TEEN PREGNANCY PREVENTION PROGRAM: TEENS’ ATTITUDES TOWARD SEXUALITY

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BY
BONNIE WAGNER

ADVISOR - DR. NAGIA ALI

BALL STATE UNIVERSITY
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Teenage birth rates in the United States (U.S.) rose in 2006 for the first time in 15 years. In 2006, a total of 435,427 infants were born to mothers 15 to 19 years of age, a birth rate of 41.9 live births per 1,000 in this age group. The birth rate rose again in 2007 by 1%, 42.5 births per 1,000. Birth rates for teens 15 to 17 years and 18 to 19 years each increased by 1% in 2007, to 22.2 and 73.9 per 1,000 (Hamilton, Martin, & Ventura, 2007). This rate rose 4% from 2005 to 2007, interrupting the 45% decline reported for 1991 to 2005. In 2005, Washington D.C. had the highest birth rate in the country (63.4 per 1,000), and New Hampshire had the lowest teen birth rate (17.9 per 1,000). In 2006, the overall birth rate for 15 to 19 year old females was 41.9 per 1,000 (Hamilton et al., 2007).

International comparisons indicated the U.S. could reduce teen pregnancy birth rates. U.S. teen pregnancy rates were the second highest among 46 countries in the developed world (Adolescent Reproductive Health, 2009). Data confirmed that U.S. teens’ sexual behavior was similar to teens of other developed countries in terms of when they started being sexually active and how often they were having sex. However, U.S. teens were less likely to use contraception or be consistent with effective methods (National Campaign to Prevent Teen Pregnancy, 2009).
When teens give birth, their future prospects and those of their children decline. Teen mothers are less likely to complete high school, more likely to live in poverty, less likely to receive prenatal care, gain appropriate weight during pregnancy, and more likely to smoke. These factors are associated with poor birth outcomes (Stanhope & Lancaster, 2004). A baby born to teen mothers are higher risk for low birth weight, prematurity, serious health issues, and even death. Babies of teen mothers are more likely to die in the first year of life, with the risk highest to those mothers under age 15. In 2005, 16.4 out of 1,000 babies born to teens less than 15 years old died, compared to 6.8 per 1,000 for babies of women of all ages (Mathews & MacDorman, 2005). Teen mothers are also more likely to have a low birth weight baby. Low birth weight babies are more likely to be born prematurely. In 2006, 10% of mothers between 15 to 19 had a low birth weight baby, compared to 8.3% for mothers of all ages (Hamilton et al., 2007).

Teen mothers are less likely to complete high school. Only 40% of teenagers, who give birth before age 18, complete high school, compared to 75% of teens from similar social and economic backgrounds that do not give birth until ages 20 or over. A teen mother may not have adequate job skills, making it difficult to find and keep a job. She may be financially dependent on family and public assistance, live in poverty, and go on welfare. Statistics indicate, 38% of females between ages 15 and 19 are poor, and 73% of pregnant teens are poor. Teenage pregnancy is viewed as a large component of the poverty cycle in the U.S., because teen mothers are more likely to rear children who repeat the cycle. A child born to a teen mother is 50% more likely to repeat a grade in
school, perform poorly, and drop out of high school (National Campaign to Prevent Teen Pregnancy, 2009).

Early onset of sexual activity increases the risk of multiple sex partners, unprotected sex and sexually transmitted diseases (STDs). STDs affect 20% of sexually active teens. Pregnant teens have higher risk of premature rupture of membranes, preterm labor, and postpartum infection (Stanhope & Lancaster, 2004).

**Background and Significance**

Teenage pregnancy is commonly identified in the medical literature as a problem for society that requires intervention. Absent from the moral, political and medical debate on teen pregnancy is the perspective from teens. While teen pregnancy may be considered a problem for society, it may less of a problem for themselves (Jewell, Tacchi, & Donovan, 2000). The majority of pregnancies among unmarried teens are unintended. Most teens do not want to become pregnant, although some are not opposed and other has ambivalent attitudes (Bruckner, Martin, & Bearman, 2004). By having a better understanding of factors associated with a desire for pregnancy among teens, health care providers may better predict the most at risk teens.

Teenagers hold a range of attitudes toward childbearing. While negative attitudes along with that spectrum protect against early pregnancy, positive ones increase the risk of unprotected sex. In-depth studies on these attitudes indicate that although few teenagers want to become pregnant in the near future, a sizable minority is ambivalent about becoming pregnant. Prevention programs need to focus more on the ambivalence, which, if left unchecked, affects adolescents’ motivation to delay sex or to use effective contraception consistently (Kalmuss, Davidson, Cohall, Laraque, & Cassell, 2003).
Tsai and Wong (2003) identified a number of risk factors that contribute to teen pregnancy. Those factors include unsafe sexual activity, under use of contraception, numerous sexual partners, substance abuse, deprivation, bad performance at school and school drop out, low family income, single parent homes, and lack of family support.

Teen pregnancy is a main issue in every health care system. Teen pregnancy can have harmful implications on a girls’ physical, psychological, economic, and social status (Tsai & Wong, 2003). Health professionals are faced with the dilemma of how to refine interventions that reduce risky sexual behavior and pregnancy in teens. Programs that include adolescents’ attitudes toward childrearing should include exercises and discussion that reality-test teens beliefs. If researchers accept that teens do not view pregnancy as a major problem themselves, then interventions designed by health professionals should have a more holistic understanding of teens’ attitudes toward sex, contraception, and pregnancy. Involving teens could be a critical link to successful programming (Jewell et al., 2000).

Statement of Problem

Teen pregnancy has been identified as a problem for teenagers, their families, and society. However, there is a lack of research into teenager’s attitudes toward pregnancy and sexual health.

Purpose of Study

The purpose of this descriptive qualitative study is to gain perspectives from teens about pregnancy, contraception, and sexual health.

Research Questions

1. At what age is it appropriate to become sexually active and start a family?
2. What are teens' attitudes concerning contraception use?
3. What are teens' attitudes concerning pregnancy?
4. How much education has teens had about contraception, STDs, and pregnancy?
5. How much family support do teens have?

Theoretical Framework


Definition of Terms

Teen pregnancy: Conceptual

According to Bruckner et al. (2004), teen pregnancy is defined in the literature as pregnancy in girls younger than 19 years old.

Teen Pregnancy: Operational

Teen pregnancy will be measured by teens' expressions of what pregnancy during teenage years is/mean to them.

Contraception: Conceptual

Contraception is method/type of birth control desired by the participant.

Contraception: Operational

Contraception will be measured by what teens believe contraception is/mean to them.
**Sexual Health: Conceptual**

According to the World Health Organization (WHO, 2009), sexuality entails going beyond reproductive health by looking at sexual health holistically and comprehensively. Sexual health is influenced by factors ranging from sexual behavior, attitudes, societal factors, and biological risk.

**Sexual Health: Operational**

Sexual health will be determined by age of first intercourse, number of sex partners at time of study, history of STDs, and previous pregnancy.

**Attitudes/Perspectives: Conceptual**

Bruckner et al. (2004) believe teens see situations through mental views, and teens’ attitudes are ways in which they perceive pregnancy, contraception, and sexual health.

**Attitudes/Perspectives: Operational**

Attitudes and perspectives toward pregnancy will be measured through information gained from interviews about teen pregnancy, contraception, and sexual health. In addition, the following question will be asked, “if you got pregnant, how stressful would this be for you?” Response categories would be strongly agree to strongly disagree.

**Assumptions**

This descriptive, qualitative, ethnographic study will be grounded on the following assumptions:

1. Improved understanding of teens’ attitudes toward pregnancy.
2. Teens’ perspectives can be a link for successful interventions.
3. Teen pregnancy is preventable with proper interventions.
4. Participants will answer questions in an honest manner.

**Limitations**

Generalization of the study’s findings will be limited to only the attitudes of female teens. Male participants were not included in the study. The sample selection was limited to Darke County, a rural community with approximately 53,000 and this will limit the generalization of the findings to teens from other countries. The study was also limited to one ethnic group, Caucasian. Darke County was 98.09% Caucasian (U.S. Census Bureau, 2008).

**Summary**

When teens give birth, their future prospects and those of their children decline. Teenage birth rates rose in 2006 for the first time in 15 years. This increase follows a continuous decline between 1991 and 2005. High teen birth rates was an important concern because teen mothers and their babies face increase risks to their health, and their opportunities to build a future was diminished (National Campaign to Prevent Teen Pregnancy, 2009). The purpose of the study was to gain insight from teens into pregnancy, and sexual health in order to implement successful intervention programs. The Nursing Model for Teen Pregnancy will provide the framework of the multi-faceted problem of teen pregnancy (Inhelder & Piaget, 1958),
Chapter II

Literature Review

Introduction

Teen pregnancy has been identified as a problem for teenagers, their families, and society. However, there is a lack of research into teenager’s attitudes toward pregnancy and sexual health. This descriptive qualitative study is a partial replication of Jewell, et al. (2000) study. The purpose of this study was to gain perspectives from teens about pregnancy, contraception, sexual health, and answer the question if by including teens’ perspectives into planning pregnancy prevention programs will decrease the teen pregnancy rates. Research questions to be answered include:

1) At what age is it appropriate to become sexually active and start a family?
2) What are teens attitudes concerning contraception use?
3) What are teens attitudes concerning pregnancy?
4) How much education has teens had about contraception, STDs, and pregnancy?
5) How much family support do teens have?

Conceptual Model/Framework

The conceptual model utilized for this study is the Nursing Model for Teen Pregnancy. This model reflects the nursing concept of individuals as bio-psychosocial human beings who function in a holistic manner (Erikson, 1959). The model is built upon the developmental theories of Erikson and Piaget and theorizes that developmental
maturity was related to teen pregnancy. The concept of maturity was divided into 3 areas: physical, psychological, and cognitive. As the 3 areas of maturity increase, so do the number of teen pregnancies. The Nursing Model for Teen Pregnancy provides a broad framework of the multifaceted problem of adolescent pregnancy (Inhelder & Piaget, 1958).

According to Jewell et al. (2000), the United Kingdom (UK) has the highest teen pregnancy rates across Europe. Teen pregnancy continues to be a problem for society and teenagers. However, there has been little research into the teens’ perspectives and attitudes. The purpose of this ethnographic qualitative study was to explore adolescent females’ attitudes of sexual health, contraception, and pregnancy (Jewell et al., 2000)

The study included female adolescents between the ages of 16 and 20, with a total of 34 participants. The study took place in clinics, general practices, and mothers groups for young people. The sample of participants included young mothers (n =16), and never-pregnant young women (n =18) from advantaged and disadvantaged socioeconomic backgrounds. Women were recruited purposefully to ensure the sample included a range of social circumstances (i.e., living in poverty, limited resources) (Jewell et al., 2000).

The researcher observed over a period of 18 months and supplemented the information with in-depth interviews. Descriptive accounts and accompanying field noted were organized around the main themes within the context of the participant’s sexual and emotional relationships and social circumstances. The major themes explored included attitudes toward teenage pregnancy, health, and sex, including their knowledge and behavior in relation to contraception, and their perceptions of society’s view of teenage mothers. The extracts from interviews provide recurring themes elicited from analysis of
field noted written throughout the 18 months of fieldwork and transcripts of over 40 in
depth interviews (Jewell et al., 2000).

The findings showed there were clear differences between those from advantaged
and disadvantaged backgrounds. In terms of attitudes toward teen pregnancy, those from
disadvantaged groups felt the best age to start a family would be between 17 and 25, and
those from advantaged groups, the appropriate age was late 20s and early 30s. Although
early motherhood was less acceptable for those in the advantaged group, their attitudes
were overall tolerant of those who did become pregnant. The advantaged group was more
likely to get an abortion. Participants in the young mother group said they had considered
abortion but could not go through with it. They also felt a great deal of pressure proving
they were good mothers (Jewell et al., 2000).

Attitudes toward sex and love in relationships clearly showed teens’ partners
affected their contraception use. Within relationships that were long term, contraception
was not always used. Emotional attachments (referred to as love) were used to explain
risk-taking behavior among some of the teens. The disadvantaged group had less
knowledge about contraception. There was a widespread lack of confidence in
contraception among the disadvantaged group. The crucial difference lay in the nature,
length, and responses to risky behavior: more advantaged women tended to take
emergency contraception, and more disadvantaged teens tended to wait and see if they
became pregnant (Jewell et al, 2000). The author’s note that the young mothers became
sexually active at an early age, felt sex education was too late, too biological, and did not
explain enough about contraception and pregnancy. The women preferred information
from peer groups, someone with personal experience.
The study reinforced the belief that in order to reduce unplanned pregnancy and encourage safer sex practices, it was necessary to have a more holistic understanding of teen’s perspectives into sex, contraception, and pregnancy issues. The approach most likely to be successful requires input from the teens themselves. The research also indicated the importance of considering emotional relationships in sexual behavior and motherhood. Overall, what was needed, a shift away from blaming young women toward a better understanding of their perspective on sexual health and relationships (Jewell et al, 2000).

Teen pregnancy was associated with a wide range of adverse consequences. Although teen pregnancy rates in the United States (U.S.) were decreasing, it still remains high. Although many studies have been done on the contraceptive behavior of teen girls, studies have been limited on focusing on evaluating the influence of the boyfriend’s perceived attitude toward pregnancy. The purpose of this cross-sectional provider administered study was to evaluate the factors associated with teenage girl’s desire for pregnancy among those seeking reproductive health services (Crowley, 2001).

The study was conducted in a health clinic within a migrant/community health center in a town with a population of 10,000. The clinic was located 25 miles from a major Midwestern city. The clinic serves clients ages 12 through 20. Inclusion criteria were girls ages 13 through 18, and never being pregnant (Crowley, 2001). A total of 202 girls were eligible and agreed to participate, with 148 as the final sample. Girls already pregnant at the initial visit were excluded (n=54). All subjects spoke English or Spanish.

A semi-structured interview was utilized to explore teen’s attitudes toward pregnancy, and contraception use. Other variables included ethnicity, age, school
attendance, employment status, social habits including alcohol and tobacco use, current
dating status and current sexual relations, family structure, age of boyfriend, and
boyfriend’s attitude toward pregnancy (Crowley, 2001). A semi-structured interview was
utilized to explore teen’s attitude toward pregnancy, and contraception use. Data were
analyzed using the (SAS) statistical program (version 8.0), and chi-squared testing for
unadjusted analysis of factors associated with teen’s attitudes toward pregnancy
(Crowley, 2001).

The author concluded that teens ambivalent about pregnancy were very similar to
those desiring pregnancy, and should be considered high risk for pregnancy. One hundred
seven (56.4%) wished to avoid pregnancy, 16 (19.8%) desired pregnancy, and 25 girls
(23.7%) were ambivalent about desiring pregnancy. The only significant difference
between teens desiring pregnancy and those ambivalent about pregnancy revealed one
difference: teens desiring pregnancy were more likely to report that their boyfriends
wanted a baby. Factors associated with a positive attitude toward pregnancy were
Hispanic ethnicity, having lived away from home for more than 2 weeks, and having left
school (Crowley, 2001).

A boyfriend’s desire for pregnancy was the best predictor in assessing teen’s
attitude toward pregnancy. When assessing risk for pregnancy, one important question
that needs asked is whether she thinks her boyfriend desires a baby. Providers should
include boyfriends in efforts to decrease pregnancy in at-risk teen girls and should
encourage communication between the teen and her partner regarding contraception and
pregnancy. Interventions focused solely on providing information about and access to
contraception is unlikely to be sufficient in strengthening a girl’s motivation to delay pregnancy (Crowley, 2001).

Teens making decisions about reproductive health occurs during the period of physical development and discovery of sexual identity and sexual experimentation. According to the 2002 National Survey of Family Growth, 54% of female adolescents, and 48% males reported being sexually active (Heavey, Moysich, Hyland, Druschel, & Sill, 2008). The purpose of this observational cross-sectional study was to examine the relationship between female adolescents desiring pregnancy and their perception of partners desiring pregnancy. Inclusion criteria consisted of adolescent females between 14 and 19 years of age who were pregnant or either awaiting pregnancy results at the time of the study from one of two obstetric clinics located in Rochester New York. Participants were from socioeconomic environments with racially diverse backgrounds (Heavey et al., 2008).

Analysis was done using SPSS (version 13.0). The majority of the teens were already pregnant (n = 78). Those not pregnant completed a different survey. The independent associations between the survey variables and pregnancy desire were analyzed using X2 test. A Spearman’s correlation coefficient was calculated comparing feelings about pregnancy and her perceptions about her boyfriend’s feelings. McNemar’s test examined happiness of each partner of participants not pregnant. Two (14%) reported desiring pregnancy now, five (36%) desired pregnancy in the next 2 years, and seven (50%) did not desire pregnancy for at least 3 years. Nine (64%) reported a partner who desired them to be pregnant and eleven (79%) reported partners who wanted them to be pregnant (Heavey et al., 2008).
The teen girls currently pregnant rated their feelings about being pregnant using a 5-point scale ranging from happy to unhappy. Thirty-seven (47%) reported the same level of happiness as their partners. Eight (20%) reported their partner had a lower level about pregnancy and thirty-two (80%) reported their partners with a higher level of happiness. McNemar’s test showed partners were more likely to feel positive about pregnancy than did the pregnant teen (P = .017). The partner’s feelings about pregnancy were clearly associated with and were reported to be more positive than their pregnant partners (Heavey et al, 2008).

The majority of public health interventions for teen pregnancy are mainly focused on teen’s that become pregnant. Information about birth control, and pregnancy should be a standard of care for both male and female. The authors concluded that currently, only 32% of teen males receive information regarding sexuality and contraception during routine health care visits. Interventions should include attitudes of male partners when teaching birth control methods. The study showed the importance of including a need to ask about pregnancy desire during routine visits. The authors suggested that by examining adolescent pregnancy desire as a “female” problem involves gender bias without considering the male in the equation. An opportunity to affect change in teen pregnancy rates may be missed (Heavey et al., 2008).

Chen, Wen, Fleming, Demissie, Rhoads, & Walker (2007), suggested approximately one million teens become pregnant in the U.S every year with 500,000 of these pregnancies occurring in 11-19 year olds. Although recent data have shown a decrease in teen pregnancy over the past 10 years, teen childbirth rate in the U.S is at least 5 times greater than in other industrialized countries. As a result, teen pregnancy
remains a health care, economical, and social problem in the U.S. The purpose of this retrospective cohort study was to determine if adolescent pregnancy is associated with an increase in adverse birth outcomes.

Criteria for the study included all nulliparous females less than 24 years of age who had a single birth during the period between 1995 and 2000 within the U.S. Maternal age was defined as the age of the mother at the time of delivery. Birth data was collected using the National Center for Health Statistics and Center for Disease Control and Prevention (CDC). Other information included maternal race, education, marital status, obstetric history, antenatal high-risk conditions, smoking, alcohol consumption, total number of prenatal visits, labor and delivery complications, gestational age, birth weight, and neonatal disease and death. Mothers 20-24 years old served as the reference group due to having the lowest risk of adverse conditions (Chen et al., 2007)

Birth outcomes of interest included pre-term delivery (<32 weeks gestation), pre-term delivery (<37 weeks gestation), very low birth weight infants (VLBW), (<1500 g at birth), LBW (<2500 g at birth), Small for gestational age (SGA), (infants with birth weights below 10th percentile for gestational age and sex), very low APGAR score at 5 min (< 4), low APGAR score at 5 min (< 7) and neonatal death within 28 days. The adjusted relative risks (RR) with 95% confidence intervals (CI) associated for teen pregnancy; with reference to the 20-24 age groups was derived through unconditional multivariate logistic regression models. All data were analyzed using SAS, version 9.1 (Chen et al, 2007).

A total of 23,654,785 live births between 1995 and 2000 were included in the data set. A total of 9.24% were born to mother’s age 20-24 years of age and 8.75% to women
< 20 years with 0.85% infants born to teens aged 10-15 years old, 3.02% to 16-17 year olds and 4.89% to teens 18-19 years old. A total of 4,254,751 first born single infants whose mothers were < 25 years of age were included. Comparing information to women aged 20-24 years old, teen mothers were more likely to be unmarried, African American, have limited prenatal care, smoked during pregnancy, and have an inadequate weight gain. Very preterm delivery, preterm delivery, very LBW, LBW, SGA, very low APGARS, low APGARS, and infant mortality were all higher in teen pregnancies with consistent increases in these values as ages of the teen decreased. Highest rates were among teens <15 years of age (Chen et al, 2007).

The authors conclude that pregnancy increases the risk of adverse birth outcomes. In order to decrease adverse outcomes and teen pregnancy, it is important to use appropriate skills and interventions in a holistic manner (Chen et al., 2007).

According to the CDC, 2004 teen birth rates have declined by 30% between 1991 and 2002. Although a great deal of research on pregnancy literature exists incorporating the use of identified predictors of teen sexual behavioral outcomes, there has not been much research on presumed underlying meaning of constructs and the relationship among these constructs. The National Institute of Child Health and Human Development, 2002 believes planned interventions should occur at an earlier age to prevent risky sexual behavior in teens. The purpose of this quasi-experimental study was to examine the effects of interventions in school based teen pregnancy prevention programs on constructs underlying teens’ beliefs, perceptions, and attitudes (ATS) (Thomas & Dimitrov, 2007).
The study was conducted using 1,136 middle school 7th graders. This allotted for program, participants and comparison groups. The experimental group consisted of 729 students, 51.6% of who were male and 48.4% female, with 22.6% being African American. The control group consisted of 293 students, of who 50.2% were male and 49.8% female with 36.4% being African American. Other characteristics of the population included the use of tobacco and alcohol and having dated at least 1 month (Thomas & Dimitrov, 2007).

Data from a 22-item questionnaire was used to measure teens’ ATS. The items used were screened for psychometric integrity and substantive relevance to prior research on teen pregnancy. A confirmatory factor analysis was used for validating the hypothesized structure of a 22-item questionnaire. Structural equation model (SEM) with M-plus was used to evaluate changes in the six constructs of teens’ ATS gender difference. In addition, SEM was used to evaluate the impact of the intervention program on changes in constructs of teen’s attitudes toward sexuality (Thomas & Dimitrov, 2007).

The SEM-based method offered an estimate of true scores on each of the ATS constructs and allowed for testing of the assumption of measurement invariance across the groups evaluated on the ATS constructs. The study provided credible evidence that constructs related to measure of teens’ attitudes toward risky sexual behavior were sufficient to detect program effects. The results from the confirmatory factor analysis for validation of 6 constructs underlying the 22-item questionnaire indicated a good model fit for both pre and post-treatment data. All parameter estimates were statistically significant (p < .001), with critical ratios ranging from 13.58 to 29.58 (Thomas & Dimitrov, 2007).
This study provided evidence that the hypothesized constructs of teens’ attitudes toward risky sexual behavior are valid and sensitive to changes under the program intervention. Because of the need to make pregnancy prevention intervention available at an earlier age, future research is needed to determine whether the findings of this study can extend beyond the study population. Attention also needs to focus on how ATS constructs operate within a system of child and adolescent support that includes parents and community entities. Research and program evaluation studies continue to provide information focused on adolescent high-risk behaviors. Establishing links between children’s and teen’s attitude toward sexuality (ATS) and their behavior is vital from both a theoretical and a practical perspective (Thomas & Dimitrov, 2007).

Adolescents may be prone to engaging in risky sexually behavior due to perceptions of personal invulnerability and their tendency to focus on the immediate. Despite the multitude of programs and policies designed to protect teens’ sexual health, debate continues over what actually influences teens’ behaviors. The purpose of this cross-sectional study was to gain views of public high school students on preventing pregnancy. The sample consisted of 49% females and 51% males in the 10th and 11th grade, from diverse racial and ethnic backgrounds. The students attended 1 of 6 Boston High Schools (Hacker, Amare, Strunk, & Horst, 2000).

A 75 question anonymous survey designed for this particular study was used. A total of one thousand surveys were received and analyzed using chi-square to assess the statistically significant differences in student responses (Hacker et al., 2000).

Hacker et al., (2000) found that 63% of students had sexual intercourse. Of these, 72% were male, and 54% female. Also, 35% used contraception, and 65% were
inconsistent users of contraception. Teens believed that more information on pregnancy and contraception (52%), relationship education (33%), better communication with parents (32%), improvement in obtaining contraception (31%), and education about the realities of parenting (30%) would help to decrease pregnancy rates in teens.

Teens using contraception were more likely to have conversations with parents (49%) (P < .001). Males were more likely to prefer contraception information from parents, 23% versus 18% female. Teens’ not sexually active (58%) believed information on birth control and pregnancy was important (p < .05). When asking why they did not use birth control, 15% (p < .001) said they had not thought about it. (Hacker et al., 2000).

Teen pregnancy carries a broad array of socioeconomic and health risks. According to the authors, it is essential that when planning teen pregnancy prevention programs, researchers must consider teens’ attitudes regarding pregnancy, contraception, and sexual health if programs are going to be successful (Hacker et al., 2000).

According to Bruckner, Martin, and Bearman (2004), the majority of pregnancies among teens’ are unintended. Most teens do not want to become pregnant, although some are unsure, and others are not opposed. Explanations of the difference in teens’ attitudes exist in the literature; however, less often considered whether these attitudes are associated with pregnancy risk and contraception use. The purpose of this longitudinal prospective study was to address whether sexually experienced teens’ attitudes toward pregnancy influence their risk of becoming pregnant. Females age 15 thru 19 who participated in two home-based interviews were eligible for inclusion into the study. The sample was limited to sexually experienced teens. Bivariate and multivariate analysis was
used to assess attitudes associated with pregnancy and contraception (Bruckner et al., 2004).

Data from the National Longitudinal Study of Adolescent Health (Add Health) were used to examine whether 15 to 19 year old teens’ attitudes toward pregnancy influence contraception use and risk for pregnancy. Audio computer-assisted self-interviewing technology was used for questions covering sexual behavior. The first interview took place from May thru December 1995 and included 20,745 in home interviews. The second interview was completed between April and September 1996 and included 88% of the sample first interviewed. A total of 14,738 completed both interviews. The final sample for interpretation included 4,877 adolescent females.

Twenty percent of teens’ had no desire for pregnancy, 8% had attitudes desiring pregnancy, and 14% were ambivalent. The remaining was considered to have mainstream attitudes. The sexually experienced teens that had attitudes toward pregnancy were not associated with risk of pregnancy. However, those that were ambivalent had reduced odds of using birth control consistently and not consistently rather than not practicing birth control at all (odds ratios 0.5 and 0.4). There was no consistency in those that had attitudes toward pregnancy and those who did not, regarding using birth control consistently. Having a positive attitude toward contraception was associated with a likelihood of inconsistent and consistent contraceptive use compared with nonuse (1.7 and 2.1) (Bruckner et al., 2004).

The authors suggest that pregnancy attitudes appear to be only subtly linked to contraception use. Programs should emphasize positive attitudes toward contraception,
effective use is strongly associated with reduction of pregnancy risk (Bruckner et al., 2004).

Unplanned teenage pregnancy constituted an important health and social problem in South Africa. There are numerous socio-economic implications of teenage pregnancy that places an enormous burden on families. Most teen mothers are still attending school and do not receive financial support from the father. The purpose of this descriptive study was to access the knowledge, attitudes, and practices of contraception and sexual awareness among high school students in rural KwaZulu-natal. The sample consisted of 200 males and 200 females in 5 surrounding high schools located in KwaZula-natal. The mean age of males was 18.1 and females 16.1 years. The schools were chosen using a random sampling technique. Participants were on a voluntary basis (Oni, Prinsloo, Nortje, & Joubert, 2005).

Two questionnaires were given, one for males and a separate one for females. Questions on knowledge of contraception, sexuality, and reproduction were asked. The questionnaire was anonymous, self administered, and placed in a box when complete. The data analysis was descriptive, and reported percentages and frequencies for categorical and continuous data (Oni et al., 2005).

The findings showed the mean age for menarche was 15. Two-thirds (61.1%) of males and 35.5% females had mated. There were 61.6% males and 27.8% females who admitted to sexual intercourse with average ages of first intercourse being 15.4 for males and 16.3 females. Those using contraception were 48.8% were males and 49.1% females. The most common contraception for males was condoms (81.4%) and female’s injection (65.4%). Only 17% males and 22.5% females admitted to always using some form of
birth control. The reasons given were “not knowing” about contraception (33% males, 50% females) and unavailability (3.5% males, and 0% females). Those who did not think about contraception at the time of intercourse were 6.6% males, and 9.4% females. Males (40.9%) did not approve of their girlfriends using contraception (Oni et al., 2005).

Most participants believed teenage pregnancy was wrong (74% male, 94.4% female). Only 7.1% males and 3.1% females reported being treated for sexually transmitted diseases (STD). A total of 74.2% males and 72.9% females understood condoms prevent STD’s. Only half of the participants knew they could become pregnant during first intercourse. The authors believe low contraception use puts teens at risk for STD’s and pregnancy. Education should be reinforced in schools and delaying sexual intercourse should be encouraged. Teens should be included in planning and implementing programs aimed at reducing pregnancy and sexual health issues (Oni et al., 2005).

Sexual intercourse places teens at risk for STDs, and unintended pregnancy. Teens with strong religious views are less likely to have sex because their religious views lead them to believe having sex has negative consequences. The purpose of this longitudinal study was to gain a better understanding of the connection between teens religious beliefs and practices, their attitudes about sex, probability of first sexual encounter, and to find out if having the first sex influences religious attitudes and practices (National Institute of Health (NIH), 2003).

The sample consisted of 90,000 seventh through twelfth graders. The analysis focused on 4,948 teens between ages 15 and 18. Inclusion into the study was limited to those who have not had sexual relations. The study uses information from the National
Longitudinal Study of Adolescent Health between 1995 and 1996. A comprehensive survey measured the effects of family, peer group, school, neighborhood, religious institution, and community on behaviors that promote good health (NIH, 2003). Teens were interviewed twice separated by 1 year.

The findings suggested that religious beliefs influenced whether teens will have sex, especially for girls. Religion only had a minor influence on boys. Both boys and girls who had a favorable attitude toward sex increased the likelihood they would have sex. Having sex did not affect boys or girls religious beliefs. Adolescents’ own religious and sexual attitudes were more important predictors of their sexual behavior than were their parents’ attitudes toward teen sex. “Parents” attitudes about religion and sex did not affect their children’s decisions about having sex (NIH, 2003).

The information provided important information for health researchers and planners when developing programs that prevent teen pregnancy (NIH, 2003).

Sather & Zinn (2002), theorize that early sexual activity can have negative effects on youth, their family, any offspring, and society as a whole. Personal and social consequences related to early sexual activity have been documented in literature. The purpose of this longitudinal, quasi-experimental study was to describe the differences in the values and attitudes of 7th and 8th graders toward premarital sexual activity. Inclusion criteria included were: (a) male or female in the 7th or 8th grade; (b) enrolled in an abstinence only curriculum (treatment group), or attended one of three schools that taught traditional sex education curriculum (comparison group); (c) able to read and understand English or Spanish; (d) have a signed parental consent; and (e) signed a youth assent. The
sample included Caucasian, Hispanic, Native American, and Asian origins. Most of the individuals were from middle class families (Sather & Zinn, 2002).

Pre and posttests were administered in a classroom setting by a trained abstinence-education teacher or by a researcher. The Nebraska Youth Profile Survey (NYPS) was administered to the treatment group prior to the abstinence only curricula. The instrument was administered to the comparison group within a few weeks. The NYPS was administered to both groups 4 months later. The NYPS measures 15 groups of variables known to impact teenage risk-taking activities (Sather & Zinn, 2002).

Analysis for the study involved comparison of the mean scores for the treatment group to the mean scores of the control group. Comparisons of percentages for each subscale were used to determine the commonalities and differences. McNemar’s statistical test was used to detect any significant changes.

The 5-point Likert scale was used to range answers from strongly disagree to agree. When asked the question, “is it okay for people my age to have sexual intercourse,” on pre-test, 57 (65.5%) of the 87 treatment group and 19 (42.2%) of the 45 control group believed that sexual intercourse before marriage was not ok. At posttest 61 (71.8%) of the treatment group and 17 (42.5%) of the control group believed sexual intercourse before marriage was not okay. McNemar’s analysis revealed no statistical change for the treatment group from pre- to post test (p = 1). When asked if it was okay for teens their age to have sexual intercourse, 81 (93.1%) of the treatment group believed it was not okay, 2 (2.3%) were not sure. At posttest, 79 (92.9%) disagreed, 2 (2.4%) were not sure, and 4 (4.7%) agreed. Control group responses were similar to the treatment group. At pretest, 39 (86.7%) believed it was not okay to have sexual intercourse, 5
(11.1%) were not sure, and 1 (2.2%) agreed. At posttest 35 (87.5%) did not think having sexual intercourse was okay, 3 (7.5%) were not sure, and 2 (5%) agreed (Sather & Zinn, 2002).

Another statement using the Likert scale was “I have definite ideas about why I should wait until marriage to have sexual intercourse.” At pretest 72 (82.8%) treatment group and 32, (71.1%) of the control group agreed. Those not sure included 13 (14.9%) of the treatment group and 10 (22.2%) of the control group. Only two (2.3%) of the treatment group and 3 (6.7%) of the control group disagreed. There was only a small positive shift from pre to posttest, although the treatment group had definite ideas about why they should wait until marriage for sexual intercourse and the control groups were unsure. When asked the question, “do you think you will have sexual intercourse while you are an unmarried teenager,” at pretest, 71 (81.6%) said they would not have sexual intercourse while an unmarried teenager. Those unsure included 12 (13.8%) of the treatment group and 6 (13.3%) of the control group. Those who thought they would included 4 (4.6%) of the treatment group, and 6 (13.3%) of the control group. At pre and posttest, the control group was more likely to report they would have sexual intercourse while an unmarried teen. There was no change with the treatment group (Sather & Zinn, 2002).

Abstinence only education did not significantly change teen’s values or attitudes about premarital sexual activity nor did it change their intentions whether or not they would wait to engage in sexual relations before marriage. Sather & Zinn (2002) believe those working with the teen population must determine their views of early sexual
activity, and determine the level of knowledge the teen has regarding the consequences of sexual activity, pregnancy, and STDs.

One important influence on teen behavior is their immediate family environment. Recent evidence has suggested family-related influences may be an important correlate of sexual risk behavior. The purpose of this pilot study was to explore whether family-related measures were associated with barriers to STD care among pregnant minority adolescent females (Crosby, Wingood, DiClemente, Harrington, Davies, & Rose, 2002).

African American adolescents, single, ages 14 to 20 less than 21 weeks gestation were eligible for the study. The subjects were recruited from prenatal clinics in a large urban hospital. The clinics were located in low-income, minority areas of Atlanta, Georgia. A four-item scale assessed adolescents’ perceived family support. The items asked teens to indicate their level of agreement or disagreement, using a 5-point response scale. (a) My family really tries to help me, (b) I get the emotional help and support I need from my family, (c) I can talk about my problems with my family, and (d) My family is willing to help me make decisions (Crosby et al., 2002).

Among 170 adolescents, more than half reported having an STD, with nearly half of these being treated for an STD in the past 6 months. Low perceived family support and infrequent communication between mother and daughter were associated with greater odds of a history of an STD. There was a significant bivariate associated with a history of STD and teens report that they did not reside with a family member. The study also found that marginal family support was also associated with financial barriers to STD care.

The findings show adolescent females may benefit from family-level primary prevention programs designed to reduce incidence of STD (Crosby et al., 2002).
Health professionals working with adolescents have increased their efforts at both designing and implementing interventions aimed at preventing teen pregnancy. Findings suggest that provisions of contraception alone is not sufficient to decrease pregnancy among sexually active adolescents. The purpose of this quasi-experimental study was to examine an intervention aimed at encouraging teens to acknowledge his or her own attitude and personal risk for involvement in an unplanned pregnancy (Out, 2001).

The sample consisted of 114 eleventh grade students (24 males, 90 females) ranging from 14-19 years. The mean age was 16.2 years (SD = 1.02 years). The groups were divided into intervention groups (53 students), and comparison groups (61 students). Baby Think It Over, an infant simulation program that seeks to modify attitudes toward teen pregnancy was used in the study. The infant was programmed to cry at random intervals of 15 minutes to 6 hours, 24 hours a day. The doll would cry for several reasons from being placed in a certain position to being handled incorrectly. A questionnaire containing measures was used to assess attitudes, behaviors, and knowledge related to contraception and fertility, and was administered during pre and posttest sessions. The Health Belief Model Approach to Adolescents assessed attitudes toward teen pregnancy, contraception, and susceptibility to an unplanned pregnancy (Out, 2001).

Reliabilities were calculated for scales and subscales. Cronbach’s alpha was found to range from .60 and .82. Multivariate analyses of variance (MANOVA) were performed to determine if differences existed between the intervention and comparison groups. Pearson correlation coefficients were calculated for each pair of dependent measures (Out, 2001). The author suggests that teens that reported feeling more
personally susceptible to an unplanned pregnancy also reported having more favorable views regarding abstinence from premarital sex. Teens who felt more personally susceptible to unplanned pregnancy reported having more positive attitudes toward using contraception. Significant association was found between perceived benefits of contraception use and attitudes toward abstinence. Teens with positive views concerning abstinence perceived fewer benefits associated with contraception use than did teens with negative views. There was no significant difference in the relationship between those who were sexually experienced and those who were not. Negative associations were observed between perception of the presence of barriers to effective contraception use and attitudes toward abstinence.

After 2 to 3 days using the simulator doll, those in the intervention group were more likely to assess their personal risk for unplanned pregnancy. The same group acknowledged that failure to use contraception during intercourse significantly increased personal risk for becoming involved in unplanned pregnancy. Both groups had negative attitudes toward unplanned pregnancy. Teens in the intervention group produced concrete examples and consequences related to child rearing. Educators need to investigate new methods of encouraging teens to foresee and understand the long-term educational, economic, and social consequences of teen parenting. Contraception alone is not sufficient enough to decrease pregnancy among sexually active adolescents (Out, 2001).

Summary

Teen pregnancy has been identified in literature as a problem for teenagers, their families, and society. The Nursing Model for Teen Pregnancy will guide the study. The model theorizes that developmental maturity is related to those at risk for teen pregnancy.
Research shows the importance of including teen’s attitudes and perspectives when planning effective, and having successful teen prevention programs.
<table>
<thead>
<tr>
<th>Source (Author, year)</th>
<th>Problem</th>
<th>Purpose/ Research Questions</th>
<th>Framework or Concepts</th>
<th>Sample</th>
<th>Design</th>
<th>Instruments</th>
<th>Results</th>
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<tbody>
<tr>
<td>1. Jewell et al. (2000)</td>
<td>The UK has the highest rate of teen pregnancy in Europe and is a problem for society and teens.</td>
<td>Explore teens’ attitudes toward sexual health, contraception and pregnancy</td>
<td>Nursing Model for Teen Pregnancy</td>
<td>34 female teens between 16 &amp; 20. Young mothers &amp; those never pregnant. Socioeconomic advantaged &amp; disadvantaged.</td>
<td>Ethnographic qualitative</td>
<td>In depth interviews, participant observation</td>
<td>Those advantaged-motherhood not acceptable, more likely to seek ER contraception.</td>
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<td>2. Crowley (2000)</td>
<td>Early adolescent childbearing is associated w/ wide range of adverse consequences and restricted life opportunities.</td>
<td>Investigate factors associated with adolescent desire for pregnancy</td>
<td>Social Cognitive theory</td>
<td>148 girls 13 - 18 yrs. not pregnant visiting an adolescent care clinic N = 54 (already pregnant)</td>
<td>Cross sectional provider administered</td>
<td>Extensive semi-structured survey</td>
<td>The perception of boyfriend’s desire for pregnancy was the only significant variable.</td>
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<td>3. Heavey et al. (2008)</td>
<td>Adolescent reproductive decision making occurs during period of rapid physical development</td>
<td>Examine relationship between females desiring pregnancy &amp; their perception of partner’s desire.</td>
<td>Social Learning theory</td>
<td>92 adolescent females 14-19 yrs. from two obstetrical clinics</td>
<td>Observational cross sectional</td>
<td>31 question self administered survey</td>
<td>There was a sig. correlation between male &amp; female pregnancy happiness, &amp; feelings about pregnancy &amp; perception of mate feelings (P = .004)</td>
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<td></td>
<td>Study Authors and Year</td>
<td>Description</td>
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<td>5.</td>
<td>Thomas &amp; Dimitrov (2007)</td>
<td>Little research has been conducted regarding precursors to risky sexual behavior.</td>
<td>Examine the effects of intervention in a school based teen pregnancy program on constructs underlying teens ATS.</td>
<td>Social Cognitive theory</td>
<td>1,136 7th grade students. 729 in experimental group &amp; 293 in control group.</td>
<td>Pretest, posttest quasi experimental</td>
<td>22-item questionnaire measuring attitudes, perceptions &amp; beliefs.</td>
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<td>7.</td>
<td>Bruckner et al (2004)</td>
<td>Teens who become pregnant do not appreciate the negative consequences &amp; prevention programs should consider teens’ attitudes.</td>
<td>To address whether sexually experienced teens’ attitudes influence their risk of pregnancy</td>
<td>Nursing Model for Teen pregnancy</td>
<td>20,745 female teens 15 to 19 years. Final sample (4,877)</td>
<td>Longitudinal Prospective</td>
<td>In home interviews</td>
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<td></td>
<td>Study</td>
<td>Research Question</td>
<td>Methodology</td>
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<td>9.</td>
<td>NIH (2003)</td>
<td>Teens not religious do not view consequences of sexual health</td>
<td>Social Learning theory</td>
<td>90,000 7th thru 12th graders age 15 to 18, virgins Final sample (4,948)</td>
<td>Longitudinal, provider administered</td>
<td>Interview, comprehensive survey</td>
<td>Having sex did not affect boys or girls religious beliefs. Religious practices influenced the decision to have sex.</td>
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<td>10.</td>
<td>Sather &amp; Zinn (2002)</td>
<td>Sexual activity has negative effects on youth, family, offspring, &amp; society.</td>
<td>Social Cognitive theory</td>
<td>7th &amp; 8th graders attending 1 of 3 schools, English or Spanish speaking</td>
<td>Longitudinal quasi-experimental</td>
<td>Pre-posttest provider administered</td>
<td>Abstinence only education did not change teen’s attitudes about pre-marital sex.</td>
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<td>11.</td>
<td>Crosby et al (2002)</td>
<td>Lack of family support can influence teens attitudes toward sexual health</td>
<td>Nursing Model for Teen pregnancy</td>
<td>African American teens, single, ages 14 to 20 &lt; 21 wks. Gestation</td>
<td>Randomized controlled trial pilot study</td>
<td>Self-administered survey. Face to face interviews</td>
<td>Low perceived family support were associated with greater odds of STDs.</td>
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<td>12.</td>
<td>Out (2001)</td>
<td>Although there have been recent downward trends in teen pregnancies, the US continues to have one of the highest rates of Western civilized nations.</td>
<td>Health Belief Model</td>
<td>114 -11th grade students (24 males, 90 females) ranging from 14 to 19 yrs. Intervention group 53, experimental group-61</td>
<td>Quasi-experimental</td>
<td>Pre, posttest questionnaire</td>
<td>Contraception alone is not sufficient to decrease pregnancy among sexually active teens.</td>
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Chapter III

Methods and Procedure

Introduction

Teenage birth rates in the U.S. rose in 2006 for the first time in 15 years. A total of 435,427 infants were born to mothers 15 to 19 years of age, a birth rate of 41.9 births per 1,000 women, more than 80% were unplanned. According to the CDC (2007), teenage pregnancy remains high with approximately 1 million teenage girls becoming pregnant each in year in the U.S. Approximately 13% of births involve teen mothers and about 25% of teenage girls who give birth have another baby within 2 years. Absent from the moral, political, and medical debate that surrounds teen pregnancy is the perspectives of teenagers. Although literature suggests that, while teenage pregnancy may be a problem for society, it may be less so for teenagers themselves (Jewell et al., 2000). This study is in part a replication of Jewell’s et al., (2000) study. The purpose of this study is to gain perspectives from teens about contraception, pregnancy, and sexual health.

Research Questions

The objective of the study is to explore teenage girl’s attitudes toward sexual health, contraception, and pregnancy. By including teen’s perspectives, researchers may have greater success in planning and implementing teen prevention programs. Research questions that will be addressed include:

1. At what age is it appropriate to become sexually active and start a family?
2. What are teens attitudes concerning contraception use?
3. What are teens attitudes concerning desire for pregnancy?
4. How much education have teens had about contraception, STDs, and pregnancy?
5. How much family support do teens have?

Population, Sample and Setting

The population will include all teenage girls between the ages of 15 and 19 who attend Darke County schools. A convenience sample of a minimum of 50 teenage girls between the ages of 15 and 19 who attend Darke County schools and who agree to participate will comprise the sample. Darke County has a population of 53,000. Those who have had prior pregnancies and those who have never been pregnant will be included. Recruitment will involve those from socio-economically advantaged and disadvantaged upbringings by including a fair distribution of participants from each school. Interviews will take place within each participant’s school setting prior to homeroom. Demographic data collected will include age, sex, race, educational level, and particular school currently attending. This information will be used to describe the population.

Protection of Human Subjects

The study will be submitted to the Ball State University review board (IRB) for approval prior to implementing the study. A cover letter will be provided to each participant 2 weeks in advance of the study. The cover letter will include an explanation, and full disclosure of the study. An informed consent will be included, and required prior to the study. Those under 18 years of age will need parental consent. Participation will be completely voluntary with right to refuse any part of the
study. Participants will be given an explanation that no personal data will be required. No risks have been identified with the study and ethical principals will be adhered to throughout the entire process.

Research Design

The study will use an ethnographic, qualitative design using anonymous surveys and questionnaires, researcher interviews, and group discussion and observation. Ethnography has a long history in social anthropology. It allows the researcher to understand and explore the lives and perspectives of the participants in their own social environment (Polit, & Beck, 2006). No attempt to control or manipulate the study will occur.

Instrumentation

Data that will be needed prior to the study will consist of teen pregnancy rates for Darke County, specific to each school. School nurses will provide this information to the researcher. Data needed to complete the research will include median age of participant, race, educational level, and family structure, ever pregnant, which socioeconomic group the participants belong to, what form of contraception use preferred, and use of emergency contraception. Participants attending schools located in identified areas of poverty will determine the socioeconomic status. Data will be gathered on teen’s perspectives through surveys, questionnaires, interviews, and discussion. Data collection will include using 5 point likert scales with ratings from strongly agree to strongly disagree. The researcher will utilize coding and groupings to determine themes and patterns. Descriptive statistics will be used to analyze variables and to determine those teens at greater risk of becoming pregnant.
Participants will be grouped according to attitudes toward pregnancy. Responses will be averaged into a single index of pregnancy attitude. Odds ratios will be calculated to assess the amount of risk the location of school district contributes to teens at risk of becoming pregnant. All research questions will be answered through chi-square analyses and odds ratios.

Methods and Procedures

After receiving proper consent forms, each participating school will be visited by the researcher. The school nurses will be recruited to assist with collection of surveys and questionnaires. An agreed upon time between researcher and participants will be planned ahead of time for discussion, and interviews. Topics such as family background, friends, boyfriends, sexual health and relationships, contraception use, career plans, issues about pregnancy and children will be discussed informally. This will be open communication among the group with no specific details asked for by the researcher. The researcher will take Field notes. At the end of the discussion period, the participants will be given a list of questions to answer, and a survey to take, with an allotted time to complete and turn in (2 weeks). There will be a total of 20 questions with a combination of direct and open-ended questions. They will be given an instruction sheet informing them to not include any personal indicators, and to place the surveys, questionnaires in the envelope provided, and completely seal after finished. The school nurses will provide a box with a cut out lid for the participants to put the envelopes into. The researcher will collect the boxes at the end of the study period. The nurses’ office remains locked at the end of the school day.
Summary

In this chapter, methods and procedures for this study are described. An ethnographic qualitative study design will be performed with an anticipated number of participants of 50. Data will be collected and analyzed accordingly. The study will partially replicate Jewell et al. (2000) study and attempt to validate similar findings. Similar results will assist in justifying the need to include teen’s attitudes and perspectives concerning pregnancy, sexual health, and contraception. Much work remains in identifying interventions that address social, cultural, and environmental influences on teen pregnancy.
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