at an age appropriate level on not just on sex in general but as well as sexual development. It includes safe sex practices like condom use and education on birth control. It gives the student a chance to ask questions that he or she may or may not want to ask a parent or they may not get to ask if they were only in an abstinence only sex education class. I think that abstinence and comprehensive should be taught together. Not this or that. FH3: Abstinence only teaches no sex but comprehensive will open up more avenues to educate more. MH4: If there is a difference, it shouldn't be.
10. Which do you prefer and why?	FR1: I prefer sex education. Some parents and adults believe that if you teach sex education you are giving the children a ticket to go out and have sex. News Flash...they are having sex anyway! Not talking about it only continues the ignorance that plagues our community when it comes to sexually transmitted diseases, pregnancy, HIV/AIDS, and etc. MR2: Comprehensive sex ed. I like to be able to help the kids see the reality, so I will	MP1: N/A. Experience leads me to prefer the latter because it deals with reality. FP2: I prefer a comprehensive sex ed program that gives parents the option of enrolling their children at their own discretion. Parents should dictate how much information/education their children has access to at schools. FP3: Absolutely, Comprehensive sex education. We're fooling ourselves if we think we can teach abstinence only and have the same impact as comprehensive sex education. For the greater good comprehensive sex education is best.	FH1: Comprehensive sex education, for reasons stated in #9. When we teach sex ed here we are able to build a rapport with our patients, they can come to us, we are unbiased and can get information without judgement. FH2: I don't have a preference, I think that both abstinence and sexual education should be taught as a whole, but abstinence is the key to avoiding unintended pregnancies and STD's.

	bringing in a girl from the rural clinic who has HIV/AIDs but you can't tell it and doesn't mind sharing her story. So when you bring someone in that they can sort of identify with; I think it has a greater effect. We started a new Ministry called we care. Where we are pushing FAMILY. I called all of my kid upfront, and asked all the adults that grew up in a single family to stand. I asked the kids look out and see that the statistics are still real. The statistics say 74% of African American are children are born in single parent families. At some point you have to help kids to see they have to break the cycle often pregnancy and sexually transmitted diseases. How do you do that, you do that by talking directly with kids… saying listen young girls take my word of this boys only want one thing. They understand that language better than sugar coating stuff. MR3: I prefer a more comprehensive sex education approach; again, to curtail many of the problems associated such activities.		FH3: I would prefer Comprehensive. MH4: N/A
11. Who do you believe should be responsible for teaching students about sex?	FR1: EVERYONE! Parents, The Schools, The Church Doctors, and The Community. MR2: Parents. Schools, Church and everybody in between. Some pastors think you're supposed to teach spiritual things and that's it. They don't understand you have to deal with the whole man emotionally, physically, economically, I think some pastors only deal with issues that are spiritual and it has nothing to do with the Bible-Belt. MR3: I believe that all education should begin with the home. However, I further believe that there is a need for a strong/wholesome curricula in our schools to support the home and the community.	MP1: Parents FP2: I think the curriculum should be adapted by grade levels. The "tone" in how one addresses a sixth grader would be different than the tone used to address a high school student. FP3: I think a full description of the human anatomy should be provided at every level of school. Pregnancy prevention and disease prevention should be started in middle school and continue throughout high school. MP4: Is that a trick question? It's a community responsibility. Do you want me to triage? It's the Parent. The Church, The Community. The School. It's everyone's responsibility. It's the Parent's responsibility because you got them first you begin. You have them at home to teach them everything. The Church because you got them and their parents, so you're teaching both, you have a dual impact. The Community because they live and exist with you; you see them on a regular basis and the school. The school because you have them during the day teaching them educational part and they interact with kids in your place of business. The parents are a part of the community, the	FH1: Ultimately, it should lie within the home according to my beliefs. However, medical providers are a good source to provide good sound education. Again, we already overtax our schools with responsibilities that should occur in the homes. FH2: Yes I do believe we, teachers, parents or guardians should be responsible for educating students about sex. A lot of times the students' parents or guardian are not open on the subject of sex education or they are just not educated themselves on the matter either. So everyone should be involved in the responsibility of sex education. FH3: All teaching starts at HOME!!! MH4: The primary responsibility should be the parent. However, we do know that every child isn't getting what he or she needs at home. I think that then it becomes the responsibility of the school system to, at the minimum, educate.

		church and the school. The parents are the trick but the rest of these components are supplemental support to that teaching.	
12. What do you believe policymakers can do to assist in the preventing teen pregnancies and sexually transmitted diseases?		MP1: Policymakers could play a role in help funding and help the people in the education field that are qualified to teach abstinence or different things about sex. They could help pass out material make it available for all the kids who wish to take it. FP2: I think that both the home and system should teach sex education. However, if parents refuse to or cannot (perhaps, because of their inabilities to effectively communicate), it becomes the "responsibility" of the school system to "provide for the common good"- in this case, a well-rounded education. MP4: I believe it should be a joint effort: parents, teachers, community leaders.	
13. What do you believe policymakers can do to assist in the preventing teen pregnancies and sexually transmitted diseases?		FP2: I think that policymakers should make it mandatory that a comprehensive ongoing sex education course be part of the core curriculum in the matter of English, Math and Science. MP4: Continue to educate the community at large on the rate of pregnancies and diseases in the community	
14. Why do you think some policymakers don't see teen pregnancy and sexually transmitted infection preventions as "their" problem?		FP2: I think they see it! I think the real question is, " why are they afraid to acknowledge it as their problem. I think that they are afraid to address anything that appears to question religious or cultural mores or community shortcomings. Also, in a sinister way, many "leaders" look away from some situations because they, or others, profit from and make markets of certain social conditions. MP4: I'm not sure. Maybe if they don't know anyone personally that is affected by this issue they don't see it as critical. They, too, might night be knowledgeable about the rates of pregnancies and disease infection. Could be ignorance.	

Appendix P: Teen Pregnancy Prevention Initiative 37 Evidence Based Programs

Teen Outreach Program (TOP)

Teen Health Project

STRIVE

Sisters Saving Sisters

SiHLE

Sexual Health and Adolescent Risk Prevention (SHARP)

Seventeen Days (formerly What Could You Do?)

Safer Sex Intervention (SSI)

Safer Choices

Rikers Health Advocacy Program (RHAP)

Respeto/Proteger

Reducing the Risk

Raising Healthy Children (formerly known as the Seattle Social Development Project)

Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention

Promoting Health Among Teens! Abstinence-Only Intervention

Project TALC

Project IMAGE

Prime Time

Making Proud Choices!

Making a Difference!

It's Your Game: Keep It Real (IYG)

HORIZONS

Heritage Keepers Abstinence Education

Health Improvement Project for Teens (HIP Teens)

Get Real (Middle School)

FOCUS

Families Talking Together

Draw the Line/Respect the Line

Children's Aid Society (CAS)-Carrera Program

Becoming a Responsible Teen (BART)

Be Proud! Be Responsible! Be Protective!

Be Proud! Be Responsible!

Assisting in Rehabilitating Kids (ARK)

All4You!

Adult Identity Mentoring (Project AIM)

Aban Aya Youth Project

¡Cuídate!