# The Boulder County Unintended Pregnancy Study

Submitted by:

John Snow, Inc.
1725 Blake Street, Suite 400
Denver, CO  80202

Research Team:
Project Director~Yvonne Hamby, MPH
Study Coordinator~Lori Nichols, MSPH
IRB Technical Consultant~Chris Duclos, MPH, Ph.D.
Research Associate~Morgan Anderson, BA
Focus Group Facilitators~
David Salina, MSPH
Alexia Eslan, MBA
Elena Thomas-Faulkner, MA
Arman Lorz, BA

Boulder County Public Health (BCPH) contracted with John Snow, Inc. (JSI) to research the local issues and factors associated with un/intended pregnancy in Boulder County. Funding for this project was provided by the Temporary Assistance for Needy Families (TANF) program

**ACKNOWLEDGEMENTS**
Special thanks to the Unintended Pregnancy Research Project Steering Committee who volunteered their time to monitor and evaluate the research process, with the goal of ensuring quality completion of the scope of work, and recommending mid-course correction when necessary.

The research team truly appreciated the willingness of the Committee to share their insights, perspectives, concerns, experience, and expertise.

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JSI is a health care research and consulting organization dedicated to improving the health of individuals and communities. JSI prides itself in its ability to provide assistance that is tailored and responsive to the specific needs of our clients ranging from small local organizations to large federal and international agencies. Our focus on health service delivery, research, program evaluation, clinical care, prevention, training, and management consulting has allowed us to apply practical, technically sound, and innovative solutions to the challenges facing health care agencies, community-based organizations, and policy makers, in both the public and private sectors.

For this particular project, JSI brought to bear its history, experience, and resources that have been developed through family planning projects for local communities.

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*"If all pregnancies were intended…We would have significant reductions in infant mortality, child abuse and neglect, Medicaid costs, and abortion would be reduced (about 50% of unintended pregnancies result in abortion)" ~Guttmacher Institute*

## I. EXECUTIVE SUMMARY

Unintended pregnancies account for the majority of all pregnancies in the United States, though the issue remains an ambiguous concept that is imperfectly measured. Generally, it refers to pregnancies that were not planned at the time of conception and includes pregnancies identified as either unwanted or mistimed at the time of conception. In support of the need for new research, the Temporary Assistance for Needy Families (TANF) program provided funds to Boulder County Public Health for research to explore general definitions and impressions of unintended pregnancy, factors associated with unintended pregnancy, and best practices for unintended pregnancy prevention.

### Goal

This research project aimed to advance the broader BCPH goal of reducing unintended pregnancy rates in Boulder County. Research was designed to spark systematic analytic thinking on the causes and consequences of unintended pregnancy and to then identify effective use of prevention resources.

### Objectives

This research project addressed three study objectives:

1. Obtain data on rates of unintended pregnancy/paternity among Boulder County residents aged 13-28 (focusing on 15-24). This was accomplished by developing an epi-profile of unintended pregnancy rates and other indicators of sexual risk-taking behaviors in Boulder County. The profile served as the first step in promoting data-driven decision making.

2. Identify factors associated with unintended pregnancy/paternity among Boulder County residents aged 13-28 (focusing on 15-24). This was accomplished through focus groups, key informant interviews (KII), and a literature review. Focus group participant recruitment targeted men and women who have had an unintended pregnancy/paternity resulting in parenting.

3. Describe best practices in primary and secondary prevention of unintended pregnancy/paternity. This was accomplished through the literature review and KII.

## Methods

Research activities included quantitative and qualitative data collection among a diverse group of young men and women, as well as their immediate social network, health care and social service providers, and key stakeholders. Key areas of interest to BCPH included: demographics, un/intentionality rates, disparities, perceptions of un/intended pregnancy, repercussions of un/intended pregnancy, obstacles to and resources for prevention. Research accessed experiences of a diverse group, including geographic and racial/ethnic diversity, with sensitivity to age- and income-related strengths and challenges. BCPH Health Planning, in coordination with the Un/intended Pregnancy Research Project Steering Committee, monitored and evaluated the research process, with the goal of ensuring quality completion of the scope of work, and recommending mid-course correction when necessary.

## Results

The findings from this research have led us to multiple conclusions related to the current rate of unintended pregnancy in Boulder County, including some key considerations for future pregnancy prevention programming. These conclusions have important implications for prevention and support services as well as public policy.

### *Focus Group Findings*

- **MOST DID NOT WORRY ABOUT GETTING PREGNANT**

- **SOCIAL CONSEQUENCES WERE FELT BY MANY**

  Partner's involvement: opposite ends of spectrum
  Strained family relationships became worse
  Old friendships ended, but new ones began

- **PREGNANCY BROUGHT MOTIVATION**

  Desire for a better life, success and being a 'different' parent

- **FATHERS OFFER A DIFFERENT PERSPECTIVE**

  Condoms for protection not prevention
  Girls get more help than they do

There are many reasons why fathers have not been the focus of research. Early studies on young fathers assumed that they were psychologically unstable and offered little support. These shaped society's stereotypes of young fathers. However recently, there is growing attention to and evidence for the beneficial role that fathers can play in children's lives (Lamb, 2004).

### *Recurring themes in the focus groups*

Across all the focus groups conducted, the following consistent themes arose:

- Before the pregnancy, there was not much thought or worry about whether pregnancy would occur;
- Pregnancy and parenting were harder than expected;

- There was an increased propensity to use birth control after the pregnancy;
- There was a desire/need for more knowledge around birth control options and their proper use;
- Barriers to preventing pregnancy were less about cost and availability and more about making it a topic of conversation with parents, peers, and partners;
- Parenting provided a strong motivation to improve their educational, emotional and financial circumstances.

***Key Informant Interview Findings***

- **INFORMATION GATHERED FROM WIDE SPECTRUM OF STAKEHOLDERS**
  Steering Committee members
  Health services
  Social services
  Parenting programs
  Prevention programs
  Statisticians
  Public health and policy

- **INTERVIEWS FOCUSED ON SUCCESSES AND CHALLENGES**
  Defining unintended pregnancy
  Measuring unintended pregnancy
  Access and barriers to services
  Coordination and integration of services
  Prevention strategies

- **KEY INFORMANTS PROVIDED SUGGESTIONS FOR PROGRAMMING**
  Start small
  Increase collaboration
  Improve communication
  Get parents involved
  Money always helps
  Be more "dad" friendly
  Increase school-based resources
  Develop social marketing campaign

***Recurring themes in the interviews***

Across the interviews, some consistent themes emerged, including:

- It is challenging to define *unintended pregnancy* among a teen and young adult population;
- Despite the wide range of reproductive health services available in Boulder County, prevention efforts are hindered by the fact that many young people are not worried about pregnancy or simply do not think it will happen to them;
- While there is a great deal of collaboration among programs and agencies in Boulder, there is always room for improvement in this regard.

***Conclusions of focus group and key informant interview findings***

- Primary research among 15-24 year olds in Boulder County who have experienced an unintended pregnancy revealed attitudes of ambivalence and of "not thinking" about the issue and reinforced the idea that more needs to be done to communicate the realities of unintended pregnancy and parenting. Schools and parents are the two most commonly suggested resources to involve in the discussions on sex and birth control in order to decrease unintended pregnancy;

- Future research among 15-24 year olds in Boulder County who have not experienced an unintended pregnancy would help identify factors associated with successful pregnancy prevention efforts and possibly suggest strategies to include in future prevention programming;

- A more active approach to focus group recruitment may have produced monolingual Spanish-speaking participants, which could yield additional valuable information about cultural factors related to unintended pregnancy;

- Increasing the availability and reliability of pregnancy and fertility measures, such as abortion, fetal death, and pregnancy interval data would provide a better estimate of the true burden of unintended pregnancy in the county.

## Recommendations and Strategies

The 1995 Institute of Medicine report recommended a new social norm where all pregnancies are consciously and clearly desired at conception (IOM, 1995). Achieving this goal requires long-term efforts to educate the public on the benefits of family planning and of spacing pregnancies (Green-Raleigh, Lawrence, Chen, Devine, & Prue, 2005). The following represents best and promising practices from the literature in helping to reduce unintended pregnancy rates:

- Improving access to family planning;
- Improving access to emergency contraception;
- Parental involvement;
- Male involvement;
- Youth development;
- Social marketing campaign;
- Integration of services, such as reproductive health and STD/HIV testing;
- Improving general health care for women.

***Evidence-based practices conclusion***. Prevention strategies and programs must address a variety of risk and protective factors through different levels of the socio-ecological framework:

- Individual knowledge, attitudes, and behaviors;
- Peer/Family knowledge, attitudes, and behaviors;
- Schools/organizations;
- Community;
- Society.

Unintended pregnancy prevention strategies must address sexual and non-sexual antecedents through a combination of new or revised policies, programs, and practices (Kirby, Lepore, Ryan 2005).

The research team focused on obtaining the appropriate breadth and depth of information and effective analysis and synthesis of ideas in the literature to support the study objectives, selection of methods and believe that the findings of this study will contribute to a new understanding of the impact of unintended pregnancy on Boulder County residents.

## Suggested Next Steps

The development of a consortium of social service, health care, and other public health providers that can address the following:

- An assessment of local programs, activities, research findings, best practices, and data to review, update, confirm/enhance public health strategies to prevent teen pregnancy and sexually transmitted infection in Boulder County;

- An assessment of data systems across the County to develop the capacity to implement specialized data collection efforts so that unintended pregnancy rates can be monitored at a local level in a timely manner;

- Further research with males to better understand their unintended paternity issues as well as with couples to develop a better estimate of intention rates with couples.

## II. INTRODUCTION

Americans increasingly desire smaller families, and women are shortening their childbearing years. As a result, Americans are spending more of their lives choosing to avoid pregnancy and in need of effective contraception (Stout, Shupe, & McLaughlin, 1998). However, the majority of all pregnancies in the United States are unintended. In this changing social context, unintended pregnancy has become an increasingly important issue, but unintended pregnancy remains an ambiguous concept that is imperfectly measured. Generally it refers to pregnancies that were not planned at the time of conception and includes pregnancies identified as either unwanted or mistimed at the time of conception.

When pregnancies are begun without planning or intent, there are fewer opportunities to prepare for an optimal outcome. Unintended pregnancies are associated with increased social, emotional, and health stressors for those affected by or born of such pregnancies. Research has shown that women with unintended pregnancies are more likely to start prenatal care late in the pregnancy; they are more likely to smoke and drink during their pregnancies, and are at greater risk for depression during pregnancy and postpartum (Brown & Eisenberg, 1995). Women whose pregnancies were unplanned also experience higher rates of domestic violence (Centers for Disease Control, 1994). Although men share an equally important role in the timing and choice of pregnancy, few studies have looked at the consequences of unintended pregnancy on men. However, the research that has been conducted indicates that fathers of newborns from unplanned pregnancies report greater levels of stress than those with planned infants (Cooney, Pedersen, & Indelicato, 1993). Approximately half of all unintended pregnancies result in births. Infants whose conception was unintended are at greater risk for low birth weight (Brown, 1995). As a group, children born after unintended conceptions have been found to suffer developmental deficits, such as lower verbal skills (Baydar, 1995).

A landmark study regarding the impact of unintended pregnancy was conducted in 1995 as part of an Institute of Medicine (IOM) report titled, "The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families." The authors concluded that, "the consequences of unintended pregnancy are serious, imposing appreciable burdens on children, women, men and families." In response to the evidence that unintended pregnancy has negative impact on both mother and child, in combination with the IOM recommendations to reduce unintended pregnancies, Boulder County Public Health (BCPH) began looking at this issue on a local level in 1998 with studies on pregnancy intention and risk factors, as well as the importance of local data in planning for programming to address and reduce unintended pregnancy.

Due to changing demographics within Boulder County in recent years, as well as continued commitment to evidence-based public health interventions, BCPH identified the need for more current information on unintended pregnancy rates and related factors. In support of the need for new research, the Temporary Assistance for Needy Families (TANF) program provided funds to BCPH to conduct this research study. Within this context, BCPH contracted with JSI Research and Training Institute, Inc. to explore

general definitions and impressions of unintended pregnancy, factors associated with unintended pregnancy, and best practices for unintended pregnancy prevention.

The purpose and intent of the study was to advance the BCPH's broader goal of reducing the rate if unintended pregnancy in the community. The key areas of interest to the BCPH included: the demographics and disparities of unintended pregnancy rates; perceptions of untended pregnancy; repercussions of unintended pregnancy, obstacles to and resources for prevention. This report is directed to local public health professionals; administrators of relevant health and social service programs, including those who are active in the fields of family planning, specifically, and reproductive health generally; social services and child welfare; and policymakers at the state and local levels and any other community leaders in a position to act on the conclusions of the report.

## III. BACKGROUND

A review of secondary data and literature helped define objectives and the target population for the qualitative data collection. This review was focused on obtaining the appropriate breadth and depth, rigor and consistency, clarity and brevity, and effective analysis and synthesis. Concepts in the literature served to justify the particular approach to the study, the selection of methods and demonstration that this study contributes a new understanding of the impact of unintended pregnancy among Boulder County residents. Two key issues emerged from these reviews:

- Data showed that unintended pregnancy extends beyond teen years;
- The male perspective was lacking in literature.

### *Study goal and objectives*

The overall goal of this project was to further understand unintended pregnancy and paternity in Boulder County by exploring 13-28 year-old women's and men's life circumstances, events, and relationships surrounding unintended pregnancy and paternity resulting in both birth and parenting. Therefore, it was important to define *unintended pregnancy*. The National Center for Health Statistics, in its 2006 National Survey of Family Growth, defined births as either intended (occurring at the time they are wanted or sooner) or unintended (not wanted at the time of conception). Among unintended pregnancies, a distinction is made between mistimed (occurring earlier than wanted), and unwanted (occurring when a mother or father did not want a child at that time or anytime in the future) (Martinez, 2006). Although pregnancy intention is a complex concept to measure, as intention changes over time, it is subject to bias and can be impacted by cultural norms and beliefs. For the purpose of this research, an unintended pregnancy was defined as a pregnancy that was either unwanted or mistimed at conception. The operational definition guided the study methodology through identifying secondary data measures and key literature reviewed.

This research project addressed three study objectives:

1. Obtain data on rates of unintended pregnancy and paternity among Boulder County residents aged 13-28 years (focusing on 15-24 years of age).

2. Identify factors associated with unintended pregnancy and paternity among Boulder County residents aged 13-28 years (focusing on 15-24 years of age).

3. Describe best practices in primary and secondary prevention of unintended pregnancy and paternity.

Specific research objectives were to:

- Probe general impressions of unintended pregnancy among the target population (15-24 year-old women and men who have experienced an unintended pregnancy or paternity which ended in parenting), as well as key stakeholders across Boulder County as identified by the Unintended Pregnancy Steering Committee (see Methodology section for more details on this committee);
- Understand how the target population and key stakeholders define unintended pregnancy and paternity and where there is variation within the target population and stakeholders;
- Identify factors that help young people avoid, delay, or address unintended pregnancy and paternity from the perspectives of both the target population and key stakeholders;
- Identify factors that inhibit young people from preventing unintended pregnancy and paternity, from the perspectives of both the target population and key stakeholders;
- Explore social, cultural, mental health, and economic aspects of unintended pregnancy and paternity in various population groups.

***Significance of the problem***

Of the over 6 million pregnancies in the United States in 2001, an estimated 3 million were unintended pregnancies (The National Campaign). Of the unintended pregnancies, approximately half resulted in a live birth, while the other half resulted in a termination of the pregnancy. The remaining pregnancies ended in miscarriage. Among live births, increased maternal high-risk behaviors, such as smoking and drinking, have been associated with unintended pregnancies at a higher rate than with planned pregnancies, as well as poorer health outcomes for the infant, such as low birth weight. Children born as a result of an unintended pregnancy are also at greater risk for child neglect or abuse and developmental delay.

*The U.S. has one of the highest unintended pregnancy rates in the industrialized world – about half of all pregnancies are unintended.*

~Michigan Department of Community Health

For the mothers who experience an unintended pregnancy, there are also correlations between lower education levels and socioeconomic status, which have life-long impact for both mother and child.

***Those most at-risk for unintended pregnancy***

Although 93% of women among reproductive age use contraceptives, there are 42 million women at risk for unintended pregnancy in the United States. The small portion of those not using contraception (7%) accounts for 47% (or 3 million) of unintended pregnancies annually (Alan Guttmacher Institute [AGI], 2000). Henshaw (1998) also found that by the age of 45, the average American woman will have had 1.42 unintended pregnancies.

Within this context, teen pregnancy is especially significant. Each year in the United States, one in eight women aged 15-19 becomes pregnant, resulting in over half a million births. Two thirds of these births are unintended (Hatcher, Trussell, Nelson, Cates, Stewart, & Kowal, 1998), while three quarters of the pregnancies are unintended (Henshaw, 1998). Furthermore, only 25% of the men involved in the pregnancies among women under age 18 are also of the same age group; three fourths are older and nearly 40 percent are at least 20 (AGI, 2000).

While there is a paucity of data on the rates of unintended pregnancy (paternity) among men, a recent analysis of the 2002 cycle of the National Survey of Family Growth (NSFG) data revealed male intendedness of pregnancies: 9% were unwanted, 25% were mistimed, and 65% were intended (Martinez, Chandra, Abma, Jones, & Mosher, 2006). These percentages include only pregnancies that ended in a live birth. Additionally, one study of unintended paternity rates, in the US Army, found 70% agreement between mother's intention status and her report of the father's perspective on intention (Custer, Waller, O'Rourke, Vernon, & Sweeney, 2002).

Although the teenage pregnancy rate in the United States has been dropping since 1990, it is still much higher than in many other industrialized countries: twice as high as in England, Wales, France, and Canada; and nine times as high as in the Netherlands or Japan (AGI, 2000). Mistimed and unwanted pregnancies are not randomly distributed among families in the United States. They occur more frequently among younger, unmarried, low-income, and minority women and those who have not completed high school (Finer & Henshaw, 2006). The following is a brief list of those who are most at-risk for and impacted by unintended pregnancy:

- Young and impoverished women
- Women with an annual household income below 200% of the federal poverty level
- African American and Hispanic women
- Low-income women without contraceptive health insurance coverage (who are twice as likely to have an unintended pregnancy) (Michigan Department of Community Health, 2007).

***National, state and local data paints a picture of unintended pregnancy***

Secondary data analysis was done on publicly available datasets. Measurements of pregnancy intention and rates are typically measured through national surveys:

- Pregnancy Risk Assessment Monitoring System (PRAMS)-the PRAMS data is collected retrospectively (2-3 months after delivery) at national, state, and county levels, and asks about maternal attitudes and experiences before, during, and shortly after pregnancy.
- National Survey of Family Growth (NSFG)-the NSFG gathers information on family life, marriage and divorce, pregnancy intention within five years of infant's birth, infertility, and use of contraception.
- National Maternal and Infant Health Survey (NMIHS)-the NMIHS is a self-administered survey which collects data on socioeconomic and demographic characteristics of mothers, prenatal care, pregnancy history, and occupational background, health status of mother and infant, and types and sources of medical care received.
- The Colorado Health Information Dataset (CoHID)–CoHID is an interactive data system from the Colorado Department of Public Health and Environment including birth, death, population, behavioral risk factors, and pregnancy statistics.

***National Data***

The national data around unintended pregnancy is important to consider, as it provides a context for examining the issue and helped to identify key areas upon which to focus this research. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, 82% of pregnant teens reported their pregnancy as unplanned in 2001. (See Table 1) While across the country, the teen birth rate declined every year from 1992 to 2005, resulting in a total decline of 34% over these years, it did increase slightly (by 3%) in 2006 and again in 2007. This increase reinforces the need for vigilance to ensure that previous successes in reducing the teen pregnancy rate are not lost and that the downward trajectory continues.

**Table 1. Proportion of Unplanned Pregnancies by Age Group, 2001**

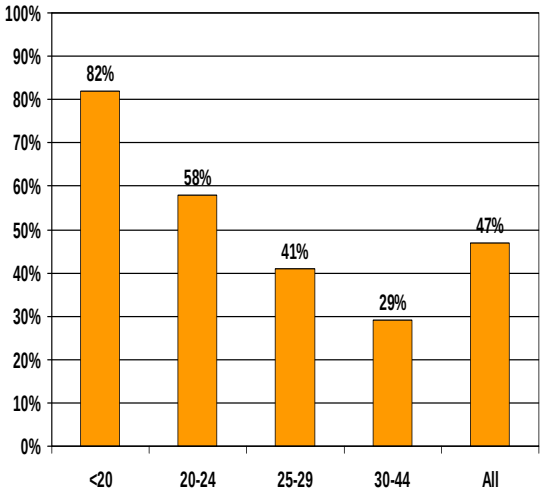
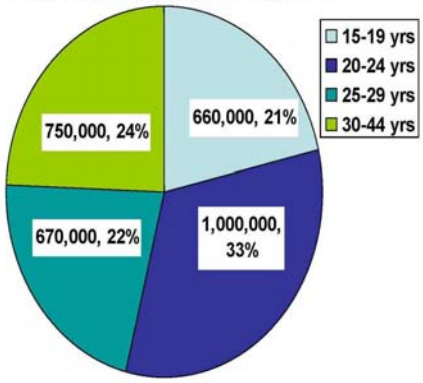


Figure 1: Number and Percent of Unplanned Pregnancies by Age Group, 2001

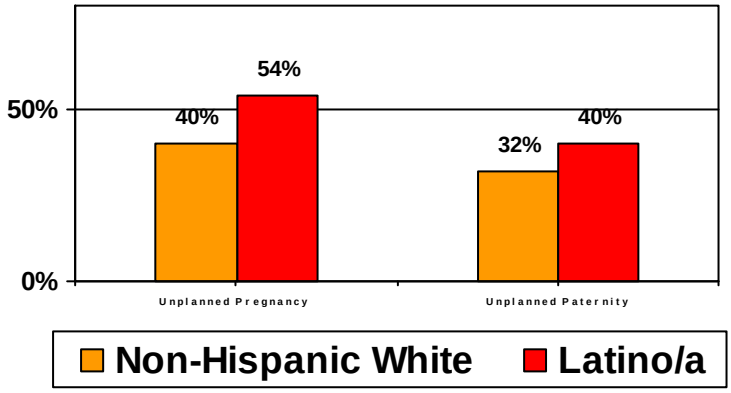



Teen pregnancies constitute approximately 20% of all unplanned pregnancies, but the data evidences that unintended pregnancy is not just a teen issue. Another 33% of unintended pregnancies are attributable to women aged 20-24 years, and approximately 77% of all unplanned pregnancies are to women aged 29 years and younger. (See Figure 1)

While the impact and consequences of teen pregnancy are significant, it will be important for Boulder County to consider the 20-24 year old population as well when developing programming to reduce the overall burden of unintended pregnancy, as this age group contributes the largest proportion of unintended pregnancies.

An additional layer to an already complex issue is seen in the data that points to a higher burden of unintended pregnancy and paternity occurring in the Latino population. From the 2001 data on unintended pregnancy, the proportion of unplanned pregnancies to Latina women were reported as 54%, which is significantly higher than the 40% reported by non-Hispanic white women. (See Table 2) However, the burden is not limited to the female population, as evidenced by the estimate of 40% of unplanned pregnancies reportedly fathered by Latino men, compared to 32% reportedly fathered by non-Hispanic white men.

**Table 2. Proportion of All Pregnancies that are Unplanned by Race/Ethnicity, 2001**




***Changing demographics in Boulder County***

Before being able to examine things such as impressions of unintended pregnancy and paternity, factors that might prevent the problem, and its social, cultural, and economic aspects, we first had to understand the changing demographics in Boulder County and consider the impact this may have on the current base of knowledge. Boulder County is a diverse county of an estimated 293,000 residents, with both urban communities across Boulder, Longmont, Lafayette, Louisville, and smaller rural communities in Lyons,

Nederland, Ward, Jamestown, Superior, Erie, and unincorporated Niwot, Gunbarrel, and Allenspark. The county is growing and changing, particularly outside of the City of Boulder, an area approaching development "build-out" which limits future building. Across the county, the population has increased almost 40% in the last 20 years. Boulder is still considered the largest city in the county, but is followed closely by Longmont, which has grown 15% since 2000.

The county has long been considered dissimilar to other counties in Colorado due to the large proportion of the population that is white and highly educated. It is estimated that 94% of Boulder County residents are high school graduates. The racial/ethnic makeup of the county is estimated at 87% White, 12.8% Latino, and about 10% a combination of other races; however, this breakdown varies greatly by community. For example, an estimated 20% of Lafayette and Longmont are Latinos. About 16% of people in the county report speaking a language other than English at home. Approximately 12% of individuals and 6% of families report incomes below the Federal Poverty Level (The Community Foundation, Boulder County, 2007).

***Measures of unintended pregnancy and local data sources***

The following indicators were used to measure unintended pregnancy in Boulder County:

- Births and pregnancies to 18-24 year olds
- Teen births and pregnancies to 15-17 year olds
- Fetal deaths/miscarriages
- Induced terminations of pregnancy
- Shorter pregnancy intervals, defined as less than twelve months between pregnancies.

Timing is a key factor in determining intendedness, as pregnancies that are too closely spaced are often unintended (Mahoning County District of Health).

***Measuring unintended pregnancy proves to be difficult***

Among the potential measures of unintended pregnancy that are mentioned above, there are reporting issues and reliability challenges that make it difficult to accurately measure the problem. The specific data limitations outlined below are just some of the factors that prevent state demographers and statisticians from including abortion and miscarriage data in their overall estimates of fertility rate. As a result, the Colorado Health Information Dataset provides a fertility rate which includes birth data only.

- Abortions (induced terminations of pregnancy): It is estimated from national statistics that nearly half of unintended pregnancies end in abortion. However, obtaining the exact number of abortions performed has proven difficult as it has long been considered to be an underreported event. In the State of Colorado, there has also historically been a lack of resources from a state level to enforce the

reporting requirement. Fortunately, due to increased resources over the past 5 years, reporting of abortions has been relatively stable. However, it has not yet been determined if the data is complete both in terms of specific providers (whose information is not captured) and in geographic distribution around the state. Currently, providers are informed that reporting is required, but the process is passive in nature. Non-reporting may be due to a lack of resources from the providers to complete and submit reports, lack of education among providers regarding reporting requirements, and/or intangible barriers such as fear among providers of reprisal from the community.

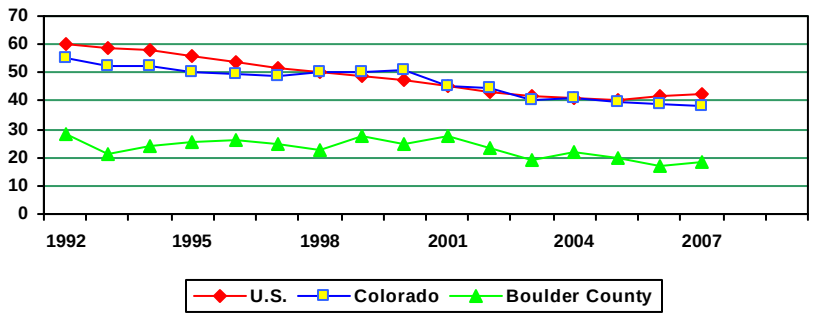
- Fetal Deaths / Miscarriages**:** The National Survey of Family Growth estimates about 1 million fetal losses per year in the United States, with the vast majority of those occurring before 20 weeks of gestation (Ventura 2008). However, there is evidence of underreporting of fetal deaths prior to 20 weeks gestation (MacDorman 2009). Therefore, estimates of fetal death data are to be used with caution. One reason for non-reporting may be the number of miscarriages that occurs without the mother's knowledge, particularly in the earliest stages of gestation. Due to the issue of underreporting of fetal deaths in the early stages of gestation, vital statistics fetal death data are generally presented (at national and state levels) for fetal deaths of 20 weeks of gestation or more.

Shupe et al, in their 1998 Boulder County baseline unintended pregnancy assessment, underscored the fact that special data collection efforts are needed in order to paint a picture of unintended pregnancy at a local level. They concluded that the use of local data on unintended pregnancy was necessary for two reasons. First, relying on national estimates could result in the misidentification of risk groups, and second, without local data, the contribution of regional intervention efforts to declines in unintended pregnancy rates could not be measured (Shupe, Smith, Stout, & McLaughlin, 2000).

***Colorado and Boulder County unintended pregnancy rates***

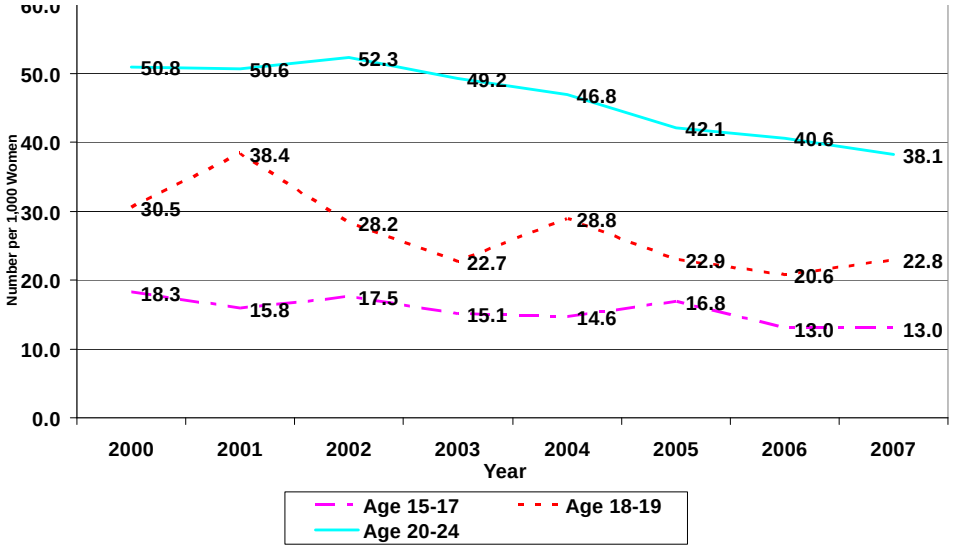
The teen birth rate in Colorado has followed a downward trend in recent years, similar to the national trend (see Table 3). In Boulder County, there was a slight increase in the teen birth rate in 2007 relative to 2006 rates, but they were still among the lowest they have been since 1990.

**Table 3. Teen Birth Rates, Unites States, Colorado, and Boulder County 1992-2007.**



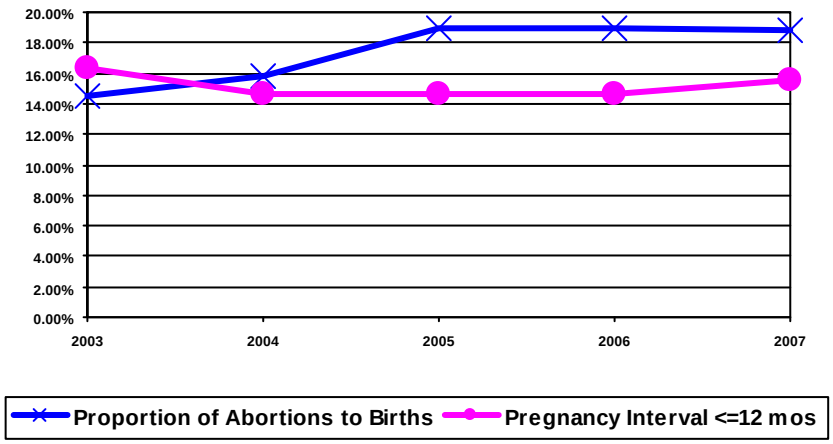
Further, even within the slight increase in 2007, the data shows that the rate among 15-17 year olds remained stable and the slight increase was attributable to teen births among 18-19 year olds (see Table 4). When comparing county and state rates, Boulder County has consistently had teen birth rates lower than those across Colorado.

**Table 4. Birth Rates Among Young Women, Boulder County, 2000-2007**



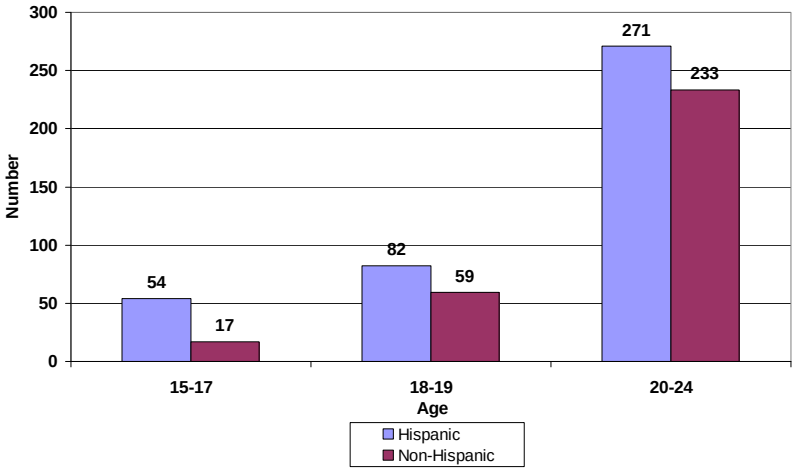

Regarding some of the additional measures that were considered possible indicators of an unintended pregnancy, such as the proportion of abortions to births in Boulder County and pregnancy intervals less than 12 months, the limited data available indicates that the frequency of these events has stabilized in recent years. (See Table 5) However, it also should be noted that prior to 2003 the abortion data for the State of Colorado was not considered very reliable due to an elimination of funding for reporting systems in 1995. Beginning in 2002, there have been collaborative efforts at the state level to improve the reporting system in Colorado, and while the true rate of abortions is not guaranteed, it is believed that improved reporting will increase the reliability of trend data.

**Table 5. Proportion of Abortions to Births and Pregnancy Intervals, Boulder County, 2003-2007**



Where Boulder County shows the greatest disparity is in birth rates by ethnicity. Hispanic women account for more births in Boulder County than Non-Hispanic white women (see Table 6). This disparity is greatest among the 15-17 year olds, and while the disparity becomes smaller in the older age groups, the disparity still holds among 18-19 and 20-24 year olds.

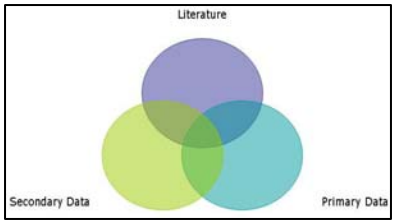
**Table 6. Number of Births to Young Women by Ethnicity, Boulder County, 2007**




This disparity is emphasized further in the Preliminary 2007 data from the 2007 Youth Risk Behavior Survey (YRBS), which indicates that Hispanic students in the Boulder Valley School District are more likely than White, non-Hispanic students to have been pregnant or fathered a baby. The rates were statistically significant with 1.3% of the White, non-Hispanic respondents reporting an unintended pregnancy/paternity compared to 8.3% of the population that identify themselves as Hispanic, any race

## IV. METHODOLOGY

### *Overview*




The research methods for this study were interdependent. The research activities included quantitative and qualitative data collection among a diverse group of young men and women, as well as their immediate social network, health care and social service providers, and key stakeholders. We accessed experiences of a diverse group, including geographic and racial/ethnic diversity, with sensitivity to age- and income-related strengths and challenges. The social, cultural, mental health, and economic aspects of unintended pregnancy/paternity were primarily explored through focus groups with the target population and also, to some extent, through key informant interviews with stakeholders.

Five primary sources of information were used to address the study's goal and objectives:

- secondary quantitative data review (i.e. existing data)
- secondary qualitative data review (i.e. existing data)
- literature review (i.e. existing data)
- primary qualitative data collection via focus groups with various segments of the target population (i.e. new data)
- semi-structured interviews with key stakeholders across Boulder County (i.e. new data)

The research plan was designed to build upon Boulder County's strong history of community cooperation and activism. The methodology described below was intended to spark systematic analytic thinking on the causes and consequences of unintended pregnancy, in order to assist BCPH in identifying the most effective use of local prevention resources aimed at multiple levels of the community, such as within the health care system, social service programs, educational system, public health programs, and policy development.

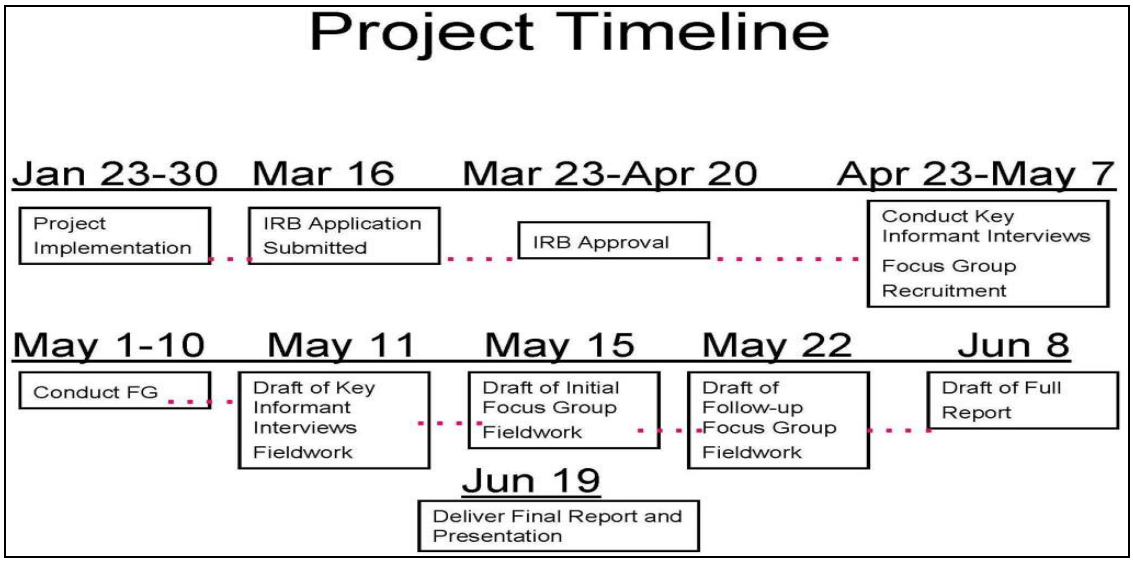
***Steering committee***

The Unintended Pregnancy Research Steering Committee for this project consisted of a diverse group of members representing Boulder County Public Health, the Colorado Department of Public Health and Environment, NARAL Pro-Choice America, Boulder Valley Women's Health Center, Colorado Organization on Adolescent Pregnancy, Parenting and Prevention, and the Pueblo City and County Health Department.

The committee was brought together to help monitor and evaluate the research process, with the goal of ensuring quality completion of the scope of work. In order to promote the integrity and effectiveness of this steering process, as well as to protect the overall interests of Boulder County, each participant was responsible for participating in monthly meetings as scheduled to collaborate with fellow committee members on establishing the working definitions for this project, as well as participating in the iterative process of developing tools and strategies.

***Study timeline***

JSI and BCPH initiated the study on January 23, 2009 with an end date of June 18, 2009. As can be seen by the graph below (see Figure 3), the timeline was quite short, particularly for this type of study, which made the input and guidance of the Steering Committee invaluable in order to assist the research team in strengthen the overall methodology.




***Institutional review board***

Before most research studies can begin, approval by an external committee known as an Institutional Review Board (IRB) must be obtained. The IRB reviews the research to make sure it is well designed, that the risks are as low as possible, and that these risks are reasonable when compared to the possible benefits of the research.

A protocol and application to research unintended pregnancy and paternity in Boulder County was developed and submitted to the Colorado Multiple Institutional Review Board (COMIRB) for their approval (Appendix A). The research was approved under an expedited review process based on the minimal risk that is posed to human subjects. IRB approval was granted prior to the recruitment and primary data collection described below.

The process of conducting IRB-approved research helps ensure respectful interaction with research participants within a clearly defined protocol, as well as regulates consistency in recruitment, screening, and informed consent processes. Focus group discussions and key informant interviews were conducted within the structure of an approved set of questions, further ensuring consistency and participant protection.

One limitation of this particular IRB review was that recruitment strategies were restricted to passive recruitment methods, meaning that the research could be advertised via flyers, but that potential participants could not actively be approached with information about the study.

***Secondary data collection and literature review***

The quantitative and qualitative secondary data review, using publicly available datasets such as surveillance data, needs assessment data, and epidemiological profiles of national and local incidence and prevalence trends, provided the information necessary to profile the extent of the burden and disparity of unintended pregnancy and paternity by detailing trends in causes and consequences of unintended pregnancy.

The types of questions that were considered in the analysis of unintended pregnancy and paternity measures of the Boulder County data included:

- Do the indicators show an increase or decrease in unintended pregnancy?
- How do measures for Boulder County compare to state and national measures?
- Do trends reflect the age profile, income levels and / or racial and ethnic diversity of the county?

The literature review provided information on existent research related to risk factors, determinants, as well as successful prevention of unintended pregnancy and paternity, and helped to identify particular data trends and gaps. The focus of the literature review was on obtaining the appropriate breadth and depth, rigor and consistency, clarity and brevity, and effective analysis and synthesis. The concepts from the literature were used to structure the research approach.

***Primary data collection***

Beyond the secondary quantitative and qualitative data review of public data to provide an epidemiologic perspective of unintended pregnancy and paternity and its risk factors, primary data was collected via focus groups among 15-24 year olds within Boulder County, as well as interviews with key informants across Boulder County, the Denver metro area, and beyond.

The qualitative primary data collected through the focus groups provided information related to behaviors, attitudes, beliefs, and trends among individuals who had experienced an unintended pregnancy and paternity that resulted in the decision to parent. The focus group findings can help inform the design of effective programs because they are based on the theory of social interaction, and explore the depth of understanding and motivations. Further, the focus group format was chosen because of its ability to generate data that could identify the scope of issues important to the target population.

The qualitative primary data collected through key informant interviews was useful in exploring issues for the purpose of program planning and implementation, especially motivation, behavior, and perspectives of clients and community partners. Further, key informant interviews are an important aspect of qualitative data collection when the aim is to generate recommendations for programs/services to address a particular health issue.

***Focus group methodology***

The target population for these focus groups included 15-24 year old men and women living in Boulder County who had either experienced or fathered an unintended pregnancy that resulted in parenting. While there are other target populations to explore regarding issues related to unintended pregnancy, such as those who choose abortion or adoption and those who have successfully prevented pregnancy, this research focused specifically on those who chose to parent.

***Sampling and recruitment strategy for focus groups***

Because the aim of the research was to understand the experience of unintended pregnancy and paternity to various population groups, in particular how culture and social context affects their experience, the research team decided that theoretical sampling methodology would be appropriate. Theoretical sampling procedure dictates that the researcher choose participants who have experienced or are experiencing the phenomena under study, i.e. unintended pregnancy. By doing so, the researcher has chosen 'experts' in the phenomena who are thus able to provide the best data available (Strauss & Corbin, 1998; Glaser & Strauss, 1967). "Theoretical sampling is cumulative" (Strauss & Corbin, 1998, p. 203). Each interview provides the researcher a slice of data on which he or she can build. Iterative analysis of the collected interviews throughout the data collection process allows the researcher to see the emerging patterns, categories, and dimensions (Strauss & Corbin, 1998).

According to the literature, the sampling frame is determined appropriate either when 'theoretical saturation' occurs, or 100 participants either for focus groups or semi-structured individual interviews have been recruited (Glaser & Strauss, 1967; Strauss & Corbin, 1998), a number concurred by the Steering Committee as the maximum number of participants. Theoretical saturation occurs when:

> (a) no new or relevant data seem to emerge regarding a category,
> (b) the category is well developed in terms of its properties and dimensions demonstrating variation, and
> (c) the relationships among categories are well established and validated. (Strauss & Corbin, 1998, p. 212).
> In other words, the researcher continues expanding the sample size until data collection (e.g. focus group participants or interviews) reveals no new data (Burgess, 1989).

While following this methodology, the sampling frame for this research addressed the geographic and racial/ethnic distribution of the 15-28 population in Boulder County. It is generally agreed in the literature that, in order to obtain an adequate focus group size, one should over-recruit by at least 50%. Therefore, if a group of 6 participants is desired, the recruiter should confirm participation of at least 12 participants. This recruitment method aims to accommodate for no-shows and cancellations. The study team found through the literature review that one and half times more Latina/Latino participants would need to be recruited in order to ensure an overall valid sample from the population group, so the recruitment strategy would oversample this group.

In order to meet Institutional Review Board (IRB) guidelines, focus group participants were recruited from the community using a convenience sampling technique, which included displaying posters located in various community sites serving the target population and encouraging interested participants to call for more information. Specific recruitment locations included - but were not limited to - Boulder County Public Health program offices (e.g. Vital Records, Immunization Clinics, GENESIS Teen Parenting, Addiction Recovery, and WIC), preschool and daycare organizations, recreation centers, community health centers, teen clinics, and low-income housing bulletin boards. The

recruitment techniques yielded a total of 8 focus groups, for a total of 37 male and female participants.

Three versions of the recruitment flyers were developed in two different languages, English and Spanish: one targeting young women, a second targeting young men, and a third considered gender-neutral (Appendix B). An anonymous telephone screening process was completed to determine eligibility for anyone interested in participating in a focus group discussion (Appendix C). Eligibility criteria consisted of a male or female Boulder County resident between the ages of 15-24 who had been experienced unintended pregnancy and paternity.

Potential participants who met eligibility criteria were given further details about time, date, and location of the appropriate focus group and asked if they would like to participate. Participants were offered child care and transportation assistance, if necessary, in addition to the food and a $30 cash incentive, provided to all participants at the time of the focus group discussion. Participants who agreed to participate were asked to provide their first name and either an e-mail address or phone number for the purpose of providing reminders prior to the focus group. Researchers used a tracking sheet to assign participants to focus groups based on age and gender, as well as to track requests for child care and transportation in order to ensure that appropriate resources were made available.

Focus groups were conducted in a variety of easily accessible locations within Boulder County, including the Boulder County Public Health campus, the Longmont Youth Center, the Longmont Recreational Center, and the Lafayette YMCA.

At the start of the focus group, all participants were given the assent form (15-17 year olds) or consent form (18-24 year olds) to read. A waiver of parental consent was obtained from COMIRB for the 15-17 year old participants, because it was felt that obtaining parental consent could hinder the participation and quality of data collected, due to the sensitive nature of the questions. The focus group facilitator then reviewed the content of the consent form, answered any remaining questions, and then signed the form, along with the participant.

Once assent/consent had been obtained, a Pre-Discussion Questionnaire (Appendix D) was administered to each and every focus group participant. This questionnaire collected demographic data, as well as attitudinal data around birth control utilization. This anonymous questionnaire was collected prior to the focus group discussion and not linked back to an individual participant in any way. An IRB-approved discussion guide provided the set of available questions for the focus group discussion (Appendix E). Discussions were recorded and transcribed before the audiotapes were destroyed. Participants agreed to be audiotaped as part of the consent process and were asked not to use names or identifying information during the recorded discussion. Immediately following the focus group discussion, participants were asked to sign their first initial and last name to a tracking sheet, for accounting purposes, in exchange for their $30 cash incentive.

Audio recordings of the focus group discussions were transcribed and then analyzed for recurring themes. Male and female group transcriptions where analyzed separately in order to identify common themes among each cohort. Most commonly reported themes in the literature were identified prior to conducting the focus groups and used as a starting point for analysis. Additional themes that emerged from the focus groups that had not previously identified were also included in the written summary (Appendix G).

Data from the Pre-Discussion Questionnaire were entered into an automated survey tool for analysis purposes. Male and female questionnaires were analyzed separately in order to identify common themes among each cohort.

***Key informant interview (KII) methodology***

The stakeholders targeted for the key informant interviews included youth service program providers, health care and social service providers, and other key stakeholders identified by the BCPH staff.

The research team proposed a preliminary list of organizations and potential interviewees to the Steering Committee. Names and contact information were then added at the request of Steering Committee members until the list was considered to be representative of the necessary key stakeholders. Potential key informants were then contacted via phone and/or email and provided with an overview of the research project and a request to participate in an interview.

Prior to all interviews, each interviewee received a copy of the key informant interview consent form. After clarifying any and all questions and assuring that each interviewee had an understanding of the study's purpose, both interviewee and interviewer signed the consent form. Researchers tracked the completion of consent forms and interviews. No financial incentives were provided to key informants for their participation in this research.

Interviews were conducted by phone, except in a few cases where a face-to-face interview was requested. Each interview was conducted by two members of the research team: one to lead the interview process and a second to assist with note taking. The interviews were guided with an IRB-approved set of questions around topics (Appendix H), such as access to reproductive health care and barriers to contraception use.

Interview notes where analyzed to identify common themes. The analysis includes a summary of commonly reported themes, as well as the complete spectrum of prevention strategies suggestions solicited during the interview process (Appendix I).

***Data management and analysis***

Key informant interviews were documented via typed notes captured during the interview process. A summary of interview findings was developed in order to eliminate the potential for specific responses to be linked to any particular individual. All focus groups were audio recorded, and consent to be audio taped was obtained during the initial consent process with each participant. Study participants were advised not to use names

or other identifying information during the discussion. Reference to personally identifying information was deleted when audio tapes were transcribed. Upon completion of the research project, all audiotapes will be destroyed.

The research team used an iterative analysis process whereby the researcher moves back and forth through the data in order to find, compare, and verify the patterns, concepts, categories, properties, and dimensions of the phenomena (Strauss & Corbin, 1998). Although review of the transcripts was an ongoing process during the focus groups, the main process of analysis was carried out when data collection was completed. A 'framework' technique developed by the National Centre for Social Research was used (Ritchie & Spencer, 1994). The first four steps of this technique were employed primarily to order and manage the data:

1. familiarization;
2. identifying a thematic framework and developing a coding structure;
3. indexing (applying codes (Appendix F) systematically to the data);
4. charting (rearranging the data according to the thematic content).

The codes were themes derived from the topic guide, points of interest for the researchers, and other important thoughts identified from the initial readings of the transcripts. The six transcripts were then coded. The team met to review the coded transcripts to reduce bias among the researchers. Finally, the transcripts were analyzed according to themes.

The following strategies were employed to enhance the validity of the primary qualitative data collection:

- The literature review and secondary data review was used to dis/confirm focus group and key informant interview findings;
- Any inconsistencies among the primary data collected were triangulated with the findings with other data sources; and
- Findings were dis/confirmed by soliciting reactions from the research team to the drawn conclusions.

***Methodological considerations***

There are some limitations to consider with this study. Women often informally discuss their personal feelings about the timing of the pregnancies, such as:

- whether a baby came a bit too early;
- whether a pregnancy occurred at a time when it interfered with future plans but would have been wanted at a later time;
- whether a baby had been desperately south for several years; or
- whether a pregnancy was not wanted at any time.

Overall, it is difficult to quantify people's feelings about a pregnancy and sort them into categories that hold comparable meaning over time and across varied social groups (Brown & Eisenberg, 1995).

Furthermore, general focus group data can not be generalized to other populations or communities; specifically for this study, the small sample size and the focus on Hispanic mothers and fathers experiencing unintended pregnancy resulting in parenting has the potential for impacting the interpretation of the results. Additionally, there may be bias in the participants' responses due to the following issues:

- Social pressure, particularly with the sensitivity of this topic;
- Focus group participants were asked to reflect on the circumstances of their pregnancies/paternities. It is possible that by the time they participated in the focus group discussions, they may have recast their thoughts and feelings in light of the pregnancy and subsequent birth; and lastly
- The passive recruitment strategy, described in the IRB section, may have impacted the representation of study participants.

These potential limitations may have had some impact on the participants' selection to participate in the focus group and responses to questions. Observations of the participants and their interaction with the facilitators, however, seemed to indicate that the participants felt comfortable discussing this topic under the circumstances. In addition, the participants' responses were not inconsistent with findings in the literature, which further supports the minimal impact of these limitations on the results.

## V. RESULTS/FINDINGS

The major findings from the analyzed transcripts of the six focus groups and twenty-eight KIIs have been categorized in a manner to help inform future primary and secondary prevention strategies for unintended pregnancy. The categories for the focus groups are impact of pregnancy/paternity, pregnancy definition, knowledge and use of contraceptives, emergency contraception, social consequences of parenting, bond/relationship with child, life circumstances post-birth, sources of support, and prevention programs. KII categories include defining unintended pregnancy; why unintended pregnancy/paternity happens, access to reproductive health services, emergency contraception, and prevention programming.

### *Focus Group Findings*

Focus groups were held in a variety of locations across Boulder County, specifically in the cities of Boulder, Longmont, and Lafayette, with the largest groups held in the Longmont locations. A total of 43 individuals completed the eligibility screening process, of whom 42 men and women were eligible. Of the 37 participants who subsequently participated in the focus groups, a majority of individuals were in the 18 – 24 year age range (81%), of Hispanic race/ethnicity (76%), and living at lower than 100% of the Federal Poverty Level (100% of all who provided income data, 46% of all participants). Table 7 provides the sampling frame for this research. In addition to providing detail on how focus group distribution was designed to address the geographic and racial/ethnic distribution of the 15-28 year old population in Boulder County, it also provides information as to the recruitment goals and actual number of participants. Due to the relatively small number of participants between the ages of 15-17 years (6 women and 1 man), focus group members were not stratified by age as originally planned.

**Table 7. Focus Group Characteristics for the Proposed Sampling Framework and Participants**

| Group | City/Town | Gender | Age Group | Race/Ethnicity | Language | Recruitment Goal | Actual # of Participants |
|---|---|---|---|---|---|---|---|
| 1 | City of Boulder | Female | 15-17 | Caucasian/Latina | English | 12 | 0 |
| 2 | City of Boulder | Female | 15-17 | Latina | Spanish | 12 | 0 |
| 3 | City of Longmont | Female | 15-17 | Caucasian/Latina | English | 12 | 6 |
| 4 | City of Longmont | Female | 15-17 | Latina | Spanish | 12 | 0 |
| 5 | Lafayette/Erie | Female | 15-17 | Caucasian/Latina | English | 12 | 0 |
| 8 | City of Boulder | Female | 18-24 | Caucasian/Latina | English | 12 | 1 |
| 9 | City of Boulder | Female | 18-24 | Latina | Spanish | 12 | 0 |
| 10 | City of Longmont | Female | 18-24 | Caucasian/Latina | English | 12 | 18 |
| 11 | City of Longmont | Female | 18-24 | Latina | Spanish | 12 | 0 |
| 12 | Lafayette/Erie | Female | 18-24 | Caucasian/Latina | English | 12 | 1 |
| 13 | City of Boulder | Male | 18-24 | Caucasian/Latino | English | 12 | 0 |
| 14 | City of Longmont | Male | 18-24 | Caucasian/Latino | English | 12 | 9 |
| 15 | Lafayette/Erie | Male | 18-24 | Caucasian/Latino | English | 12 | 1 |
| 16 | City of Longmont | Male | 15-17 | Caucasian/Latino | English | 0 | 1 |

In order to remain cognizant of the sensitive nature of discussing sex, pregnancy, and birth control among people of different ages, races, and backgrounds, the consent process explained to participants that their participation was voluntary and they maintained the right to stop at any time. It should be noted that no participants exited the discussion prior to its conclusion. In addition, there were no significant differences in pre-discussion questionnaire responses between those aged 15-17 years and those 18-24 years of age, further supporting the decision to combine the age groups in each discussion.

The following demographic information (Table 8) was obtained from the confidential pre-discussion questionnaire completed by each participant prior to the focus group discussion. As the table illustrates, the majority of the focus group participants were between the ages of 18-24 years. The overall median age of female participants was 19 years old and for male participants the median age was 20 years old. 73% of female participants and 82% of male participants reported their race/ethnicity as Hispanic/Latino and of those; all but one individual reported their country of origin as the United States. More than half of all participants described their relationship status as either married or in a committed relationship with one person. Of those participants who provided income status (approximately half of all participants) all were below 100% of the Federal Poverty Level. And lastly, more women than men (27% versus 9%) reported some college or vocational training beyond high school.

**Table 8: Demographic Characteristics of Focus Group Participants, Boulder County Unintended Pregnancy Research Project**

| | Female Participants (N=26) | Male Participants (N=11) |
|---|---|---|
| **Age** | | |
| 15-17 years | 6 | 1 |
| 18-24 years | 20 | 10 |
| **Race/Ethnicity** | | |
| White or Caucasian | 5 (19%) | 2 (18%) |
| Black or African American | 2 (8%) | 0 |
| Asian | 0 | 0 |
| Hispanic/Latino | 19 (73%) | 9 (82%) |
| American Indian or Alaska Native | 0 | 0 |
| No Response | 0 | 0 |
| **Country of Birth** | | |
| United States | 20 (74%) | 10 (91%) |
| Mexico, Spain, Central America or South America | 5 (19%) | 1 (9%) |
| Other | 1 (5%) | 0 |
| **Marital Status** | | |
| Married | 5 (19%) | 3 (27%) |
| Single, not in a relationship | 6 (23%) | 4 (36%) |
| Single, in casual relationship with several partners | 0 | 2 (18%) |
| Single, in committed relationship with one partner | 15 (58%) | 2 (18%) |
| **Income Level** | | |
| <100% Federal Poverty Level | 13 (50%) | 4 (35%) |
| No Response | 13 (50%) | 7 (65%) |
| **Insurance Status** | | |
| Private | 1 (4%) | 0 |
| Medicaid | 15 (55%) | 0 |
| Other Government Coverage | 1 (4%) | 1 (9%) |
| Uninsured | 3 (11%) | 7 (64%) |
| Student | 1 (4%) | 1 (9%) |
| Prefer Not to Answer | 5 (19%) | 2 (18%) |
| **Education Level** | | |
| Some school but no diploma | 8 (31%) | 4 (36%) |
| High School or GED | 11 (42%) | 6 (55%) |
| Vocational/Technical Training | 1 (4%) | 0 |
| Some College or Associate Degree | 6 (23%) | 1 (9%) |

***Recurring themes in the focus groups***

Across all the focus groups conducted, the following consistent themes arose (these are highlighted below):

- Before the pregnancy, there was not much thought or worry about whether pregnancy would occur.
- Pregnancy and parenting were harder than expected.
- There was an increased propensity to use birth control after the pregnancy.
- There was a desire/need for more knowledge around birth control options and their proper use.
- Barriers to preventing pregnancy were less about cost and availability and more about making it a topic of conversation with parents, peers, and partners.
- Parenting provided a strong motivation to improve their educational, emotional and financial circumstances.

These themes, and more, are discussed in more detail below and enhanced by direct quotes of focus group participants.

## *IMPACT OF PREGNANCY AND PATERNITY*

***Emotional/psychological***

Unintended pregnancy takes place within a complicated web of peer pressure, life aspirations, and notions of romance that shape an individual's decisions about sex, contraception, and pregnancy.

> *"I took, like 4 pregnancy tests, I couldn't believe it. I just kept looking at it and then put it away. I'd wake up in the morning and look at it again and that little line just didn't go away."* [female participant]

The literature tells us that certain groups of adolescents, such as those who are in the foster care system or suffer from depression, have particularly high rates of unintended pregnancy. Additionally, there is research that shows that many unintended pregnancies were preceded by sexual abuse or nonconsensual sex. Two focus group participants opened up about their particular experiences by describing the unfortunate circumstances that surrounded their pregnancies. One told us, *"I had an interesting emotional problem. I ended up in a mental hospital for being suicidal."* [female participant] Another disclosed that,*" My son is not my husband's, I was raped for my first son."* [female participant]

Furthermore, several participants expressed the primary impact from the pregnancy was not being able to do the same things they were used to. Some women experienced a feeling of isolation and depression during their pregnancy, particularly if the pregnancy was a result of non-consensual intercourse.

> *"I didn't want to be pregnant. I didn't know anyone who was pregnant. I didn't know what to expect. I kept to myself a lot, didn't want people know what happened. Everything turned out for the best. When I was pregnant I was sad all the time, I was suicidal."* [female participant]

*"I probably would have been done with school. I would have graduated with my class."* [female participant]

However for several participants, the pregnancy seemed to have a positive affect on many of the girls, in that they would have continued many risky behaviors (drinking, smoking, drugs) if they had not become pregnant.. Comments like, *"If I didn't have my boy then, I wouldn't be where I am now. I would still be drinking and partying and being a teenager"* [female participant] were common. They described their actions as having been driven by boredom and that they were trying to find new things to do, but they acknowledged that these behaviors "were getting out of hand." Many women described feeling the baby kick as a 'wow' moment, at which they resolved to improve their behavior.

***Family relationships***

The effect that unintended pregnancy had on familial relationships varied from person to person. Some participants experienced disappointment from family members who said things like the baby was going to treat them the same way they treated their own parents. Fortunately for the young mothers, some unsupportive family members eventually changed their attitude. One participant explained, *"They grew into it, life after you have the baby it's a different story. They love you and they love the baby."* [female participant]

Others experienced supportive family members from the beginning, particularly if their parent had been through an unexpected pregnancy him or herself. Some male participants expressed support and encouragement from their family. One participant said his brother tells him, *"You can do it [be a good father]… it's all about communication."* [male participant]

*"My mom told me, 'I'll be behind you no matter what you decide to do. If you decide to get an abortion or keep the baby, I'll be there for you to help you through it. But I'm not the parent, you are, so you aren't just going to leave your baby with me.' She helped me a lot through it."* [female participant]

*"My dad actually helped me when I got morning sickness."* [female participant]

***Friendships***

When asked about how friendship may or may not have changed as a result of the pregnancy, participant's most common responses were: 1) that they could no longer go out and have fun with their friends, and 2) that friends were disappointed that they could no longer party with them.

*"Sometimes when you're pregnant you lose all your friends."* [female participant]

In contrast, however, some participants also responded *"Most of my friends have babies already, so pretty much it was just like 'whatever'." [ female participant]*

### *DEFINING THE PREGNANCY*

When talking to the female and male focus group participants and trying to define what a planned pregnancy meant to them, the participants agreed that a *planned pregnancy* signified one that was premeditated. Some girls felt that they were not capable of planning their pregnancy because "*a baby is a baby.*" For one participant, planning a pregnancy happened, "*…when people already have their shit set like an apartment or married. I got married when I was twelve or thirteen but it wasn't a planned pregnancy for us.*" [female participant] One male participant stated, "*I don't believe that there is a planned pregnancy. If it's your first baby, no two people are ever really ready.*"

On the other hand, *unplanned pregnancy* was defined as a situation in which either they were not thinking about it or did not have a choice about it. Many described it as, "*I wanted to get pregnant someday, but not now.*" [female participant]

*Defining the Pregnancy:*

*"Unplanned"*
*"Unexpected"*
*"Oops"*
*"Surprise"*
*"Mistimed"*

*[male and female focus group participants]*

This said, when asked about using the term *unintended* versus *unplanned*, many women did not know exactly what was meant by *unintended*. Some associated it with a pregnancy that resulted from a one-night stand. One participant described it as, "*They don't really know the man and they're like, 'Oh yeah, I'm pregnant.*" [female participant] Other terms, such as *unwanted*, also seemed to carry very negative connotations.

#### *Attitudes toward pregnancy*

Prior to their own pregnancy, many of the focus group participants said they viewed other pregnant girls as "sluts." However, their opinions changed after they discovered that they were pregnant themselves. They realized they could not say those things anymore and no longer gossiped about other pregnant girls. *"When you go to school and see the girls are pregnant, you used to be like, 'did you see who was pregnant?' and now you can't do that because you're like, 'so am I'."* [female participant]

## *KNOWLEDGE AND USE OF CONTRACEPTIVES*

### *Discussing sex/prevention with partner*

Most female participants thought that if they were comfortable being naked in front of their partners, then they could talk about sex with them. However, they mentioned that men were easily excited and once they were at that point, the girls could not talk to them.

> *"Yeah, we talked about it. And I was on Depo but then stopped."* [female participant]

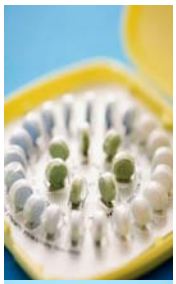
### *Contraceptive responsibility*

Most female respondents felt that it was both the male and female partners' responsibility to provide and use birth control, though when it came down to taking action one young woman said, "*I've never left it to a guy.*" [female participant] While the general feeling was that men do not know a lot about birth control methods, women felt that their male partner has a responsibility to use condoms if they do not know whether or not the women is already on another form of birth control.

> *"It makes it convenient for them because most guys don't like condoms, so they figure if you're on birth control, then they don't have to worry about it."* [female participant]

However, the lack of knowledge about birth control by male partners makes it more difficult or uncomfortable for the women to talk about what method they may be using or considering using. As a result, most women in the groups mentioned not being able to talk with their partner about birth control beforehand. Some expressed that they had not used any birth control method. They expressed feeling resentful, such as "*I hate it when guys blame it on the chick like, 'Oh you should have had birth control.' Well you should have provided it! It goes both ways.*" [female participant]

The male participants echoed a similar response. The majority of the men stated that it was their own responsibility to provide the birth control in a relationship. Some participants stated that it was the responsibility of both people involved. One participant explained, "*I feel it's more of the responsibility of the guy to do it, because it is a lot easier for him to go out and get condoms than it is for a woman to go out and get the various types*." [male participant]



***Facilitators & barriers to contraceptive use***

Participants' parents' attitudes about birth control and sexual activity were sometimes barriers for women using birth control. One woman described her experience as,

"*My dad doesn't believe in birth control, because obviously it means you're whoring around, and it just gives you the chance to whore around and not get pregnant. I wanted birth control when I was 13 in case I went to a party and something happened. But he said 'No'.*" [female participant]

Another focus group participant said, "*If you can get a birth control that your parents don't know about, it's free, and you can get it, get it! That's why a lot of girls don't go in to get birth control, because they are scared of their parents."* [female participant]

Most girls stated that cost was also an issue in terms of obtaining birth control, and therefore the Longmont Teen Clinic was considered an extremely valuable resource to them. The Clinic was where most of the girls heard about or received their birth control, and girls described their access to the Clinic as, "*Why not do it? You don't even need insurance*." [female participant] While most saw the Teen Clinic as a great resource, one participant indicated that she did not know about the Clinic until someone told her about it.

> *"The Teen Clinic should make their name more heard of because I didn't know about it until my GENESIS worker told me."* [female participant]

The literature shows that healthcare providers are an important source of information for young women and can have a strong influence on their contraceptive behaviors. Participants underscored the value of providers.

> *"I think doctors should spend more time talking about birth control. Even if it's just 15 minutes, like this is what it is, this is what it's going to do to you, this is what it may cause for you. Because for them, what's that? What's 5 minutes to them for a lifetime to someone else? That right there could change someone's life. They're getting paid good money, why don't they sit there for another 10 minutes? It's not going to hurt."* [female participant]

Choice of method is the fundamental element of providing quality in family planning services. The evidence is overwhelming that if a woman receives her first choice of contraceptive method (or understands why she did not) she is more likely to continue using it. Furthermore, research shows that a range of methods, competently provided, will attract more acceptors and provide for the switching among methods that is the foundation of satisfied and sustained use (Hamby, 2008). The general consensus by the participants in the groups was that they felt able to get their first choice of birth control, if they were currently using any. It was also common to hear the women talk about the

different birth control methods they had tried before finding the one that worked best for their lifestyle.

Furthermore, the information imparted during a contraceptive method visit is very important, as it enables clients to choose and employ contraception with satisfaction and technical competence. Research has shown that a lack of information is a reason for discontinuing method use, and belief in rumors may be a deterrent to use altogether (Hamby, 2008). The common response was that women would like more information about the method that they are going to use so that they can make sure that it will fit into their lifestyle, among other considerations.

> *"But more information on what the side effects are and how well they work because a lot of people are thinking of what they are going to get and how busy they are and much time it's going to take…. So depending on how busy you are helps you decide what to get."* [female participant]

Providing information goes beyond providing written indications about a particular method.

> *"They want you to read it. And you should and I read it but it's always nice for people to explain it too. I mean, it says that you're going to have changes. But they need to explain it to you more."* [female participant]

Two participants indicated that they had needed more information about how to use their chosen method accurately.

> *"I got pregnant on birth control twice, but the second time it was my fault I think because on the pill, it says that if you miss a pill in your second week then you can just take two and continue regularly, but if you miss in your third week you gotta start a new pack. But nobody ever told me, so I don't know if it's my fault or what, 'cuz I was on the pill and ended up pregnant."* [female participant]

> *"And with the patch, the first time I got pregnant, it fell off in the shower and I called them and was like, it fell off, what do I do? Because I didn't want to get sick. And they asked me if it still sticks and I was like, "yeah, it sticks" so they said to just put it back on, you'll be fine, because it hadn't been off for 24 hours. So I put it back on and ended up pregnant."* [female participant]

Additionally, there was limited knowledge around some of the newer forms of birth control (e.g. Yaz), although the women had heard of heavily advertised methods (e.g. Mirena). While the women had all heard of and attended sex education classes in high school, they recalled not taking them seriously.

***Contraception use after pregnancy***
Almost always, the focus group participants were much more adamant about using birth control once they had their baby. The participants were familiar with methods such as Depo-Provera, IUDs, Implanon, condoms, and pills. The longer-term methods, such as Implanon and IUD, seemed to be the most preferred methods. Similarly, male participants expressed that their girlfriends are now on an IUD or some other form of birth control. One man stated, "*I told her that I'm not having sex with her unless she got the IUD.*"

Some participants indicated that it was easier to 'get on a method' after having the baby as their doctor talked to them more directly about using a contraceptive method.

> …"*But once I had her I thought it was way easier because they tell you at the clinic at your check up to think about what birth control you want and you just do it.*" [female participant]
>
> "*Oh I got birth control right away.*" [female participant]

While most participants indicated that they chose a different method, most of the time, a longer-acting method such as an IUD, at least one indicated that she would not change the way that she was preventing pregnancy.

> "*At the end, I'm still going to using condoms and the pull-out method. We always use condoms.*" [female participant]

***Emergency contraception***
General awareness and knowledge of Emergency Contraception (aka Plan B, EC) was inconsistent among male and female participants. Even those who said they knew what it was, expressed not learning about it until after their pregnancy. One participant thought that, "*People don't know how to get it. I know that for sure. None of my friends knew about EC. I know a lot of girls that have no idea about it.*" [female participant]

There was also confusion over how it worked - whether the pill prevented a pregnancy or terminated a pregnancy and the proper time-frame in which the pill has to be taken in order to be effective.

## *SOCIAL CONSEQUENCES OF PARENTING*
### *Life Circumstances After Birth*

***Friendships / socializing***
Many of the women in the focus groups described one of the biggest changes for them as no longer being able to do the same things they were used to and feeling alone with taking care of the child as they found it difficult to make time for friends.

One participant described it as, "*You know, it's different when the baby's still in your stomach because you carry him everywhere, but after you have him it's like 'damn, you can't do nothing.'*" [female participant]

*"You sometimes feel alone knowing you are the only one there taking care of that baby."* [female participant]

*"Not the same friends. Of course, they are still doing their thing and you're in your own little world with your boyfriend or with your family."* [female participant]

*"If I had waited 5 or 10 years, I think I would have a lot of soccer moms to hang around with. Like, that's cool."* [female participant]

Others described it as having to grow up so much faster than they planned and wanting to be able to get back to the same life that they had previous to having their baby, but they now had to think about how their decisions would affect their child.

*"I think the hardest thing was going from the point of being a teenager and having no responsibility to jumping in to being a mother and providing the meals and taking care of someone else. All this before you even had to really take care of yourself."* [female participant]

*"And having to grow up faster then you normally would. Now you have to be grown-up and an adult. So you have to figure it out."* [female participant]

*"I did want to get my life back to where it left off. But it's really hard to get stuff done."* [female participant]

Whereas the focus for the male participants was on the need to change their priorities and get a job in order to be there for their baby and have some money to provide for their baby. *"I had to drop out of school and get a job. I didn't have to technically drop out, but I had to work at Burger King, McDonald's or anywhere that would hire me, to start making money."* [male participants]

***Relationship with partner***

For many of the female focus group participants, the baby changed their relationship with the baby's father... Before the pregnancy, they could fight and leave each other, but now they know they have come to back to one another and work it out. Some said that it made their relationship stronger. Others felt it made things more stressful because of the responsibility being placed on both parents. There was resentment by some new mothers when their male partners continued to live life the way they had before the pregnancy. A few girls mentioned that they thought their boyfriends were going to start cheating on them because of the erratic way they were acting. They also admitted to being angry over how the guys still wanted to go hang out with their friends and were less willing to change their lifestyles; one girl said that the pregnancy made her relationship worse with her partner because her hormones made her a 'bitch and then he started hitting me, so everything went downhill.'

*"Well, for me I had a bad experience. He was great at first. But we got into domestic violence and that ruined a lot of things even for my baby."* [female participant]

Most girls stated that the pregnancy brought out a different side of their partner and put a lot of responsibility on both of them. As one participant put it, "There's more of an open opportunity for guys not to be involved." Another participant retold a recurring conversation with her husband, which was, *"'Hey honey, do you want to change the diaper?' and he's like 'No, I don't want to do it.' I'm like, 'Do you want to hold him and feed him?' And he's like, 'No, I don't want to do those things.'"* [female participant]

All male participants agreed that being a dad had been challenging, especially for some who indicated that their relationship with their girlfriend was not going well. Nevertheless, some participants indicated having no regrets about becoming a father and have become closer to their girlfriend. One man expressed, *"there's no regret; like first year after the baby was born was hard. And then we split up and I didn't see him for a while, like 6 months*." [male participant]

***Education attainment / job***

All focus groups spoke about the challenge of financial obligations and providing a good life for the child. Both men and women discussed the motivation to succeed that resulted from the pregnancy. Most participants expressed that they would work harder now that the baby was born. Some thought they might not have gone so far as to graduate high school if they had not gotten pregnant.

One participant said "*When you're pregnant, you realize you need to do something with your life*." [female participant] And, "*Having my kids has opened me to other things. I want to be a neonatal nurse. It has opened my husband to other things too*." [female participant]

Male participants' responses were similar to those of the female participants; most participants state that they now have plans for the future, despite not having had them before they became fathers.

*"I have plans for the future now. I never had them and now I have them. I plan to keep working."* [male participant]

***Living arrangements***

Living situations varied for the women after having their babies. For some their living arrangements were tenuous and changed quite often but for others, they were able to find a stable situation.

***…."****And that's what sucks - when you live with your family or their family and don't get along with them because you can't say nothing about it 'cuz you don't want to hurt their*

*feelings and there's nothing else you can do. You have to live with it."* [female participants]

***Emotional / psychological state***

Depression, frustration, fear, and other emotional problems are some of the emotions that may experienced when young people, especially young mothers, face parenting as a result of an unintended pregnancy. The females in this study expressed having this type of experience after giving birth.

…*"Because sometimes you get stressed out, especially when you first have them."* [female participant]

*"I have to put my baby in the crib, sometimes when my husband is out and my baby is just crying, I can't handle it."[*female participant]

*"I got a little stressed afterward because we were like, ok we gotta get a job and take our jobs more seriously."* [female participant]

***Bond/relationship with child***

While being a young parent was sometimes a source of stress, many of the participants the bond that they share with their child was a great source of joy and comfort.

*"When I'm depressed and stuff I just sit there and talk to my daughter."* [female participant]

The unconditional love and knowing that the baby was theirs was a huge positive for them. The fear of anything happening to their baby was difficult for the girls.

*"It's just hard now 'cuz you're always thinking about your baby. Like, what if something happens to it? It's like, now that I'm here I'm wondering, "is my baby okay?" I know she's fine with my mom, it's just a feeling of more responsibility."* [female participant]

Some compared themselves to older mothers or aunts that they would see at the pool or grocery store. These older mothers were viewed to have their lives more together but feeling as though they will be able to relate better to their children as they get older as a result of being young when having them.

*"I'll be able to relate to my children when the get older."* [female participant]

The male participants came to the same consensus that as young fathers they would be able to relate to their children better than if they were older and they would also be able to have more fun with their children.

*"I think it's easier to relate to them as opposed to parents who are 20 to 25 years apart, so that's an advantage; easier communication, kind of show them the ropes."* [male participant]

***Sources of support***

The GENESIS program, husbands, parents, the partners, boyfriends, and sisters were all mentioned to be helpful during and after the pregnancy. A couple of the women stated that the baby's father was initially helpful, but that he had later decreased his help or left the picture all together. It was not uncommon to hear, *"At first it was my boyfriend, but now it's just my mom."* [female participant]

An important finding is that male focus group participants felt that little attention is given to the concerns and feelings of the male partner, but rather the attention is provided to the female partner. In order to deal with it all, participants expressed that they go hang out with friends and play ball to get their mind off of what is going on.

One participant stated, *"I feel like we don't even get that kind of concern for our side because we're guys and don't show anything."* [male participant]

***Primary prevention programs***

When asked how an unintended pregnancy could have possibly been prevented for them, men and women responded with a variety of thoughts, feelings, and suggestions. One participant said, *"If I could see myself right now," it would have helped wait to get pregnant."* [female participant] *"Think before you act man, because once you have a baby, it's over. You're going to be the one taking care of it."* [male participant] At least one young man suggested education in schools at an earlier age*." You have to pretty much hit [educate] them [boys] by middle school because that's when I first had sex."* Most of the women said that they did not "really listen" to what was being taught in the schools regarding birth control, particularly when it was abstinence-based. *"Abstinence curriculum is not good. No one wanted to hear that…"* [female participant] In addition, many young women did not believe a teenage pregnancy could happen to them. Knowing the consequences, they felt, would have helped them. *"I would tell girls that it* is *possible to get pregnant, because so many think that it won't happen. Take advantage of the birth*

Why do you think the unplanned pregnancy happened?

*"Didn't worry about it."*

*"I didn't think I could get pregnant."*

*"Wasn't thinking."*

*"The longer in the relationship, the more we felt like "eh, whatever."*

*"I was on birth control and they [the doctors] still don't know how I ended up pregnant."*

*"EC didn't work."*

*[male and female focus group participants]*

*control that's available; there's no reason not to."* [female participant] Other participants responded by saying, *"If I wasn't pregnant, I would definitely take advantage of all the programs that are out there to help me. There's a lot of help out there."*[female participant]

Male participants agreed that condoms should always be used. They also noted that it is important to get to know their partner and to think before they act. One participant suggested putting weekly goals on a piece of paper as a reminder to what he needs to accomplish that week. Another male participant said that people should not be afraid to ask their partner if they are using any type of birth control. Additional suggestions were to develop alternative forms of birth control for men, other than just condoms, and starting pregnancy prevention education in middle school instead of high school. More communication among family members and talking to people who have gone through a similar situation were some specific suggestions brought up by the men. One participant simply stated that one should wait because they have their whole life ahead of them.

### *Key Informant Interview Findings*

A total of 28 key informant interviews were conducted among a variety of programs, agencies and organizations, all of which are listed in Table 9. Interviews focused on successes and challenges, as well as highlighted strength in collaborations and resources. Lastly, key informants provided suggestions for programming

**Table 9. Participating Organizations in Key Informant Interviews, Boulder County Unintended Pregnancy Research Project, 2009**

| **Key Informant Organizations** |
|---|
| **HEALTH SERVICES** |
| Boulder Valley Women's Health Center - Contraceptive Services |
| Boulder Valley Women's Health Center - Abortion Counseling |
| Clinica Campesina: People's Site - Administrative Services |
| Planned Parenthood Boulder |
| Planned Parenthood Longmont |
| **SOCIAL SERVICES** |
| Boulder County Public Health - Community Health Division |
| Boulder County Public Health - Family Health Division |
| Boulder County Public Health - GENESIS , Case Management |
| Boulder County Public Health - GENESIS, Parent Education |
| Boulder County Public Health - Health Planning |
| Boulder County Public Health - Health Programs |
| Boulder County Public Health - Nurse Family Partnership Program |
| Boulder County Public Health - Unintended Pregnancy Prevention Program |
| Boulder County Public Health - Women, Infants and Children (WIC) Program |
| Girls Incorporated of Metro Denver |
| **PARENTING PROGRAMS** |
| Faireview High School - Teen Parenting Program |
| Florence Crittenton School - High School and Child Care Center |
| Parent Pathways - Young Fathers Services |

**OTHER**

Boulder County Commissioners Office - County Commissioner
Colorado Department of Health & Environment - Health Statistics
Colorado Department of Health and Environment - Family Planning Program
Colorado Department of Health and Environment - Family Planning Expansion
Colorado Department of Health & Environment - Maternal and Child Health
Colorado Department of Health & Environment - Pregnancy Risk Assessment Monitoring System
Colorado Department of Health & Environment - Vital Statistics
Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention
NARAL Pro-Choice Colorado
Pueblo City-County Health Department - Community Health Division

***Recurring themes in the interviews***

Across the interviews, some consistent themes emerged, including:

- It is challenging to define *unintended pregnancy* among a teen and young adult population.
- Despite the wide range of reproductive health services available in Boulder County, prevention efforts are hindered by the fact that many young people are not worried about pregnancy or simply do not think it will happen to them.
- While there is a great deal of collaboration among programs and agencies in Boulder, there is always room for improvement in this regard.

These themes, as well as suggestions for prevention programming, are detailed below.

## *DEFINING UNINTENDED PREGNANCY*

Many key informants use terms such as *unintended* and *unplanned* interchangeably to refer to a pregnancy that is either mistimed or unwanted at the time of conception. This mirrors how these terms are used in secondary data and literature. However, most of the professionals who were interviewed also acknowledged that these terms do not always resonate with young people, and that in a clinical setting, getting at pregnancy intention may take some "digging" and also may depend on interpretation. The thought was that as soon as a pregnancy happens for a young person, they may not want to consider it "unintended" because of negative associations and a dimension of shame that may come with that term. The belief is that young people do not want to feel they did anything wrong, so they may start to believe that "*it was meant to be*." In the clinic setting, the term *unwanted* was also described as a particularly negative description of the event for fear that it may infer that abortion or adoption are being (or should be) considered, which in many cases is not the case. Therefore, many health care professionals consider the terms *mistimed*, *unexpected*, and *unplanned* to be more universally accepted.

## *WHY UNINTENDED PREGNANCY AND PATERNITY HAPPENS*

As key stakeholders on the issue, interviewees were questioned about why so many unintended pregnancies continue to occur among 15-24 year olds. The most common theory was, "*it is just not on the radar, as if it is not possible to even happen.*" It is thought by many that the denial among young people comes from a sense that they are smarter than others, can control things better than others, and that it takes more work than it actually does to conceive a child. In order to combat the ambivalence of men and

women thinking *"If it happens it happens*" or "*I just wasn't thinking about it.*" It was suggested that future prevention programming could be designed to influence the mind-set so that young people could better consider what a pregnancy would really mean for them.

## *ACCESS TO REPRODUCTIVE HEALTH SERVICES*

Many key informants mentioned as a key strength of Boulder County the abundance of reproductive health services in the community, relatively easy access to services, and a strong referral network across organizations The access points most commonly mentioned were Planned Parenthood clinics in both the cities of Boulder and Longmont, Boulder Valley Women's Health Center (BVWHC) (which operates free teen clinics in both Boulder and Longmont), and Community Health Centers (CHCs), namely Clinica Campesina in Boulder and Lafayette and Salud Family Health Center in Longmont. At many of these locations, particularly Planned Parenthood and BVWHC, there are often same-day appointments available and wait-times are kept to a minimum. These clinics also provide a critical point of access for young people to receive medical care and birth control without requiring their parents' insurance, which in many cases might potentially expose themselves to negative consequences if their parents are not supportive of their use of birth control. With such a wide range of reproductive health care sites, the interviews did not reveal any perceived gaps in health care services. However, key informants did remark on how improvements could be made in the continuity aspect of contraception in order to provide birth control options that women can use throughout their life. Because many young people tend to move around a lot or have a change in circumstances, creating more case management type positions might help clients better keep track of birth control methods and availability.

### *Barriers to accessing services*

While there are many choices for where to go for family planning and reproductive health care, key informants expressed that "some appointments are easier to schedule than others," and that greater availability of appointments would help encourage more timely use of birth control. If individuals are not persistent enough to make or keep their contraceptive appointment, or if they have to wait too long before being seen, it presents a window of opportunity to change their minds or forget about birth control, leaving them vulnerable to an unintended pregnancy.

Another barrier to accessing services is the perceived lack of knowledge about different birth control methods and their associated costs, availability, and side effects. Without the power of knowledge, young people are not able to fully utilize the resources at their disposal because they simply do not have the tools to make an educated choice about the best birth control method for themselves. Many interviewees were supportive of long-lasting methods of birth control and one key informant also suggested, "*Make it so young people would have to choose to become pregnant [by removing a birth control method] versus having to choose not to be pregnant [by taking a pill or using a condom]*."

## *EMERGENCY CONTRACEPTION (EC)*

The belief among the community stakeholders was that young people know what Emergency Contraception is, and in recent years have been better able to distinguish EC from the "abortion pill" due to increased awareness and education. However, there is still a disparity between knowing what EC is and knowing how to access it or use it properly. In addition, there is also still resistance by many to using EC due to a perceived stigma attached and a general feeling that they are not at risk for getting pregnant.

### *Access to EC*

While EC is available through several clinics on a sliding fee schedule (and can therefore be distributed at no cost), accessing EC outside of the clinic setting has proven to be more difficult. In situations where someone wants to access it proactively and not necessarily in response to a broken condom or situation of unprotected sex, the cost of $60 can be prohibitive for many young people. This, combined with the fact that some pharmacists in Boulder County either do not or will not stock or dispense EC, creates significant challenges to more widespread use of this resource.

### *Proper use of EC*

There is a perceived lack of knowledge among women regarding the proper window of time in which EC can effectively be used. The fact that a single dose of EC helps in an isolated incident of unprotected sex, rather than multiple situations of unprotected sex that may have occurred over time, is something that should be further communicated to women who use EC. Overall, more education could be done about how and when it is properly used, as well as its success rate, which is estimated at approximately 80 percent.

### *Psychological resistance to EC*

In cases of unprotected sex, there remains the challenge of overcoming a sense of shame, a feeling that "something went wrong" and a fear of being judged by telling someone they need EC. The key informants reported "*disapproving looks and rolling of the eyes*" by pharmacists as a significant deterrent to young people getting the courage up to ask for it. However, the most challenging barrier to overcome may be the belief that even if they knew how and where to get it, at no cost if possible, that many women still will not access it because they do not believe they will get pregnant.

## *PREVENTION PROGRAMMING*

### *Coordination and integration of prevention services*

The interviewees for this project consistently reported a high level of coordination and integration of prevention services in and around BCPH. Specific programs such as Women, Infants and Children (WIC), the GENESIS Teen Parenting Program, Unintended Pregnancy, and Nurse Family Partnership were mentioned as examples of programs that appropriately and effectively refer clients to each other, as well as referring to services and resources external to BCPH. Nevertheless, key informants desired and encouraged increased and improved integration, as integration was described as sometimes being a "*rocky road*." It did sound like more programs and agencies are beginning to participate in cross-program discussion of the issues surrounding unintended pregnancy and how beginning to talk about how each program can help the other. Two

of the biggest barriers to further collaboration were thought to be working across physical locations and recognizing cultural differences between communities.

***Barriers to prevention***

The interviews seemed to echo some of the prevention barriers and obstacles that were expressed from the focus group participants: that young people need more education around the facts of birth control, how their body works, and what resources are available to them. In addition, it was thought that many teens do not feel comfortable seeking out birth control because it indicates a level of premeditated sexual behavior versus something more spontaneous.

Among key informants, there is also the notion that sexual activity and parenting are not necessarily related concepts in the minds of young people, and that there is a "super-hero" effect that makes them think pregnancy will not happen to them. Very few young people are willing to express a need for more information regarding pregnancy prevention. Some girls, even those who have the ability to make safe decisions, will often engage in risky (unprotected) sex in order to gain that experience.

Interviews also expressed lack of goals for the future as another significant barrier to preventing unintended pregnancy, because in the absence of future aspirations, the pregnancy often becomes their default plan or is considered a path to something else, such as keeping a partner or having someone to love.

In terms of preventing subsequent pregnancies, a lack of awareness around healthy pregnancy intervals and the inability to make educated family planning decisions was believed to be a considerable barrier. In cases where an unintended pregnancy has occurred, some young parents think they should get subsequent pregnancies "out of the way," or that every child should have a sibling and therefore subsequent pregnancies are either planned or not prevented.

***Increasing capacity to do primary prevention of unintended pregnancy***

One of the most consistent themes throughout the interviews, regardless of the type of organization represented by the stakeholder, was the need for more comprehensive sexual health education in schools. Admittedly, this would require a sensitive balancing of roles between parents and schools and the need to provide parents with tools to help them talk to their sons and daughters about sex. But given that to most, it seemed that parents did not get a "wake-up" call about the severity of unintended pregnancy until it was their child who experienced it (and for some parents, this did not even provide the motivation to talk to their child about sex or support the use of birth control), there was a strong conviction that parents need to get more involved in this discussion.

In addition to involving parents in the discussion around sex and birth control, another strong belief among key informants was that peer education, such as the Sexual Health Advocate Peer Education (SHAPE) program in Boulder County, seem to work well. The strategy is that a peer educator receives some formal training in sexual health and can then provide information back to the community.

***Additional suggestions for future prevention programming***

In addition to some of the suggestions mentioned above, key informants also brought forward some additional ideas to improve future prevention programming. The suggestions ranged in size and scope from *"Start small and expand on successes," to "Create a social marketing campaign to normalize how the community talks about sexual health."* Across all the suggestions, there were consistent themes around providing more education, involving parents and community, and increasing communication.

The single most frequent suggestion reported was to provide school-based health centers where contraception could be distributed. Key informants felt like this would break down many access barriers and would also help normalize the discussion around sexual health. Additional school-based suggestions were to: 1) provide a comprehensive sexual health curriculum around physical changes, values, healthy relationships, self esteem, peer pressure, and assertiveness; 2) develop a Life Skills program to assist with decision-making skills around family planning; and 3) provide more activities in order to help prevent the cases of students *"having sex because there was nothing else to do or because everybody else was doing it."*

To support the efforts of schools and community agencies, many interviewees felt that a greater level of parental involvement could bring a much needed positive influence on their kids who may be having unprotected sex. With the right tools, parents were perceived as great potential resources in helping to build their child's self-esteem, guide the development of values and concepts around healthy relationships, as well as serve as a trusted resource for information. However, the stakeholders also acknowledged that parents and their sons or daughters may not always be comfortable talking with each other about sex, and therefore additional suggestions were made, such as, *"Gain a better understanding of peer networks and letting young people know there are places to talk about things that they don't want to talk to parents about."*

*"Identify the primary population that has influence with teens and work through that population to get the message across. But don't dilute the parental influence; rather create awareness about its power and teach parents how to apply it." [key informant comment]*

## VI. BEST PRACTICES FOR PRIMARY AND SECONDARY PREVENTION STRATEGIES

Health promotion definitions acknowledge that behavior choices are influenced by many external factors and discuss the need for comprehensive strategies to reinforce, through community and societal actions, behavior choices that promote health. Green's widely cited definition of health promotion carefully incorporates both individual and societal measures. Health promotion is "any combination of health educational and related organizations, economic, and political interventions designed to facilitate behavioral and environmental changes conducive to health" (Green & Kreuter, 1990).

Interventions designed to decrease behavioral risk factors and their consequences logically lead to consideration of settings which they can relevantly, economically and effectively be monitored. Building upon Green's health promotion definition, the socio-ecological model remains a serviceable framework for unintended pregnancy prevention. The socio-ecological model recognizes the interwoven relationship that exists between the individual and their environment (see Figure 1).


- Individual is at center with knowledge, skills attitude.
- Relationship includes family, friends, social network and relationships among organizations.
- Community explores settings, such as schools, workplaces, and neighborhoods, in which social relationships occur
- Community relationships among organizations.
- Societal factors include social and cultural norms. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society. (Dahlberg & Krug, 2002).

In general, unintended pregnancy in the United States is inextricably tied to individual, psychosocial, and cultural phenomena. Because these phenomena have even more of an impact on adolescents, a population that carries more of the psychological, economical, and social burden of unintended pregnancy and paternity, the summary of best practices will primarily focus on prevention programs directed to promoting sexual health in adolescents.

Reconceptualizing the issue within a socio-ecological framework may provide an opportunity to better confront the challenges of unintended pregnancy prevention. In the discussion of prevention best practices, DiClementa et al (2005) use a socio-ecological framework to identify determinants of adolescents' sexual risk and protective behaviors

framework to identify determinants of adolescents' sexual risk and protective behaviors as well as antecedents of their unintended pregnancy. The goal is to provide a synthesis of several discrete categories of research. Subsequently, we propose an integrated strategy that addresses the unintended pregnancy impact among adolescents by promoting a socio-ecological perspective in both basic research and intervention design. This approach may expand the knowledge base and facilitate the development of a broader array of intervention strategies, such as community-level interventions, policy initiatives, institutionally based programs, and macro-level societal changes. Although there are inherent challenges associated with such an approach, this approach is more likely to sustain prevention efforts over time than any single intervention (DiClemente, Salazar, Crosby, & Rosenthal, 2005).

A way that primary prevention for unintended pregnancy and STIs, especially for adolescents, can be accomplished is by helping to foster behavioral changes that reduce the risk of pregnancy as well as acquiring or transmitting STIs. This can be achieved by delaying the age at first intercourse, decreasing the number of sex partners, encouraging the use of condoms, and decreasing the use of alcohol and drugs (CDC, 1992).

All teenagers need encouragement to postpone sexual involvement and information on pregnancy prevention if they become sexually active. These components, however, are not enough by themselves to make a significant impact on the reduction of pregnant and parenting teens. The issues of adolescent pregnancy are too complex for simple solutions. The Children's Defense Fund (1996) emphasizes that young people need both "the motivation and the capacity to avoid too-early pregnancy and parenting." Further, young people are not a homogenous group, so solutions must be sensitive to individual and group differences. Boys and girls who do well in school, participate in nonacademic activities, and plan for their future are less likely to become pregnant or bear a child during their teenage years. A wide range of interventions aimed at youth is also insufficient; however, if we do not address the larger overriding issues of poverty, racism and media messages that contribute to the complexity of the problem (Christensen & Rosen, 1996).

Understanding important factors related to sexual behavior is important not only to change that behavior; it is important to identify those who are most at risk of having sex and unprotected sex. Programs can use these factors to identify those adolescents at greater risk; then they can address the important factors affecting their behavior (Douglas, Lepore, & Ryan, 2005).

Kirby, with The National Campaign (2005), identified many of these factors and explained their implications for those working to help youth avoid risky sexual behaviors and potential consequences. They divided the relevant factors into two categories: risk factors and protective factors. "Risk factors" are those that encourage one or more behaviors that might lead to pregnancy or sexually transmitted disease (e.g., initiating sex at a young age or having sex frequently and with many sexual partners) or discourage behaviors that might prevent pregnancy or sexually transmitted disease (e.g., using contraception, or condoms in particular). Similarly, "protective factors" are those that do just the opposite – they discourage one or more behaviors that might lead to pregnancy or

STD or encourage behaviors that might prevent them (Kirby, Lepore, & Ryan, 2005). Only a select list of risk and protective factors that may affect adolescent sexual behavior are presented below.

**(+) = a protective factor (-) = a risk factor**

**Community Level:**
(-) Greater community social disorganization (violence, hunger, substance use)

**Family Level:**
(+) Higher parental education
(+) Live with 2 biological parents
(+) Greater parental supervision and monitoring
(+) Higher quality family interactions and connectedness
(+) Greater parent/child communication about sex
(+) Parental support of contraception if sexually active
(+) Parental disapproval of premarital or teen sex
(-) Household substance abuse
(-) Mother's early age at first birth
(-) Physical abuse

**Peer Level:**
(-) Older age of peer group
(-) Romantic partner is older
(-) Peers' use of drugs/alcohol
(-) Sexually active peers
(+) Peer use of condoms
(+) Peer support for condoms or contraceptive use

**Individual Level**:
(-) Perceive more personal and social benefits rather than costs of having sex
(-) Alcohol/drug use
(-) Being African American (vs. white)
(-) Being Hispanic (vs. Non-Hispanic)
(+) Older age of physical maturity /menarche
(+) Greater connectedness to school
(+) Higher academic performance
(+) High educational aspirations / plans for the future
(+) More positive attitudes, greater self efficacy and greater motivation to use condoms and other forms of birth control
(+) Discussing pregnancy & STI prevention with partner
(+) Greater motivation to avoid pregnancy, HIV and other STIs

The literature shows that the most successful programs are ongoing and comprehensive. They combine several strategies which focus on helping adolescents and young adults succeed. Below is a brief list (Christensen and Rosen, 1996) of the most commonly identified components of successful strategies.

***Multilevel approach.*** While the sexual experiences of youth differ greatly, the fact remains that most will become sexually active during their adolescent years, and many will become pregnant or father as a child. Consequently, the goals for programs addressing teenage pregnancy must be threefold: first, directed at delaying the initiation of sexual intercourse; second, directed at preventing pregnancy for youth who are

sexually active; and third, directed at ensuring the well-being of young people who do become parents, including the avoidance of additional pregnancies.

***Sexuality education.*** While some have voiced concern that sex education increases sexual activity, studies show that this is not the case. In fact, effective sex education programs can decrease sexual activity and increase contraceptive use among those already sexually active. Successful programs have a number of similar components, such as:

- Maintaining a narrow focus on reducing specific sexual risk-taking behaviors;
- Providing accurate information about sexuality;
- Building interpersonal and communication skills to resist sexual pressures;
- Addressing both social and media influences on sexual behaviors;
- Reinforcing individual values and group norms linked to responsible behavior and decision-making; and finally;
- Involving students in the learning process through small group discussions, role-playing, interviewing parents, and other activities.

Many programs have also involved older teens as role models. Participants echoed these priorities.

> *"Sex education classes where it's mandatory and not optional. I remember ditching health class a lot of times. Abstinence curriculum is not good. No one wanted to hear that…" "If parents knew what they can prevent through sex ed, they would want it taught in schools."* [female participant]

> *"You have to pretty much hit them by middle school because that's when I first had sex."* [male participant]

***Access to childbearing alternatives.*** Both male and female teenagers who are sexually active need easy access to contraceptives and confidential family planning services. Young women who are poor or low-income also need the same opportunities as their more advantaged peers to terminate a pregnancy if they decide that they are not capable of bearing and raising a child.

> *"Birth control, not just condoms."* [female condoms]

> *"I think they should talk about when girls are younger. And the doctor should bring it up first instead of waiting for the 12 year old to ask about it. A younger girl is not going to bring it up with her doctor."* [female participant]

***Not for girls only.*** Too often, adolescent pregnancy is viewed as a problem having to do exclusively with teenage girls. Overlooked are the teenage boys and men who share equally in this responsibility. Their need for pregnancy prevention information and services is no less important.

*"Don't do [have sex with] the baby's mom. Think before you act man, because once you have a baby it's over. You're going to be the one taking care of it."* [male participant]

***Clear, consistent messages.*** Young people need to hear strong and consistent messages about responsible sexual behavior. Certainly parents - through discussion and example - carry the primary responsibility for guiding their children, and they should be supported in doing so. But the larger community, and especially the media, must regularly reinforce parents with complementary rather than contradictory messages.

*"Create a social marketing campaign to normalize how the community talks about sexual health." [key informant interview]*

***Future prospects.*** Positive life options give teens hope for the future and the motivation to avoid early childbearing. Students need the skills and advanced training that will enhance their prospects for employment. They also need assurance that further education and/or meaningful employment will be available to them. Schools and businesses can play a crucial role in making this happen.

*"Just wait, because if you have plans or not, just go to school and finish school. You've got your whole life ahead of you."* [male participant]

***Nonacademic opportunities for success.*** When children are isolated from their peers, lack positive adult role models or experience few successes, they are at-risk of slipping into problem behaviors. Communities must ensure that children have access not only to nurturing adults, but also to a broad spectrum of programs, activities, and service opportunities that can build self-confidence, bolster self-esteem, and forge positive connections.

***Family support and parenting programs.*** Current studies show that when fathers are involved in the physical care of their children before the age of three, they are less likely to sexually abuse their own or any other child in the future. To break the cycle of sexual abuse which often leads to teenage pregnancy, intensive family support programs, such as Healthy Families, are needed to teach fathers about parenting and help them connect with their children from birth (Christensen & Rosen, 1996). Participants underscored this, as well.

*"More encouragement from my parents. I was in school and they could have said stuff like 'hey you're almost done, hang in there."* [female participant]

*"I think my parents didn't care what I was doing. I was the party girl who always had friends in my car. It was party car and there were people in the front, in the back, and in the trunk. I cut class all the time and just wanted to party with my friends. All I thought about was, cool we're going to go drink, we're going to go get high. So I was just headed down a bad path."* [female participant]

## VII. DISCUSSION

The review of literature and secondary data, as well as input from Steering Committee members, provided valuable guidance on how to structure the research methodology for this study. Along with defining unintended pregnancy, a fundamental methodological consideration in designing the research protocol was determining the age and gender of the target population, and how pregnancy outcome might also factor in to determining a target population. In addition, because the funding for this research was being provided by the Temporary Assistance for Needy Families program, it was also important for the research team to consider ways to include perspectives from individuals at lower incomes.

Available research and data suggest that while unintended pregnancy has significant impact on teens in regards to educational level and socioeconomic status, the issue extends beyond the teenage years. Local and national data show that the pregnancy rate among 13-14 year olds is relatively low and begins to dramatically increase at age 15. However, while a majority of pregnancies to 15-19 year olds are reported as unintended, the largest proportion of the total number of unintended pregnancies is attributable to those between the ages of 20-24 years before declining in the 25 years and older population. Given that unintended pregnancy is not just a teen issue, it was decided that the target age group for this study would include women from 15-24 years of age.

However, talking to women would only provide the female perspective. A second consideration was how to address unanswered questions about how unintended paternity affects young men and their perspective on the how to prevent unintended pregnancy. Because the literature was lacking in terms of providing a male perspective on this issue, the research was designed to encompass both unintended pregnancy and paternity. To that end, the inclusion of male perspectives was incorporated into the key informant interview process and focus group methodology.

A third consideration was how to address to disparity of unintended pregnancy between Hispanic and non-Hispanic women that was evident in the research. Nationally, Hispanic women make up the largest proportion of unintended pregnancies to women 15-24 years of age. The changing demographics in Boulder County indicate a growing Hispanic population and the disparity between unintended pregnancies among Hispanic and non-Hispanic women holds true for Boulder County as well. Given that cultural sensitivity and language considerations must be factored into any future prevention programming, the research strategy was to include as many Hispanic participants as possible. The Steering Committee provided an array of suggestions for recruitment locations and focus group sites that would help increase the likelihood of Hispanic participation, which was achieved in 73% of the female focus group participants and 82% of the male focus group participants reported their ethnicity as Hispanic. The fact that recruitment tools and focus groups facilitation was also available for monolingual Spanish speakers did not yield successful recruitment of monolingual participants, which

could indicate a methodological limitation in reaching that particular population as described in the Methodological Considerations section of this report.

***Focus Groups***

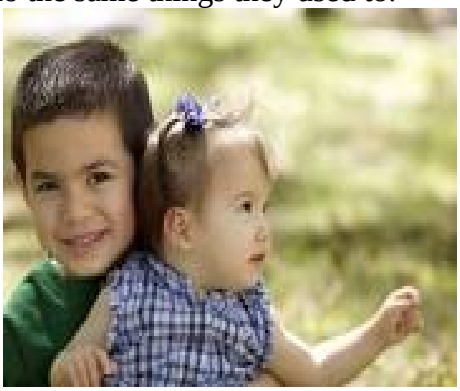
When assessing the effectiveness of the research methodology, some indicators of success were the high proportions of low-income, Hispanic individual in the focus group discussions and the fact that two groups of men were also included. Though less than half of the participants provided their specific income level, of the 18 responses received, all were below 100% of the Federal Poverty Level. Of the 37 total participants, 28 were Hispanic and 9 were non-Hispanic, including 9 of the 11 men, all 6 women in the 15-17 year age group and 13 of the 20 women in the 18-24 year age group. This provided an opportunity to measure cultural differences in beliefs and perceptions around contraception and pregnancy. When comparing responses between Hispanic and non-Hispanic women, there were no significant differences in the most common forms of contraception that were used, if any. However, one of the biggest differences between the two groups of women was that Hispanic women were more likely than non-Hispanic women to report not using birth control in the last year, despite already having at least one unexpected pregnancy and not wanting to get pregnant again (47% versus 33%). Of those women who were using a method of birth control, Hispanic women reported a much more frequent use of the "withdrawal" method than non-Hispanic women. Many more Hispanic women also reported reasons for not using birth control as; not having sex regularly, not being confident that it would work, and not knowing what kind of birth control to use, while non-Hispanic women more commonly reported their reason being *"I wasn't thinking."* Another difference was that a higher percentage of non-Hispanic women than Hispanic women reported not using birth control while under the influence of drugs or alcohol or because she and her partner had agreed not to have sex with other people. In terms of barriers to accessing contraception, more Hispanic women than non-Hispanic women felt that transportation was an issue, while cost was a barrier mentioned equally across the ethnic groups.

Hearing the male perspective in focus groups allowed for some interesting comparisons and contrasts regarding where knowledge and perceptions of contraception and parenting differ between men and women. When asked about why they thought an unplanned pregnancy happened for them, the most common responses from both the men and women were that they were not worried about getting pregnant or not thinking about it. Some female participants said, "*I didn't think I could get pregnant*" while others said "*The longer in the relationship, the more we felt like "eh, whatever.*" However, the discussion with the young women uncovered that there were also fluctuations in ambivalence, where one day they might feel they definitely did not want a baby but on another day they thought "maybe" they did. When contraception was used, both women and men most often said they used condoms. Hispanic men in particular gave reasons for not using birth control as not worrying about their partner getting pregnant and not minding if she became pregnant. Non-Hispanic men more commonly reported that they did not use birth control when they had sex because they "weren't thinking," were under the influence of drugs and alcohol or did not like how it felt to use a condom. For women, it was not that they did not mind getting pregnant but rather that they did not use

contraception because they did not think they would become pregnant or had agreed not to have sex with other people. Many more women than men also reported using the "withdrawal" method with their partner as a birth control method (50 % of women versus 27% of the men).

After the pregnancy, both men and women reported similar social impacts, primarily the feeling that they are no longer being able to do the same things they used to.

One positive, and somewhat surprising finding, was that both men and women also reported a much higher level of motivation to succeed now that they are a parent, which for them meant finishing school, getting a better job and becoming more financially secure in order to "provide a good life" for their child.



The women acknowledged that there are great resources across Boulder County to help them accomplish their goals and meet their needs, while men expressed a need for more community agencies to help meet their needs as new fathers. Male focus group participants felt that little attention is given to the concerns and feelings of the male partner, but rather the attention is primarily targeted to the female partner. In order to deal with it all, participants expressed that they go hang out with friends and play ball to get their mind off of what is going on.

One participant stated, *"I feel like we don't even get that kind of concern for our side because we're guys and don't show anything."* [male participant]

Another unexpected finding in the research was the difference in how key informants and focus group participants defined the event of having a baby unintended pregnancy. While the key informants reported common use of the term "unintended" and defining it similarly to how it is defined in the literature, the focus group participants who had actually experienced the pregnancy did not define their experience as "unintended." The most common terms they chose to use were "unexpected" and "unplanned." On the other hand, when asked to define "unintended" many young men and women either did not know how exactly to define it or had negative connotations associated with its meaning, similar to an "unwanted" or "accidental" pregnancy.


Of the over two dozen key informant interviews that were completed among stakeholder organizations in and around Boulder County, there was an overwhelming consistency in the appreciation for the depth and breadth of reproductive and health services across the county. Obviously, by talking with stakeholders from a variety of organizations, one expectation was that there would be a variety of perspectives on reasons for unintended pregnancies and strategies to prevent it from occurring. However, it was also interesting to see that there were several points on which all the interviewees agreed, including the idea that young people often do not think that an unintended pregnancy will happen to them, and the notion that both parents and schools need to be more involved in prevention strategies. Their were strong feelings were that teens and young adults should be provided with more opportunities to think and learn about what an unintended pregnancy would mean in their life, including the social, educational, and financial consequences. Key informants also felt that parents needed more tools to facilitate talking with kids about sex, as well as increased awareness of current sexual health issues and the importance of preventing an unintended pregnancy. Normalizing the communication around sexual-related topics was a recurring suggestion, and one that most key informants expressed very strongly. Interviewees also noted that more education in the schools could be provided and that school-based health centers would go a long way in breaking down barriers to accessing and using contraception. Even in a community such as Boulder County, where there is a wide range of accessible and confidential reproductive health services available to young people, often at no cost, there are still logistical barriers of scheduling and keeping appointments. The consistent sentiment was that school-based resources would help motivate more individuals to take action before an unintended pregnancy occurs. With so many ideas from stakeholders, the challenge for Boulder County will be to bring service providers together to strategize about next steps.

## VIII. SUMMARY AND CONCLUSIONS

The findings from this research have led us to multiple conclusions related to the current rate of unintended pregnancy in Boulder County, including some key considerations for future and future pregnancy prevention programming. These conclusions have important implications for prevention and support services as well as public policy.

***Focus Group Findings***

- **MOST DID NOT WORRY ABOUT GETTING PREGNANT**

- **SOCIAL CONSEQUENCES WERE FELT BY MANY**

Partner's involvement: opposite ends of spectrum
Strained family relationships became worse
Old friendships ended, but new ones began

- **PPREGNANCY BROUGHT MOTIVATION**

Desire for a better life, success and being a 'different' parent

- **FATHERS OFFER A DIFFERENT PERSPECTIVE**

  Condoms for protection not prevention
  Girls get more help than they do

There are many reasons why fathers have not been the focus of research. Early studies on young fathers assumed that they were psychology unstable and offered little support. These shaped society's stereotypes of young fathers. However recently, there is growing attention to and evidence for the beneficial role that fathers can play in children's lives (Lamb, 2004).

***Recurring themes in the focus groups***

Across all the focus groups conducted, the following consistent themes arose (these are highlighted below):

- Before the pregnancy, there was not much thought or worry about whether pregnancy would occur.
- Pregnancy and parenting were harder than expected.
- There was an increased propensity to use birth control after the pregnancy.
- There was a desire/need for more knowledge around birth control options and their proper use.
- Barriers to preventing pregnancy were less about cost and availability and more about making it a topic of conversation with parents, peers, and partners.
- Parenting provided a strong motivation to improve their educational, emotional and financial circumstances.

***Key Informant Interview Findings***

- **INFORMATION GATHERED FROM WIDE SPECTRUM OF STAKEHOLDERS**

  Steering Committee members
  Health services
  Social services
  Parenting programs
  Prevention programs
  Statisticians
  Public health and policy

- **INTERVIEWS FOCUSED ON SUCCESSES AND CHALLENGES**

  Defining unintended pregnancy
  Measuring unintended pregnancy
  Access and barriers to services
  Coordination and integration of services
  Prevention strategies

- **KEY INFORMANTS PROVIDED SUGGESTIONS FOR PROGRAMMING**
  Start small
  Increase collaboration
  Improve communication
  Get parents involved
  Money always helps
  Be more "dad" friendly
  Increase school-based resources
  Develop social marketing campaign

***Recurring themes in the interviews***

Across the interviews, some consistent themes emerged, including:

- It is challenging to define *unintended pregnancy* among a teen and young adult population.
- Despite the wide range of reproductive health services available in Boulder County, prevention efforts are hindered by the fact that many young people are not worried about pregnancy or simply do not think it will happen to them.
- While there is a great deal of collaboration among programs and agencies in Boulder, there is always room for improvement in this regard.
  Develop social marketing campaign

***Conclusions of focus group and key informant interview findings***

- Primary research among 15-24 year olds in Boulder County who have experienced an unintended pregnancy revealed attitudes of ambivalence and of "not thinking" about the issue and reinforce the idea that more be done to communicate the realities of unintended pregnancy and parenting. Schools and parents are the two most commonly suggested resources to involve in the discussions on sex and birth control in order to decrease unintended pregnancy.

- Future research among 15-24 year olds in Boulder County who have <u>not</u> experienced an unintended pregnancy would help identify factors associated with successful pregnancy prevention efforts and possibly suggest strategies to include in future prevention programming.

- A more active approach to focus group recruitment may have produced monolingual Spanish-speaking participants, which could yield additional valuable information about cultural factors related to unintended pregnancy.

- Increasing the availability and reliability of pregnancy and fertility measures, such as abortion, fetal death, and pregnancy interval data would provide a better estimate of the true burden of unintended pregnancy in the county.

## IX. RECOMMENDATIONS AND INTERVENTION STRATEGIES

The 1995 Institute of Medicine report recommends a new social norm where all pregnancies are consciously and clearly desired at conception (IOM, 1995). Achieving this goal requires long-term efforts to educate the public on the benefits of family planning and of spacing pregnancies (Green-Raleigh, Lawrence, Chen, Devine, & Prue, 2005).

***Improving access to family planning.*** The Institute of Medicine report and *Healthy People 2010* both call for more reproductive health education and better access to clinical reproductive health services. Family planning services supported through federal Title X family planning funding, Medicaid, and state funding provide women control over their reproduction, which prevents unintended pregnancies. Medicaid family planning expansions have also been shown to lower birth rates (Lindrooth & McCullough, 2007).

***Improving access to emergency contraception.*** The American Medical Association, the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Pediatrics, among other national organizations, support increased access and use of emergency contraception (EC) as a way to prevent unintended pregnancies (ACOG, 2004).

Nationally, the U.S. Food and Drug Administration (FDA) in August 2006 approved EC for over-the-counter availability for those 18 years and older. However, availability did not change dramatically with FDA approval. Despite over-the-counter status, EC is still kept behind the pharmacy counter. Proof of age is required to obtain EC because the FDA rule states women younger than 18 years can obtain EC only with a prescription.

***Parental involvement.*** If parents disapprove of teens having sex, then teens are less likely to have sex. If parents support contraceptive use, then teens are more likely to use contraception if they do have sex.

If parents communicate their beliefs and values about sex, condoms, and other forms of contraception, then under some circumstances this communication may lead to less sexual risk-taking. When parents have conversations with their children about sex and contraception well before their teens become sexually active, the conversations may delay the initiation of sex or increase the use of condoms or other contraceptives. This effect is most likely to occur when the teen is a daughter (as opposed to a son), when the parent is the mother (as opposed to the father), when the teens and their parents feel connected to one another, when the parents disapprove of teens having sex or support contraceptive use, and when parents can discuss sexuality in an open and comfortable manner (Kirby, Lepore, Ryan, 2005).

The Association of Pediatric Adolescent Medicine (2007) summarized the following in relation to programs targeting parental involvement to preventing unintended pregnancy:

- Many studies to increase parent/child communication about sexual health have had little effectiveness and low reach.
- Recent randomized control trial of the "Parents Matter" program has shown some promising results.
- Most promising approach may be assigning homework assignments for teens requiring parent/teen discussion about sexual health.
- Programs may be more effective if they are longer in duration and also focus on appropriate parental monitoring and on parents' role modeling responsible sexual behavior (Forehand et al., 2007).

***Male involvement.*** Programs targeting men's role in decisions about contraceptive use show promise. A growing body of literature and research has concluded that increased male involvement in family planning (FP) and reproductive health (RH) is essential to addressing reproductive health issues facing medically disenfranchised groups (put in reference). Research shows that while men see contraception as the woman's responsibility, they can have a strong impact on contraception behaviors. Healthy People 2010, a national initiative, includes many targets impacting men in reproductive health, with a specific objective to increase male participation in pregnancy prevention and family planning efforts (Edwards, 1994). The challenge, however, has been translating this objective and research into a pragmatic application of increased gender equality in the field. The California Family Health Council has developed programs for both male and female partners to discuss joint responsibility in pregnancy prevention, teaching communication skills to discuss contraceptive and ways that males can take a larger role in pregnancy prevention such as using dual method (Amey et al., 2008).

***Youth development.*** While some youth development programs appear to show promise in reducing adolescent pregnancy rates, further evaluation is needed to determine the impact on unintended pregnancy among this age group. Youth development programs are typically ones that decrease school drop out, improve attachment to school, school performance, educational and career aspirations (Kirby, 2002).

***Social marketing campaign.*** Agencies should use the media to inform the public about the dangers of closely spaced pregnancies and about the need to plan pregnancies. Kirby identified four key elements for increasing the effectiveness and impact of media campaigns. Media campaigns addressing sexual risk behaviors should be sustained, tailored to audience, based in health education theory, and connected to health and social services in the community (Kirby, 2005).

***Integration of services***. Conditions leading to STDs and unintended pregnancy are similar, however few programs provide initial family planning services in an STD clinic. Additionally, women with an annual household income below 200% of the federal poverty level are disproportionately affected by unintended pregnancy; as well as those who suffer with mental health and substance abuse issues show a significant association with engaging in risk sexual behaviors. As a result, women and men who face these challenges present opportunities for social service and public health professional to provide comprehensive prevention services. Drs. Klerman and Dawson maintain that agencies and practitioners who work with mothers and children from birth to 3 can play an important role in achieving these benefits. Agency protocols should call for discussing family planning goals with all mothers. Family planning should be included in all case plans. Social workers, therapists, and others who work with parents should receive training on (a) how to raise the family planning issue, (b) methods of contraception, and (c) availability of contraceptive services. Furthermore, representatives of local family planning agencies should be invited to present periodically at training sessions in order to maintain interest in this subject and to update information (Klerman and Dawson, 2009).

***Improving general health care for women.*** The U.S. Centers for Disease Control and Prevention (CDC, 2006) and experts elsewhere have recently recommended a change in the provision of health care for women that better integrates health care across a woman's lifespan, including preconception and interconception health care (Atrash et al., 2006). While there are no data to substantiate that providing comprehensive health care to women will prevent unintended pregnancy or improve spacing between pregnancies, recent recommendations include better integration of family planning services for women. The CDC, ACOG, and other national organizations have developed preconception health care guidelines and recommendations (CDC, 2006).

Strategies to increase preventive health care to every woman at every visit are needed. These strategies should address provider time constraints, insurance coverage, and professional guidelines for content of care. In addition, women should be encouraged to create a reproductive life plan and discuss it with their providers at every visit.

The CDC's preconception clinical guidelines have shown promise in preventing pregnancy in adult women and men over 18 years of age:

- Longstanding approach for prevention and chronic disease
- Health care provider recommendation is central to patient acceptance

***Evidence-based practices conclusion***. Prevention strategies and programs must address a variety of risk and protective factors through different levels of the socio-ecological framework:

- Individual knowledge, attitudes, and behaviors
- Peer/Family knowledge, attitudes, and behavior
- Schools/organizations
- Community
- Society

Unintended pregnancy prevention strategies must address sexual and non-sexual antecedents through a combination of new or revised policies, programs, and practices (Kirby, Lepore, Ryan 2005).

The research team focused on obtaining the appropriate breadth and depth of information and effectively analysis and synthesis of ideas in the literature to support the study objectives, selection of method and believe that the findings of this study will contribute to a new understanding of the impact of unintended pregnancy on Boulder County residents.

**Suggested next steps**
The development of a consortium of social service, health care, and other public health providers that can address the following:

- An assessment of local programs, activities, research findings, best practices, and data to review, update, confirm/enhance public health strategies to prevent teen pregnancy and sexually transmitted infection in Boulder County.

- An assessment of data systems across the County to develop the capacity to implement specialized data collection efforts so that unintended pregnancy rates can be monitored at a local level in a timely manner.

- Further research with males to better understand their unintended paternity issues as well as with couples to develop a better estimate of intention rates with couples.

**REFERENCES**

Alan Guttmacher Institute. (1999). Issue Brief 7/1999. Accessed on June 2009 at http://www.guttmacher.org/pubs/ib_0799.html.

Alan Guttmacher Institute (2000). Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics. New York: Author.

American College of Obstetrics and Gynecology. (2004). ACOG News Release, May 4, 2004. Accessed on March 2009 at http://www.acog.org/from_home/publications/press_releases/nr05-04-04-3.cfm.

Amey, A., Perrucci, A., Alvarado, R., Puffer, M. (2008). Implementing best practices for reproductive health care services to males 25 and over in family planning settings, conference sseion: American Public Health Association Conference.

Baydar N. (1995). Consequences for Children of Their Birth Planning Status. Family Planning Perspectives, 27 (2), 228-234.

Brown, SS & Eisenberg, L, eds. (1995). The Best Intentions: Unintended Pregnancy and The Well-Being of Children and Families. Committee on Unintended Pregnancy, Institute of Medicine. Washington, DC: National Academy Press.

Burgess RG (ed.). (1989). Field Research: A Sourcebook and Manual. London: Routledge.

U.S. Centers for Disease Control and Prevention. (1994). Physical Violence During the 12 Months Preceding Childbirth- Alaska, Maine, Oklahoma, and West Virginia, 1990-1991. Morbidity and Mortality Weekly Report, 43,132-6.

U.S. Centers for Disease Control and Prevention. (2006). Recommendations to Improve Preconception Health and Health Care–United States: a report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. Morbidity and Mortality Weekly Report, *55*(RR-6), 1-23.

U. S. Centers for Disease Control and Prevention (1992). STD Surveillance Report.

Children's Defense Fund (1996). The State of American's Children.

Christensen S. and Rosen, A. (1996). Teenage Pregnancy**.** Accessed on May 2009 at http://community.michiana.org/famconn/teenpreg.html.

Community Foundation, Boulder County (2007). Boulder County Civic Forum 2007 Community Indicators Report.

Cooney, TM, Pedersen, FA, Indelicato, S. (1993). Timing of Fatherhood: Is On-time Optional? Journal of Marriage and Family, 55 205-215.

Custer, M., Waller, K., O'Rourke, K., Vernon, S., & Sweeney, A. (2002). Unintended Pregnancy Rates among a US Military Population. Under review for publication.

Dahlberg LL, Krug EG. (2002). Violence-A Global Public Health Problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization,1-56.

DiClemente RJ., Salazar LF., Crosby RA. and Rosenthal SL. (2005). Prevention and Control of Sexually Transmitted Infections among Adolescents: The Importance of a Socio-Ecological Perspective—A Commentary. The Royal Institute of Public Health, 119 825-836.

Edwards SR. (1994). The role of men in contraceptive decision-making: current knowledge and future implications. Family Planning Perspectives, 26 (2):77-82.

Finer, L. B., & Henshaw, S. K. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. Perspectives on Sexual and Reproductive Health, 38 (2), 90–96.

Forehand R, Armistead L, Long N, Wyckoff SC, Kotchick BA, Whitaker D, Shaffer A, Greenberg AE, Murry V, Jackson LC, Kelly A, McNair L, Dittus PJ, Miller KS. (2007). Efficacy of a family based, youth sexual risk prevention program for parents of African American preadolescents. A randomized controlled design. Archives of Pediatrics & Adolescent Medicine, 161, 1123 - 1129
.

Glaser, B. G., & Strauss, A. L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. New York: Aldine Publishing Company.

Green L., Kreuter M. (1990) . Health Promotion as a Public Health Strategy for 1990s. Annual Review of Public Health,11 313-334.

Green-Raleigh, K., Lawrence, J. M., Chen, H., Devine, O., & Prue, C. (2005). Pregnancy Planning Status and Health Behaviors Among Nonpregnant Women in a California Managed Health Care Organization. Perspectives on Sexual and Reproductive Health, 37 179-183.

Hamby, Y. (2008). Regional Quality Improvement Program Annual Report. Tri-Annual Summary.

Hatcher, R., Trussell, J., Nelson, A., Cates, W., Stewart, F., & Kowal, D. (1998). Contraceptive Technology. New York: Ardent Media, Inc.

Henshaw, S. (1998). Unintended pregnancy in the United States. Family Planning Perspectives, 30 (1), 24-28

Kirby, 2002). Effective approaches to reducing adolescent unprotected sex, pregnancy and childbearing. Journal of Sex Research, 39 51-57.

Kirby D, Lepore G, Ryan J. (2005). Sexual Risk and Protective Factors: Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing And Sexually Transmitted Disease: Which Are Important? Which Can You Change? Report for ETR Associates, August 2005.

Klerman, L. and Dawson, P. (2009). Helping plan the next pregnancy. Zero to Three, March 2009.

Lamb, M. (2004). The role of the father: An Introduction. In M.E. Lamb (Ed.). The Role of the Father in Child Development. New York: John Wiley & Sons, Inc.

Lindrooth, R. C., & McCullough, J. S. (2007). The effect of Medicaid family planning expansions on unplanned births. Women's Health Issues, 17 66-74

MacDorman M, Kirmeyer S. (2009). The Challenge of Fetal Mortality. National Center for Health Statistics Data Brief, No 16.

Martinez, G. M., Chandra, A., Abma, J. C., Jones, J., & Mosher, W. D. (2006). Fertility, contraception, and fatherhood: Data on men and women from cycle 6 (2002) of the National Survey of Family Growth. Vital and Health Statistics Series, 23(26), 1–142.

Michigan Department of Community Health. (2007). A New Clinical Guideline for Preventing Unintended Pregnancy in Adults. Developed under the auspices of the Governor's Blueprint for Preventing Unintended Pregnancies, State of Michigan, 2007

Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman, & R. Burgess (Eds.). Analyzing Qualitative Data. London: Routledge.

Stout, C., Shupe, A., McLaughlin, H. (1998). Unintended Pregnancy in Boulder County Data Highlights.

Shupe, A., Smith, A., Stout, C. McLaughlin, H. (2000). The importance of local data in unintended pregnancy prevention programming. Maternal and Child Health Journal, 4 (3), 209-214

Strauss, A., & Corbin, J. (1998). Basics of Qualitative Research: Grounded Theory, Procedures and Techniques. Newbury Park, CA: Sage.

The National Campaign to Prevent Teen and Unplanned Pregnancy. Proportion of All Pregnancies that are Unplanned by Various Socio-Demographics, 2001. Accessed on March 2009 at http://www.thenationalcampaign.org/national-data/pdf/Proportion-Unplanned-Pregnancies-United-States.pdf.

## X. APPENDICES

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# APPENDIX A
# IRB Research Protocol

**PROTOCOL #:**

(Use Protocol Manager on the COMIRB Website)

# COMIRB Protocol

**COLORADO MULTIPLE INSTITUTIONAL REVIEW BOARD**
**CAMPUS BOX F-490 TELEPHONE: 303-724-1055 Fax: 303-724-0990**

**Project Title:** Boulder County Unintended Pregnancy Research Project

**Principal Investigator:** Christine Duclos, PhD

**I. Hypotheses and Specific Aims**:
This research project aims to advance the broader BCPH goal of reducing unintended pregnancy rates in Boulder County. The research is designed to support systematic analytic thinking on the causes and consequences of un/intended pregnancy, to then identify effective use of prevention resources.

The specific aims of the study being addressed:
1. Obtain data on rates of unintended pregnancy/paternity among Boulder County residents aged 13-28. This will be accomplished by developing an epi-profile of unintended pregnancy rates and other indicators of sexual risk-taking behaviors in Boulder County using secondary data analyses of publically available data reported in aggregate format. The profile serves as the first step in promoting data-driven decision-making.
2. Identify factors associated with unintended pregnancy/paternity among Boulder County residents aged 15-24. This will be accomplished through focus groups, key informant interviews (KII), and a literature review. Focus group participant recruitment will target men and women who have had an unintended pregnancy/paternity resulting in parenting.
3. Describe best practices in primary and secondary prevention of unintended pregnancy/paternity. This will be accomplished through the literature review and KII.

**II. Background and Significance**:
A previous study conducted in 1998 examined unintended pregnancy in Boulder County. The focus of this study was to demonstrate how the Boulder County Health Department addressed the problem of the lack of local data on pregnancy intnededness by conducting its own assessment. The information gathered served as the basis for collaborative population-based programming and policy development aimed at decreasing unintended pregnancy in the county. The study found, through a random-digit-dial telephone survey and six focus groups, that the prevention strategies identified by the focus group participants lead to the development of locally relevant interventions among specific high-risk populations identified in the telephone survey. Programmatic and policy initiatives included raising awareness among key service providers and the community at large, creative means of bringing information and resources to those at risk, strengthening the delivery of clinical services, and promoting school involvement in unintended pregnancy prevention. Finally the study concluded that maternal and child health authorities should encourage the collection and use of pregnancy intendedness data at the local level. However, due to changing demographics within Boulder County, as well as commitment to evidence-based public health interventions, BCPH has identified the need for more current information.

**III**. **Preliminary Studies/Progress Report:**

Not applicable

**IV. Research Methods**

**A. Outcome Measure(s):**

The overall goal of this project is to further understand unintended pregnancy/paternity in Boulder County by exploring 13-28 year-old women's and men's life circumstances, events, and relationships surrounding unintended pregnancy resulting in both birth and parenting.

The specific research objectives are to:

- Probe general impressions of un/intended pregnancy among 15-24 year-old women and men who have experience an unintended pregnancy which ended in parenting (Focus Group target population) and key stakeholders (Key Informant Interviews) across Boulder County;
- Understand how the target population and key stakeholders define un/intended pregnancy (variations within the target population and stakeholders);
- Identify factors that help young people avoid, delay, or address unintended pregnancy from both the target population and key stakeholder perspectives;
- Identify factors that inhibit young people from preventing unintended pregnancy, from both the target population and key stakeholder perspective;
- Explore social, cultural, mental health, and economic aspects of unintended pregnancy in various population groups, such as:
    - young women's recollection and perceptions surrounding their experience of their unintended pregnancy
    - young men's recollection and perceptions surrounding their experience of their unintended paternity
    - themes related to the circumstances of the pregnancy/paternity, relationship with baby's mother/father, family and friends, both pre/post birth
    - post-birth life events including, but not limited to, subsequent pregnancies/paternities, education pursuit, employment, living arrangements, child rearing, health problems, and contraception.

**B. Description of Population to be Enrolled: Study Design and Research Methods**

**Description of population to be enrolled:** For the primary data collection, 15-24 year olds living in Boulder County that either had an unintended live birth pregnancy or fathered a live birth unintended pregnancy will be targeted for focus groups of all ethnicities. For Key Informant Interviews, we will include youth service program providers and other key stakeholders identified by the BCPH staff.

**Study design and Research Methods:**

I. First, we will conduct secondary data analyses of public data reported in aggregate format for an epidemiologic perspective of unintended pregnancy and its risk factors within Boulder County.

II. Second, we will conduct focus groups (approximately six to eight but will sample and conduct groups until data saturation) with young men and women aged 15-24 that includes

both quantitative (pre discussion questionnaire) and qualitative data collection (semi-structured interview guide) among a diverse group of young men and women.

III. Third, we will conduct key informant interviews with health care and social service providers, and key stakeholders.

**First data source: Quantitative secondary data review**

The Epi-Profile will describe the extent of the burden and disparity of unintended pregnancy by detailing trends in causes and consequences of unintended pregnancy. The Epi Profile serves as the first step in promoting data-driven decision-making. Secondary data will be done of publically available datasets. The following questions will be considered for all indicators used to measure and report on unintended pregnancy in Boulder County:

- How has this indicator been changing? Is it getting better or worse?
- How does Boulder County compare on this indicator to other communities (counties, the state, the nation)?
- Do the trends seem reflective of the age profile of the county? Of the racial/ethnic diversity of the county? Of the poverty rates in the county? Of other factors?

**The Epi-Profile will report the following key data points:**

**General county demographics:**

- Total population for state and county
- Percent of population below 200% of poverty level for state and county
- Population breakdown for gender, age (13-28), race/ethnicity

**Data sources for general demographics:**

- Boulder County Government
- Vital statistics
- US Census
- Piton Foundation Neighborhood Summary

**Questions to consider in relation to the demographic summary:**

- How does the Boulder County population differ from that of Colorado, in terms of age, race, and sex? What are the greatest distinctions?
- Is the Boulder County population increasing or decreasing?
- What are Boulder County's largest age groups? Are there large variations that are likely to impact health or the need for certain types of pregnancy/pregnancy prevention health promotion and disease prevention activities?
- Do the data suggest special health needs in [PREGNANCY/PREGNANCY PREVENTION?] areas, such as family planning or prenatal care?
- Is Boulder County becoming more racially and ethnically diverse?

**Reproductive health and sexual risk-taking measures among 13-28 year-old residents of Boulder County**

- Fertility rates
- Percent of women accessing family planning services who need these services
- Rates of sexually-transmitted disease in men and women

- Contraception use at last intercourse in men and women
- Drinking at the last intercourse in men and women
- Percent of women physically abused by partner during pregnancy
- Percent of women drinking alcohol during last 3 months of pregnancy
- Percent of women smoking tobacco during last 3 months of pregnancy

**Data Sources for reproductive health and sexual risk-taking measures:**

- Centers for Disease Control and Prevention (CDC)
- Family Planning Annual Report (FPAR)
- Behavioral Risk Factor Surveillance Survey (BRFSS)
- Youth Risk Behavior Survey (YRBS)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- National Survey of Family Growth (NSFG)
- Colorado Organization of Adolescent Pregnancy and Parenting (COAPP) State of Sexual Health

**Questions to consider in relation to reproductive health and sexual risk-taking measures**

- How do Boulder County infectious disease rates compare to other counties and the state?
- Are these rates increasing or decreasing?
- Are there disparities in these rates among various subpopulations in Boulder County?

**Unintended pregnancy measures for 13-28 year-old Boulder County Residents**

- Overall pregnancy rate
- Overall birth rate
- Birth outcomes (low birth weight, premature births)
- Abortion rate
- Teen births
- Teen pregnancy (live births, abortions, fetal deaths (miscarriages)
- Intervals between pregnancy-pregnancies that are too closely spaced are often unintended. "Too closely spaced" defined as less than 12 months between pregnancies

**Data sources for unintended pregnancy measure:**

- Measurements of pregnancy intention are typically measured through national surveys:
  - PRAMS Pregnancy Risk Assessment Monitoring System
    - Data collected retrospectively and asked 2-3 months after delivery
  - NSFG National Survey of Family Growth
    - Within 5 years of infant's birth
  - NMIHS National Maternal and Infant Health Survey
    - Self-administered survey

**Local Data Sources**

- Birth certificates
- Fetal death certificates
- Abortion reports

**Questions to consider for un/intended pregnancy measures:**

- For planning purposes, has the birth rate increased over the past years? Has the poverty rate also increased?
- What are the demographic characteristics of mothers? Has the percent of mothers over age 20 increased over the years? Has the percent under age 20 increased? What is the racial composition of mothers? Has this changed over time?

- Are infants born healthy (look at birth outcomes of infants, including low birth weight, infant mortality, and prematurity)? May be necessary to aggregate years for these indicators.

**Second data source: Qualitative secondary data review**

- 1998 study by Shupe et al
- GENE(SIS)TER Project Focus Group Report
- NARAL/Laurie Hawkins Qualitative Interview Report on Contraceptive Use and Pregnancy
- Latina Teen Fertility Project Report, Fort Collins
- Understanding Early Teen Pregnancy Interview Report
- The Young Male Perspective of Birth Control and Sexual Decision-Making Report

**Third data source: Literature review**

The literature offers the opportunity to conduct a review of the existent research in relation to risk-factors, determinants and well as successful prevention of unintended pregnancy. The focus of the literature review is to analyze the body of literature published on unintended pregnancy to identify particular trends and gaps.

The research team will focus on obtaining the appropriate breadth and depth, rigor and consistency, clarity and brevity, and effective analysis and synthesis; in other words, the use of the ideas in the literature to justify the particular approach to the study, the selection of methods and demonstration that this study contributes a new understanding of the impact of unintended pregnancy among Boulder County residents.

**Fourth data source: Qualitative primary data collection - Focus Groups**

Focus groups offer researchers the ability to discover insights into behavior, attitudes, beliefs, and trends among those interviewed. Focus groups are based on the theory of social interaction, and explore the depth of understanding and motivations regarding the subject of interest (unintended pregnancy). They can provide a source of risk information essential to the design of effective programs. Further, the focus group format was chosen because of its ability to generate data which will identify: 1) program concepts; 2) the scope of issues important to the target population; and 3) successful prevention strategies.

Last, the focus groups will use an open-ended methodology that would generate as much information as possible from participants.

**Fifth data source: Qualitative primary data collection - Key Informant Interviews (KIIs)**

KIIs are useful in exploring issues for the purpose of planning and the implementation of a program, especially when there is a need for us to understand motivation, behavior and perspectives of clients and community partners. KIIs are an important aspect of qualitative data collection when the outcome is to generate recommendations for programs/services to address a particular health issue.

### C. Description, Risks and Justification of Procedures and Data Collection Tools:

**Primary Data Collection with Focus Groups.** Nine to twelve focus groups will be conducted with those 15-24. We will schedule and conduct focus groups until data saturation or groups are not contributing any new information. Focus groups are planned with both females who experienced an unintended pregnancy and males who fathered an unintended pregnancy that resulted in live births. They are stratified by male and female, ethnicity, and under 18 and over 18.

We will recruit potential focus group participants with the help of Boulder County Public Health (BCPH) who will post and distribute flyers within their organization and to their clients as well as within the community and community youth serving agencies. The flyers has contact information

for those that are interested in participating. Once potential participant contacts study staff, they will receive additional information about the focus groups and asked if they want to participate, and a short anonymous screen will be conducted for eligibility (screener attached). For those wanting to participate and screen eligible, contact information will be recorded (separate from screening information) for scheduling of focus group. For those not eligible, screening information will be destroyed.

Focus groups will be conducted in an easy accessible room within Boulder County identified with the help of BCPH staff. When place and time is set, participants will be recontacted with the information. Once recontacted, all contact information will be destroyed.

At the start of the focus group, all participants will be given the assent or consent (which ever is age appropriate) to read. The consent will be reviewed by the focus group facilitator (a member of study team) and questions will be solicited. The group will then be asked to repeat back what the study entails to access full comprehension and/or make clarifications if needed. After assent or consent is gotten, a Pre-Discussion Questionnaire will be handed out for self report. This questionnaire is anonymous and will not be able to be linked back to an individual participant. Questionaires will be collected, and then the focus group discussion will begin guided by a semi-focus group discussion guide (attached).

We request a waiver of parental consent for the 15-17 year olds. Obtaining parental consent we feel will hinder participation and quality of data collected. The questions are sensitive and may bring undue hardship to the youth if parents were involved. We are also asking for waiver of assent or consent for conducting the screener. The screener will be completely anonymous other than asking for place of residence within Boulder County. We need this information to schedule the groups as well as help us recruit from a wide area within Boulder County. Once eligibility or noneligibility is determined the screening information will be destroyed.

All focus groups will be audio-taped. We will request that the participants not use names within the groups. However, if any names are used, the transcriber will delete and only transcribe what is said by a unique identifier such as “Participant A.” A $30 incentive will be given to focus group participants.

**Primary Data Collection with Key Informant Interviews**

Eighty key informant interviews are planned and will be guided by a Key Informant Semi-Structured Interview Guide (see attached). The BCPH staff will provide youth service providers andf key stakeholder contacts and a search will be done of youth serving agencies within Boulder County. Key informants will be contacted by email and/or phone (see attached telephone/email script). The interview does not ask about any personal information but only includes questions about their perceptions of unintended pregnancies within Boulder County and the services provided within the County. If provider or key stakeholder agrees to participate, a consent will be emailed or sent to them and an interview time scheduled. On the scheduled interview time, the consent will be reviewed with the participant and any additional questions answered. The interview will commence. We expect it to last approximately 1 to 1 ½ hours. No incentive will be provided. Thie interview will not be audiotaped. Notes will be maintained by the interviewer.

We are requesting waiver of documentation of consent for the telephone survey. Conducting the interview by telephone hinders receiving a signed document.

**D. Potential Scientific Problems:**

Potential scientific problems include bias of data towards those that self select to participate. Recruitment will be directed at the whole universe of 15-24 year olds and service providers/key stakeholders, however we do realize this is a limitation.

### E. Data Analysis Plan:

Quantitative data will be input into an SPSS database and analyzed for descriptive frequencies (ex. Pre discussion questionnaire). ualitative data will be analyzed using content and editing analyses that allows for emerging themes using ATLAS qualitative software. Audiotapes will be transcribed into an electronic text document that will then be downloaded into ATLAS software.

### F. Summarize Knowledge to be Gained:

Knowledge to be gained is an understanding of the context around unintended pregnancy which then could be used to provide services that will reduce the unintended pregnancy rate for 13-24 year olds within Boulder County  The causes and consequences of unintended pregnancy for 13-24 year olds in Boulder County gathered from data from the participants themselves including barriers and facilitators for preventive services will inform more effective prevention programming and use of prevention resources.

# APPENDIX B
# Focus Group Recruitment Flyers

# Look familiar?

Did you have an unexpected pregnancy?
Are you between the ages of 15-24?
Do you live in Boulder County?

If so:
Come join Boulder County Public Health in **a research study** of unplanned pregnancy. We are holding focus groups with moms between the ages of 15-24. If you qualify, you can be a part of a group discussion with other women who have gone through an unexpected pregnancy.

***Food and incentive will be provided to each group member. Child care will also be available, if needed.***

**For more info, please call 303-262-4330.**

# ¿Se te hace familiar?

¿Quedaste embarazada sin planearlo?
¿Tienes entre 15 y 24 años de edad?
¿Vives en el condado de Boulder?

Si es así:
Únete al departamento de salud del condado de Boulder en un estudio de investigación sobre embarazos no planeados. Estamos llevando a cabo grupos de enfoque con madres de 15 a 24 años de edad. Si te encuentras en ésta situación, participa en una discusión con otras mujeres quienes también han enfrentado un embarazo no planeado

*Se proveerá comida e incentivos para cada participante.*
*Habrá cuidado de niños disponible si es necesario.*

Para mas información llama al 303.262.4330.

# Has your life changed in a heartbeat?

Boulder County Public Health is looking for people who have experienced an unexpected pregnancy.

If you are between the ages of 15-24 and live in Boulder County then you are invited to join us in a research study of unplanned pregnancy. If you qualify, you can be part of a group discussion to share your experiences with others.

*Food and incentive will be provided to each group member. Child care will also be available, if needed.*

For more information please call 303.262.4330.

# ¿Te cambió la vida inesperadamente?

## ¿Has enfrentado un embarazo no planeado?

## ¿Tienes entre 18 y 24 años de edad?

## ¿Vives en el condado de Boulder?

Si es así:
Únete al departamento de salud del condado de Boulder en un estudio de investigación sobre embarazos no planeados. Estamos llevando a cabo grupos de enfoque con padres y madres de 18 a 24 años de edad. Si te encuentras en ésta situación, participa en una discusión con otros quienes también han enfrentado un embarazo no planeado.

*Se proveerá comida e incentivos para cada participante.*
*Habrá cuidado de niños disponible si es necesario.*

**Para mas información llama al 303-262-4330.**

# Paternidad Inesperada

¿Eres padre de un bebe?

¿Tienes entre 18 y 24 años de edad?

¿Vives en el condado de Boulder?

Si es así:
Únete al departamento de salud del condado de Boulder en un estudio de investigación sobre embarazos no planeados. Estamos llevando a cabo grupos de enfoque con padres de 18 a 24 años de edad. Si te encuentras en ésta situación, participa en una discusión con otros hombres quienes también han enfrentado un embarazo no planeado.

*Se proveerá comida e incentivos para cada participante.*
*Habrá cuidado de niños disponible si es necesario*

**Para mas información llama al 303-262-4331.**

# Unexpected Fatherhood

Have you fathered a baby?

Are you between the ages of 18-24?

Do you live in Boulder County?

Come join Boulder County Public Health in a research study of unplanned pregnancy. We are holding focus groups with dads between the ages of 18-24. If you qualify, you can be part of a group discussion with others who have gone through unexpected fatherhood.

***Food and incentive will be provided to each group member. Child care will also be available, if needed.***

**For more info please call 303-262-4330.**

# APPENDIX C
# Focus Group Screening Form

PI: Christine Duclos
COMIRB #: 09-0216
Version #1
04/08/09

# Focus Groups on Unintended Pregnancy/Paternity Issues
# Screening Form

1. How old are you?
   _____13-14 years of age
   _____15-17 years of age
   _____18-24 years of age
   _____25-28 years of age
   _____none of the above* (*if selected, discontinue the screening process - eligibility criteria not met)

2. Which of the following best describes the place where you live?
   _____ Boulder
   _____ Erie
   _____ Jamestown
   _____ Lafayette
   _____ Longmont
   _____ Louisville
   _____ Lyons
   _____ Nederland
   _____ Niwot
   _____ Superior
   _____ Ward
   _____ None of the above* (*if selected, verify that the individual is a resident of Boulder County before discontinuing the screening process due to ineligiblity)

3. What is your gender?
   _____Male --If male, skip to question #7
   _____Female

4. Have you ever been or are you currently pregnant?

   _____Yes
   _____No* (*if selected, discontinue the screening process - eligibility criteria not met)

5. How old were you when you gave birth? _____

6. Thinking back to just before you got pregnant, how did you feel about becoming pregnant?
   _____ Wanted sooner(*if selected, discontinue the screening process - eligibility criteria not met)
   _____ Wanted later
   _____ Wanted then(*if selected, discontinue the screening process - eligibility criteria not met)
   _____ Never wanted

**<u>THIS COMPLETES THE SCREENING TOOL FOR FEMALES</u>**

7. Have you ever gotten your girlfriend/sexual partner pregnant?
   _____ Yes
   _____ No (*if selected, discontinue the screening process - eligibility criteria not met)

8. How old were *you* when your girlfriend/sexual partner gave birth? _____

9. How old was your girlfriend/sexual partner when she gave birth? _____

10. Thinking back to just before the pregnancy, how did you feel about it?
    _____ Wanted sooner (*if selected, discontinue the screening process - eligibility criteria not met)
    _____ Wanted later
    _____ Wanted then (*if selected, discontinue the screening process - eligibility criteria not met)
    _____ Never wanted

**THIS COMPLETES THE SCREENING TOOL FOR MALES**

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## INSTRUCTIONS FOR SCREENERS:

**If the participant IS eligible for participation in the study:**

1. Congratulate him/her for being eligible to participate in a focus group.
2. Tell him/her the time, date and location of their assigned focus group.
3. Tell him/her that $30 will be given for their participation in the focus group.
4. Ask whether or not transportation assistance will be needed.
   a. If yes, explain what will be provided.
5. Ask whether or not child care assistance will be needed.
   a. If yes, explain what will be provided.
6. Ask if they have any additional questions at this time.
7. Ask how they would like to be contacted (either by phone or email) one day prior to the focus group with a reminder.
8. Tell him/her that he/she should feel free to pass along our contact information to anyone they know of who may be interested and eligible for the study.

**If the participant is NOT eligible for participation in the study:**

1. Thank them for calling.
2. Explain why he/she is not eligible.
3. Ask if they have any additional questions at this time.
4. Tell him/her that if he/she should feel free to pass along our contact information to anyone they know of who may be interested and eligible for the study.

# APPENDIX D
# Focus Group
# Pre-Discussion Questionnaires

PI: Christine Duclos, PhD
COMIRB #: 09-0216
Version #1
04/08/09

PRE-DISCUSSION QUESTIONNAIRE FOR FEMALES

Thank you for agreeing to participate in a focus group to help us better understand planning for a pregnancy.

We are doing this study to find out why some women become pregnant even when they really didn't want to get pregnant. During our discussion we are going to talk about your thoughts and feelings on birth control, pregnancy and what it's like to have a baby.

Everything said during the discussion will be held confidential by the researcher. We will not ask you your name, thus cannot link anything you say to the results. If someone accidently mentions your name, who ever transcribes the tape recordings will delete your name.

As researchers, we cannot control what is said outside the group but we ask that all participants keep what is said in the group within the group and not discuss what is said with anyone outside the group.

Before our discussion, we have some other questions about you and your experience with sex, birth control, and pregnancy. There are no wrong answers to any of the questions. It will help us a lot if you can answer as many questions as possible, but you do not have to answer any question you don't want to. **PLEASE DO NOT PUT YOUR NAME ON THIS FORM.**

THANK YOU FOR YOUR TIME AND HONESTY!

---

How old are you? _____

What race and or ethnicity do you think you are? Mark all that apply.

_____ White or Caucasian
_____ Black or African American
_____ Asian
_____ Hispanic / Latino
_____ American Indian or Alaska Native
_____ Hawaiian / Pacific Islander
_____ Prefer not to answer

What country were you born in?

_____United States
_____Mexico, Spain, Central America, South America
_____Other

**If NOT the United States, then**: How long have you lived in the United States?

_____less that one year
_____1 to 5 years
_____6 to 10 years
_____10 or more years

What is your marital status?

_____Married
_____Single, not in a relationship
_____Single, in casual relationships with several boyfriends/partners
_____Single, committed relationship with one boyfriend/partner

What kind of health insurance do you have?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ Private health insurance (HMO, PPO, or other) | _____ Military Insurance | _____ Medicaid | _____ Other Gov't insurance Such as CHP (Child Health Plan) or CHICP (Colorado Indigent Care Program) or Other | _____ I Don't have insurance/ Uninsured | _____ Student / Other | _____ Prefer not to answer | _____ Don't know |

What is the highest year of school you completed? Include this year if you are still in school.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ Didn't go to school | _____ Some school but no diploma or GED | _____ High School or GED | _____ Vocational/ Technical training | _____ Some college or Associate Degree | _____ B.A. or B.S/Four Year college degree | _____ Graduate School | _____ Prefer not to answer |

In 2008, what was your total estimated family income from all sources, if you know?
_____

How many people live on this income, including yourself?

_____1
_____2
_____3
_____4 or more
_____Prefer not to answer

Have you ever been sexually active? (only mark "yes" for sex that includes a penis being put in a vagina)

_____Yes
_____No
_____Prefer not to answer

How old were you the first time you had sex? _____

Have you ever been diagnosed with a sexually transmitted disease/infection (STD/STI)?

_____Yes
_____No
_____Not sure
_____Prefer not to answer

How many times have you ever been pregnant? Please include all pregnancies regardless of if they resulted in a live birth or not. _____

Have you ever had a miscarriage?

_____Yes
_____No
_____Prefer not to answer

Have you ever had an abortion?

_____Yes
_____No
_____Prefer not to answer

How many babies have you had? _____

Thinking back to all pregnancies you have had in the past, have you ever gotten pregnant when you were not actively trying to?

_____Yes: One time
_____Yes, More than once
_____No
_____Prefer not to answer

| | For any of your pregnancies, what form of birth control were you using (if any) **when you got pregnant?** Please check all that apply. | What kind of birth control did you use **the last time you had sex**? Please check all that apply. | What method of birth control have you used **most often** in the last year? |
|---|---|---|---|
| I didn't use birth control | | | |
| Birth control pills | | | |
| Condoms | | | |
| Shots like, Depo Provera or Lunelle | | | |
| IUD such as Paragard or Mirena | | | |
| Diaphragm or Cervical cap | | | |
| Female condom | | | |
| Nuva ring (hormonal ring inserted in the vagina) | | | |
| Foam, jelly, cream, film or suppository | | | |
| Sponge | | | |
| Implanon | | | |
| Patch, such as Evra | | | |
| Norplant | | | |
| Rhythm Method/Natural Family Planning | | | |
| Withdrawal (boyfriend/husband pulled out) | | | |
| Emergency Contraception (EC, morning-after pill, Plan B) | | | |
| Abortion | | | |
| Other | | | |
| Prefer not to answer | | | |

How frequently do you use the type of birth control you selected above?

| | | | | |
|---|---|---|---|---|
| _____ Every time | _____Most times | ____About 1/2 the time | _____Sometimes | _____Only once |

If you take birth control pills, how frequently do you take the pill?

| | | | | |
|---|---|---|---|---|
| _____ Every day | _____Most days | ____About 1/2 the time | _____Sometimes or when I remember | _____Rarely |

If you use birth control shots (Depo), how regularly did you return for your shots? In other words, how on time or late were you? You should count it as late if you were more than one week past your due date for your next shot. Were you:

| | | | |
|---|---|---|---|
| _____Always on Time | _____Late one time | _____Late 2 times | _____Late 3 or more times |

Have you had sex in the past year without using birth control when you did NOT want to get pregnant?

_____Yes
_____No
_____Prefer not to answer

Have you ever had sex without using birth control while you were under the influence of drugs or alcohol?

_____Yes
_____No
_____Prefer not to answer

Thinking about the times you had sex without birth control when you did NOT want to become pregnant, why didn't you use birth control? Check all that apply?

| | |
|---|---|
| _____ | I was not having sex regularly |
| _____ | I would not have minded being pregnant |
| _____ | I used the rhythm method or the natural family planning method |
| _____ | My partner pulled out/withdrew |
| _____ | I didn't care or worry about getting pregnant |
| _____ | I forgot |
| _____ | I don't like how it feels with a condom |
| _____ | I wasn't thinking |
| _____ | I didn't know what kind of birth control to use |
| _____ | My church tells me that it is wrong to use birth control |
| _____ | I left it to chance or fate when I would have babies |
| _____ | I left it to God's will when I would have babies |
| _____ | I believe birth control is unhealthy or unnatural |
| _____ | I stopped using birth control because of side effects |
| _____ | My husband/boyfriend would not allow birth control |
| _____ | My husband/boyfriend doesn't like birth control |
| _____ | I have no privacy at my clinic or doctor's office and I was embarrassed to ask |
| _____ | I have no access to a doctor, health clinic or pharmacy |
| _____ | I was drunk, high or under the influence of drugs or alcohol |
| _____ | I am/was in a relationship and my boyfriend/husband and I had agreed not to have sex with other people |
| _____ | I lost my insurance |
| _____ | My insurance doesn't cover birth control |
| _____ | Birth control costs too much |
| _____ | I don't know |
| _____ | This does not apply to me |
| _____ | I was afraid if I insisted, he'd leave me |
| _____ | I didn't want my parents to find out I was on birth control |
| _____ | My mother/father doesn't want me on birth control |
| _____ | I was afraid if I insisted he'd think I thought he had an STD |
| _____ | I couldn't ask about it |
| _____ | Other:_____ |

On a scale of 1 to 5, how would you rate the cost of birth control - with 1 being "not expensive at all" and 5 being "very expensive?"

| | | | | | |
|---|---|---|---|---|---|
| 1<br>not expensive at all | 2 | 3 | 4 | 5<br>very expensive | 0<br>Prefer not to answer |

On a scale of 1 to 5, how big an issue is it to get transportation to a doctor, clinic or pharmacy that can give you birth control - with 1 being “not an issue at all” and 5 being “a very big issue”?

| 1<br>Not an issue at all | 2 | 3 | 4 | 5<br>a huge issue | 0<br>Prefer not to answer |
|---|---|---|---|---|---|

What else makes it hard for you to get birth control?

_____

Are you able to get/use your first choice of birth control?

_____Yes
_____No
_____Prefer not to answer

**(For Spanish Speakers Only)** Do you have trouble finding clinics that offer birth control options that have staff that speak Spanish?

_____Yes
_____No
_____Don’t know
_____Prefer not to answer

How often do you think other women your age use birth control?

| _____ Don’t know | _____Never | _____Sometimes | _____Most times | _____Every time they have sex |
|---|---|---|---|---|

**How strongly do you agree or disagree with each of the following statements**
**A "1" response says that you strongly disagree with the statement, while a 5" says that you strongly agree with the statement.**

| | Strongly Disagree | | | | Strongly Agree |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| If I use birth control, my boyfriend might think I'm being unfaithful. | | | | | |
| If I use birth control, I'm "easy". | | | | | |
| Why should I use birth control if it can fail? | | | | | |
| My boyfriend would think I don't love him if I insisted on using birth control. | | | | | |
| Only women who sleep around use birth control. | | | | | |
| No one I know uses birth control. | | | | | |
| I don't have any control over when I get pregnant. | | | | | |
| I'm willing to ask my partner if he has pregnancy protection with him. | | | | | |
| I don't mind stopping during sex to get a condom. | | | | | |
| I care more about safety than being "in the moment" during sex. | | | | | |
| I'm okay with stopping sex if I don't have birth control. | | | | | |
| I'm willing to discuss birth control with my partner before sex. | | | | | |
| If a man wants to have sex with me he has to agree to using birth control. | | | | | |
| If a man cares about me he won't mind using a condom. | | | | | |
| If I don't have a method available for preventing pregnancy I just won't have sex. | | | | | |
| If I lost my health insurance, I would still use birth control. | | | | | |

| | Strongly Disagree | | | | Strongly Agree |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| I make sure I always have birth control with me. | | | | | |
| The side effects from birth control are worth managing | | | | | |
| If my usual birth control is unavailable I will use something else. | | | | | |
| I plan for birth control even when I am not regularly having sex. | | | | | |
| I am never too busy to worry about getting pregnant. | | | | | |
| I don't like waiting until the last minute to decide about birth control. | | | | | |

PI: Christine Duclos, PhD
COMIRB #: 09-0216
Version #1
04/07/09

PRE-DISCUSSION QUESTIONNAIRE FOR MALES

Thank you for agreeing to participate in a focus group to help us better understand planning for a pregnancy.

We are doing this study to find out why some men become fathers even when they really didn't want to get their girlfriend or partner pregnant. During our discussion we are going to talk about your thoughts and feelings on birth control and what it's like to be part of an unplanned pregnancy.

Everything said during the discussion will be held confidential by the researcher. We will not ask you your name, thus cannot link anything you say to the results. If someone accidently mentions your name, who ever transcribes the tape recordings will delete your name.

As researchers, we cannot control what is said outside the group but we ask that all participants keep what is said in the group within the group and not discuss what is said with anyone outside the group.

Before our discussion, we have some other questions about you and your experience with sex, birth control, and unplanned pregnancy. There are no wrong answers to any of the questions. It will help us a lot if you can answer as many questions as possible, but you do not have to answer any question you don't want to. **PLEASE DO NOT PUT YOUR NAME ON THIS FORM.**

THANK YOU FOR YOUR TIME AND HONESTY!

---

How old are you? _____

What race and or ethnicity do you think you are? Mark all that apply.

_____ White or Caucasian
_____ Black or African American
_____ Asian
_____ Hispanic / Latino
_____ American Indian or Alaska Native
_____ Hawaiian / Pacific Islander
_____ Prefer not to answer

What country were you born in?

_____United States
_____Mexico, Spain, Central America, South America
_____Other

**If NOT the United States, then**: How long have you lived in the United States?

_____less that one year
_____1 to 5 years
_____6 to 10 years
_____10 or more years

What is your marital status?

_____Married
_____Single, not in a relationship
_____Single, in casual relationships with several girlfriends/partners
_____Single, committed relationship with one girlfriend/partner

What kind of health insurance do you have?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ Private health insurance (HMO, PPO, or other) | _____ Military Insurance | _____ Medicaid | _____ Other Gov't insurance Such as CHP (Child Health Plan) or CHICP (Colorado Indigent Care Program) or Other | _____ Don't have insurance/ Uninsured | _____ Student / Other | _____ Prefer not to answer | _____ Don't know |

What is the highest year of school you completed? Include this year if you are still in school.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ Didn't go to school | _____ Some school but no diploma or GED | _____ High School or GED | _____ Vocational/ Technical training | _____ Some college or Associate Degree | _____ B.A. or B.S/Four Year college degree | _____ Graduate School | _____ Prefer not to answer |

In 2008, what was your total estimated family income from all sources, if you know?
_____

How many people live on this income, including yourself?

_____1
_____2
_____3
_____4 or more
_____Prefer not to answer

Are you in a sexual relationship right now? (only mark "yes" for sex that includes a penis being put in a vagina)

_____No
_____Yes, with several people
_____Yes, with one person
_____Prefer not to answer

How old were you the first time you had sex? _____

Have you ever been diagnosed with a sexually transmitted disease/infection (STD/STI)?

_____Yes
_____No
_____Not sure
_____Prefer not to answer

| | For any of your partner's pregnancies, what form of birth control were you using (if any) **when she/they got pregnant?** Please check all that apply. | What kind of birth control did you and any of your partners use **the last time you had sex**? Please check all that apply. | What method of birth control have you and any of your partners used **most often** in the last year? Please check all that apply. |
|---|---|---|---|
| We didn't use birth control | | | |
| She is on birth control pills | | | |
| Condoms | | | |
| Shots like, Depo Provera or Lunelle | | | |
| IUD such as Paragard or Mirena | | | |
| Diaphragm or Cervical cap | | | |
| Female condom | | | |
| Nuva ring (hormonal ring inserted in the vagina) | | | |
| Foam, jelly, cream, film or suppository | | | |
| Sponge | | | |
| Implanon | | | |
| Patch, such as Evra | | | |
| Norplant | | | |
| Rhythm Method/Natural Family Planning | | | |
| Withdrawal / Pulled out | | | |
| Emergency Contraception (EC, morning-after pill, Plan B) | | | |
| Abortion | | | |
| Other | | | |
| Prefer not to answer | | | |

How frequently do you or your partner use the type of birth control you selected above?

| | | | | |
|---|---|---|---|---|
| _____ Every time | _____Most times | ____About 1/2 the time | _____Sometimes | _____Only once |

How many partners have you gotten pregnant when you were not actively trying to?
_____

Have you ever unexpectedly gotten the same partner pregnant more than once?

_____Yes
_____No
_____Don't know
_____Prefer not to answer

Have you had sex in the past year without using birth control when you did NOT want to get your partner pregnant?

_____Yes
_____No
_____Prefer not to answer

Have you ever had sex without using birth control while you were under the influence of drugs or alcohol?

_____Yes
_____No
_____Prefer not to answer

Thinking about the times you had sex without using birth control when you did NOT want to get someone pregnant, why didn't you use birth control? Check all that apply.

| | |
|---|---|
| _____ | I was not having sex regularly |
| _____ | I would not have minded her being pregnant |
| _____ | We used the rhythm method or the natural family planning method |
| _____ | I pulled out/withdrew |
| _____ | I didn't care or worry about getting my partner pregnant |
| _____ | I forgot |
| _____ | I don't like how sex feels with a condom |
| _____ | I wasn't thinking |
| _____ | I didn't know what kind of birth control to use |
| _____ | My church tells me that it is wrong to use birth control |
| _____ | I left it to chance or fate when I would become a father |
| _____ | I left it to God's will when I would become a father |
| _____ | I believe birth control is unhealthy or unnatural |
| _____ | I don't like birth control |
| _____ | I have no privacy at my clinic or doctor's office and I was embarrassed to ask |
| _____ | I have no access to a doctor, health clinic or pharmacy |
| _____ | I was drunk, high or under the influence of drugs or alcohol |
| _____ | My partner and I agreed not to have sex with other people |
| _____ | I lost my insurance |
| _____ | My insurance doesn't cover birth control |
| _____ | Birth control costs too much |
| _____ | I don't know |
| _____ | This does not apply to me |
| _____ | I was afraid if I insisted she'd think I had an STD |
| _____ | I couldn't ask about it |
| _____ | Other:_____ |

On a scale of 1 to 5, how would you rate the cost of birth control - with 1 being "not expensive at all" and 5 being "very expensive?"

| | | | | | |
|---|---|---|---|---|---|
| 1<br>not expensive at all | 2 | 3 | 4 | 5<br>very expensive | 0<br>Prefer not to answer |

On a scale of 1 to 5, how big an issue is it to get transportation to a doctor, clinic or pharmacy that can give you birth control - with 1 being "not an issue at all" and 5 being "a very big issue"?

| | | | | | |
|---|---|---|---|---|---|
| 1<br>Not an issue at all | 2 | 3 | 4 | 5<br>a huge issue | 0<br>Prefer not to answer |

What else makes it hard for you to get birth control?

_____

Are you able to get/use your first choice of birth control?

_____Yes
_____No
_____Prefer not to answer

**(For Spanish Speakers Only)** Do you have trouble finding clinics that offer birth control options that have staff that speak Spanish?

_____Yes
_____No
_____Don't know
_____Prefer not to answer

How often do you think other men your age use birth control?

| | | | | |
|---|---|---|---|---|
| _____ Don't know | _____Never | _____Sometimes | _____Most times | _____Every time they have sex |

**How strongly do you agree or disagree with each of the following statements**
**A "1" response says that you strongly disagree with the statement, while a 5" says that you strongly agree with the statement.**

| | Strongly Disagree | | | | Strongly Agree |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| If my girlfriend uses birth control, I might think she's unfaithful. | | | | | |
| If my girlfriend use birth control, she's "easy". | | | | | |
| Why should I use birth control if it can fail? | | | | | |
| Only people who sleep around use birth control. | | | | | |
| No one I know uses birth control. | | | | | |
| I don't mind stopping during sex to get a condom. | | | | | |
| I care more about safety than being "in the moment" during sex. | | | | | |
| I'm okay with stopping sex if we don't have birth control. | | | | | |
| I'm willing to discuss birth control with my partner before sex. | | | | | |
| If I don't have a method available for preventing pregnancy I just won't have sex. | | | | | |
| I make sure I always have birth control with me. | | | | | |

# APPENDIX E
# Focus Group Discussion Guides

PI: Christine Duclos, PhD
COMIRB #: 09-0216
Version #1
04/08/09

**Proposed focus group guide for 15-17 year-old females**

**Brief overview and review of the purpose of the focus group.**

Hello everyone. My name is _____ and I am here on behalf of Boulder County Public Health, to help facilitate this focus group about understanding planning for a pregnancy.

First, we appreciate you taking time to join this discussion. Please help yourself to drinks and snacks at any time. And to thank you, we will also be giving everyone their cash incentives before you leave today.

As I mentioned, we are doing this study to explore reasons why some women become pregnant even when they may not really want to. Everyone in the group today has had a baby, so we are going to be talking about birth control, pregnancy and what it's like to have a baby.

We ask that everyone participates and please know that everything you say here today is confidential and we will not be using your name or identifying you personally in any way in any of our research. We also ask that everyone keeps what is said in the group within the group and not discuss what is said to anyone outside the group. While we can protect what you say in our data and results we cannot protect what you say from other members of the group.

We would like to tape record the discussion because it is hard for me to run the group and also remember everything that is said. The tapes will be destroyed after we have transcribed notes from the discussion. We won't use anyone's names in our discussion here today. And if someone accidently mentions your name, who ever transcribes the tape recordings will delete your name from the notes. In our research study we may reference a comment you made such as “she said that she didn’t like to use condoms,” but your name will never be used and you will be identified only by a study number in any of our records. Is everyone comfortable with us tape recording?

Our talk should last about 90 minutes. There are no wrong answers to any of the questions. We are just looking for your opinions and feelings, so anything you have to say will be helpful. Although the questions are asked in a specific order, please jump in if you think of something related to an earlier subject.

Please speak one at a time so that the tape recorder can clearly record what you say.

Do you have any questions?

Okay then, let’s get started...

**Messaging (Warm-up Questions)**

Let's start by talking about what people your age like to do and where do you like to hang out?
*Prompts: on the street, around school, in cars, parks, , shopping, mall, , friends house, home, party, sports, clubs.*

If you want to learn about how to have relationships or sex, would you use the radio, TV, internet, movies, or magazines to help figure it all out?

If you wanted to get information about birth control, where might you go?
*Prompts: school, medical office, parents, friends, aunt, internet,*

**Defining Unintended Pregnancy:**

For you, what is a "planned" pregnancy?

For you, what is an "unplanned" pregnancy?
*Prompts:*

- *trying hard not to get pregnant*
- *getting pregnant when you didn't want to be*
- *didn't want to be pregnant yet, maybe later*
- *never wanted to be pregnant*

For you, what is an "unintended" pregnancy?
*Prompts: Is it the same as unplanned?*

**General Impressions of Unintended Pregnancy:**

Thinking back to when you became pregnant, what did the other kids think about you, or say to you when they found out?

What things changed for you when you realized you were pregnant?
*Prompts: living arrangements, school, daily activities, health status, social life, family life, risk behaviors*

What were some happy or good times for you when you were pregnant?
*Prompts: describe specific events, other people involved; why was this time particularly good for you?*

When you see another teen that is pregnant, what do you think?

What did you think it would be like to have a baby?
*Prompts:*

- *It's difficult / Babies cry all the time*
- *It's fun / Babies are fun to have around*
- *People are nicer to me when I have a baby*
- *It's easy / It's not as hard as some people say it is*
- *Friends and family will help babysit*
- *I have other plans for my immediate future*
- *A baby would complicate my life*

Describe what your life is like now. How do you think your life would be if you had not had a baby when you did?

Tell me about some of the things you like about having a baby at a young age?

What are some of the things that are difficult about having a baby at a young age?

**Factors that make it more likely that people will get pregnant:**

Next, we'd like to learn more about what people your age think about relationships, sex and pregnancy. We'd also like you to help us understand more about how you talk about sex and decide whether or not to use contraception/birth control with your partners. In your opinion…

Do people your age hear messages about how not to get pregnant? If so, from where?
*Prompts: friends, TV, movies, teachers/school, parents/family, church, doctor's office*

Do you know what "emergency contraception" is? (Otherwise known as EC, morning-after pill, day-after pill)

How much do you think your family relationships effect whether someone your age gets pregnant or not? How?
*Prompts: religion, parent's relationship, strict/not strict*

How much older or younger should your partner be? How much older is too old?

Are you, or were you, comfortable talking with your boyfriend about having sex?

Whose responsibility is it to provide the birth control in a relationship? Why?

What do you think are some of the reasons that some people your age don't use birth control and/or condoms?

Why? What stories have you heard about other people using birth control?

Do you think birth control doesn't work sometimes? Why do you think that happens?

When is it a good time for a woman to go on birth control?

When/why do you think some teens have sex without using protection?
*Prompts:*

- *Can't afford birth control*
- *Don't know how to use birth control*
- *Don't like using birth control*
- *Partner doesn't like using birth control*
- *Overwhelmed by the urge to have sex (The urge to have sex is too strong)*

Can you think of things that would make it easier for teens to get and use birth control and/or condoms?

Were you able to get your first choice of birth control you wanted? If not, why?

Have you heard about some of the newer methods of birth control (NuvaRing and the Patch)?

Do you think these are good choices for teens? Why or why not?

Have you heard about some of the long-acting methods of birth control? (such as IUDs (Paragard and Mirena or Implanon)?

Do you think these are good choices for teens? Why or why not?

What kind of support from friends, family and/or teachers do you think people your age need in order to avoid pregnancy?

Looking back, what might have helped you either wait to get pregnant or avoid becoming pregnant?

What do you think is different between girls that become pregnant at your age and girls that don't? *Prompts: Is there something different that helped them prevent becoming pregnant before they wanted to?*

**Mental Health Aspects of Unintended Pregnancy:**

Thinking about your life before you got pregnant, what was different for you?
*Prompts: where you lived, school, what you spent time doing (how you spent your free time), relationships with friends.*

How did you feel when you found out you were pregnant? Were you glad, or sorry or terrified, or all of them at once?

And how did you cope with all these feelings? *Prompts: depression, anger, substance abuse/cigarettes*

Who helped you during and after your pregnancy? *Prompts: Boyfriend, friends, family, neighbors, teachers, doctors, other adults*

How did people act towards you after you had the baby?

What kind of things did people say or do that were helpful?

What kinds of things did people say or do that really made you feel bad?

How did you feel after your baby was born?

What do you do when the baby cries a lot? How do you make yourself feel better when the baby is having problems?

Do you think that your family and friends treat you the same way as before you were pregnant? Is it better or worse now?

Tell me how the pregnancy changed your relationship with your boyfriend?
*Prompts: better, worse, we're together more, he's never around, we fight all the time*

Do you feel different now compared to before you had your baby?
*Prompts: more grown up, more stressed out, more tired, happier, lonelier because my friends get to go out all the time*

How has having a baby changed or impacted your plans for the future?

**Wrap Up:**

If there was one thing that could be done to help other teens keep from getting pregnant if they don't want to be, what would it be?

What else would you like to say about getting pregnant that you think we should know?

**Summary: Thank you for sharing your thoughts and taking the time to participate.**

PI: Christine Duclos
COMIRB #: 09-0216
Version #1
04/08/09

**Proposed focus group guide for 18-24 year-old females**

**Brief overview and review of the purpose of the focus group.**

Hello everyone. My name is _____ and I am here on behalf of Boulder County Public Health, to help facilitate this focus group about understanding planning for a pregnancy.

First, we appreciate you taking time to join this discussion. Please help yourself to drinks and snacks at any time. And to thank you, we will also be giving everyone their cash incentives before you leave today.

As I mentioned, we are doing this study to explore reasons why some women become pregnant even when they may not really want to. Everyone in the group today has had a baby, so we are going to be talking about birth control, pregnancy and what it's like to have a baby.

We ask that everyone participates and please know that everything you say here today is confidential and we will not be using your name or identifying you personally in any way in any of our research. We also ask that everyone keeps what is said in the group within the group and not discuss what is said to anyone outside the group. While we can protect what you say in our data and results we cannot protect what you say from other members of the group.

We would like to tape record the discussion because it is hard for me to run the group and also remember everything that is said. The tapes will be destroyed after we have transcribed notes from the discussion. We won't use anyone's names in our discussion here today. And if someone accidently mentions your name, who ever transcribes the tape recordings will delete your name from the notes. In our research study we may reference a comment you made such as “she said that she didn’t like to use condoms,” but your name will never be used and you will be identified only by a study number in any of our records. Is everyone comfortable with us tape recording?

Our talk should last about 90 minutes. There are no wrong answers to any of the questions. We are just looking for your opinions and feelings, so anything you have to say will be helpful. Although the questions are asked in a specific order, please jump in if you think of something related to an earlier subject.

Please speak one at a time so that the tape recorder can clearly record what you say.

Do you have any questions?

Okay then, let’s get started...

**Messaging (Warm-up Questions)**

Let's start by talking about what people your age like to do and where do you like to hang out?
*Prompts: on the street, around school, in cars, parks, , shopping, mall, , friends house, home, party, sports, clubs.*

If you want to learn about how to have relationships or sex, would you use the radio, TV, internet, movies, or magazines to help figure it all out?

If you wanted to get information about birth control, where might you go?
*Prompts: school, medical office, parents, friends, aunt, internet*

**Defining Unintended Pregnancy:**

For you, what is a "planned" pregnancy?

For you, what is an "unplanned" pregnancy?
*Prompts:*

- *trying hard not to get pregnant*
- *getting pregnant when you didn't want to be*
- *didn't want to be pregnant yet, maybe later*
- *never wanted to be pregnant*

For you, what is an "unintended" pregnancy?
*Prompts: Is it the same as unplanned?*

**General Impressions of Unintended Pregnancy:**

Thinking back to when you became pregnant, what did people around you (friends/family/boyfriend) think about you, or say to you when they found out?

What things changed for you when you realized you were pregnant?
*Prompts: living arrangements, school, daily activities, health status, social life, family life, risk behaviors*

What were some happy or good times for you when you were pregnant?
*Prompts: describe specific events, other people involved; why was this time particularly good for you?*

When you see another person your age that is pregnant, what do you think?

Before you became pregnant, what did you think it would be like to have a baby?
*Prompts:*

- *It's difficult / Babies cry all the time*
- *It's fun / Babies are fun to have around*
- *People are nicer to me when I have a baby*
- *It's easy / It's not as hard as some people say it is*
- *Friends and family will help babysit*
- *I have other plans for my immediate future*
- *A baby would complicate my life*

Describe what your life is like now. How do you think your life would be if you had not had a baby when you did?

Tell me about some of the things you like about having a baby at a relatively young age?

What are some of the things that are difficult about having a baby at a relatively young age?

**Factors that Inhibit Unintended Pregnancy:**

Next, we'd like to learn more about what people your age think about relationships, sex and pregnancy. We'd also like you to help us understand more about how you talk about sex and decide whether or not to use contraception/birth control with your partners. In your opinion…

Do people your age hear messages about how not to get pregnant? If so, from where?
*Prompts: friends, TV, movies, teachers/school, parents/family, church, doctor's office,*

Do you know what "emergency contraception" is? (Otherwise known as EC, morning-after pill, day-after pill)

How much do you think your family relationships effect whether someone your age gets pregnant or not? How?
*Prompts: religion, parent's relationship, strict/not strict*

How much older or younger should your partner be? How much older is too old?

Are you, or were you, comfortable talking with your boyfriend or partner(s) about having sex?

Whose responsibility is it to provide the birth control in a relationship? Why?

What do you think are some of the reasons that some people your age don't use birth control and/or condoms?

Why? What stories have you heard about other people using birth control?

Do you think birth control doesn't work sometimes? Why do you think that happens?

When is it a good time for a woman to go on birth control?

When/why do you think some people your age have sex without using protection?
*Prompts:*

- *Can't afford birth control*
- *Don't know how to use birth control*
- *Don't like using birth control*
- *Partner doesn't like using birth control*
- *Overwhelmed by the urge to have sex*

Can you think of things that would make it easier for women your age to get and use birth control and/or condoms?

Were you able to get your first choice of birth control you wanted? If not, why?

Have you heard about some of the newer methods of birth control (NuvaRing and the Patch)?

Do you think these are good choices? Why or why not?

Have you heard about some of the long-acting methods of birth control? (such as IUDs (Paragard and Mirena or Implanon)?

Do you think these are good choices? Why or why not?

What kind of support from friends, family and/or teachers do you think people your age need in order to avoid pregnancy?

Looking back, what might have helped you either wait to get pregnant or avoid becoming pregnant?

What do you think is different between guys that become fathers at your age and guys that don't?
*Prompts: Is there something different that helped them prevent becoming a dad before they wanted to?*

**Mental Health Aspects of Unintended Pregnancy:**

Thinking about your life before you got pregnant, what was different for you?
*Prompts: where you lived, school, what you spent time doing (how you spent your free time), relationships with friends.*

How did you feel when you found out you were pregnant? Were you glad, or sorry or terrified, or all of them at once?

And how did you cope with all these feelings? *Prompts: depression, anger, substance abuse/cigarettes*

Who helped you during and after your pregnancy? *Prompts: Boyfriend, friends, family, neighbors, teachers, doctors, other adults*

How did people act towards you after you had the baby?

What kind of things did people say or do that were helpful?

What kinds of things did people say or do that really made you feel bad?

How did you feel after your baby was born?

What do you do when the baby cries a lot? How do you make yourself feel better when the baby is having problems?

Do you think that your family and friends treat you the same way as before you were pregnant? Is it better or worse now?

Tell me how the pregnancy changed your relationship with your boyfriend/partner?
*Prompts: better, worse, we're together more, he's never around, we fight all the time*

Do you feel different now compared to before you had your baby?
*Prompts: more grown up, more stressed out, more tired, happier, lonelier because my friends get to go out all the time*

How has having a baby changed or impacted your plans for the future?

**Wrap-up:**

If there was one thing that could be done to help other young women to keep from getting pregnant if they don't want to be, what would it be?

What else would you like to say about getting pregnant that you think we should know?

**Summary: Thank you for sharing your thoughts and taking the time to participate.**

PI: Christine Duclos
COMIRB #:09-0216
Version #1
04/08/09

**Proposed focus group guide for 18-24 year-old males**

**Brief overview and review of the purpose of the focus group.**

Hello everyone. My name is _____ and I am here on behalf of Boulder County Public Health, to help facilitate this focus group about understanding why some men become fathers unexpectantly.

First, we appreciate you taking time to join this discussion. Please help yourself to drinks and snacks at any time. And to thank you, we will also be giving everyone their cash incentives before you leave today.

As I mentioned, we are doing this study to explore reasons why some men become fathers even when they may not really want to. Everyone in the group today has fathered a baby, so we are going to be talking about birth control and what it's like to have a baby.

We ask that everyone participates and please know that everything you say here today is confidential and we will not be using your name or identifying you personally in any way in any of our research. We also ask that everyone keeps what is said in the group within the group and not discuss what is said to anyone outside the group. While we can protect what you say in our data and results we cannot protect what you say from other members of the group.

We would like to tape record the discussion because it is hard for me to run the group and also remember everything that is said. The tapes will be destroyed after we have transcribed notes from the discussion. We won't use anyone's names in our discussion here today. And if someone accidently mentions your name, who ever transcribes the tape recordings will delete your name from the notes. In our research study we may reference a comment you made such as “he said that he didn’t like to use condoms,” but your name will never be used and you will be identified only by a study number in any of our records. Is everyone comfortable with us tape recording?

Our talk should last about 90 minutes. There are no wrong answers to any of the questions. We are just looking for your opinions and feelings, so anything you have to say will be helpful. Although the questions are asked in a specific order, please jump in if you think of something related to an earlier subject.

Please speak one at a time so that the tape recorder can clearly record what you say.

Do you have any questions?

Okay then, let’s get started...

**Messaging (Warm-up Questions)**

Let's start by talking about what people your age like to do and where do you like to hang out?
*Prompts: on the street, around school, in cars, parks, , shopping, mall, , friends house, home, party, sports, clubs.*

If you want to learn about relationships or sex, would you use the radio, TV, internet, movies, or magazines to help figure it all out?

If you wanted to get accurate, up to date and realistic information about birth control, where might you go?
*Prompts: school, medical office, parents, friends, aunt, internet*

**Defining Unintended Pregnancy:**

To you, what do you think a "planned" pregnancy means?

To you, what does "unplanned" pregnancy mean?
*Prompts:*

- *trying hard not to get pregnant*
- *getting someone pregnant when you didn't want to*
- *didn't want to become a father yet, maybe later*
- *never wanted to be a father*

To you, does an "unintended"pregnancy mean the same thing as "unplanned?"

**General Impressions of Unintended Pregnancy:**

Thinking back to when your girlfriend/partner became pregnant, what did friends and family say to you when they found out?

Did your life change, or did things pretty much go along the same way while your girlfriend was pregnant? What happened after the baby was born?

*Prompts: living arrangements, school, daily activities, health status, social life, family life, risk behaviors*

When you see another dad your age, what do you think?

Did other people act differently towards you when they found out you were a father?

Before you became a dad, what did you think it would be like to have a baby?
*Prompts:*

- *She would take care of it, if there was one.*
- *It's difficult / Babies cry all the time*
- *I thought it would be Fun / Babies are fun to have around*
- *Easy / It's not as hard as some people say it is*
- *I could help take care of my kid*
- *Friends and family will help babysit*
- *I have other plans for my immediate future*
- *She should have aborted it*
- *A baby would complicate my life*
- *Her family is mad at me*

Tell me about some of the things you like about having a baby at a relatively young age?

What are some of the things that are difficult about having a baby at a relatively young age?

How did you find out that your girlfriend was pregnant?

- She told me right away
- I found out through friends
- Somebody told me after she had the baby

How did you feel when you found out your partner was pregnant?

If your girlfriend wanted you to go with her to a family planning clinic, would you go?

Were you involved with your girlfriend/partner during the pregnancy?

Did you talk about options like abortion or adoption?

Are you as involved with the baby as you would like to be?
*Prompts: See him/her often, help take care of him/her, don't know where they (partner and child) are.*

Do you feel different about yourself now that you are a father?

**Factors that Inhibit Unintended Pregnancy:**

Next, we'd like to learn more about what people your age think about relationships, sex and fatherhood. We'd also like you to help us understand more about how you talk about sex and decide whether or not to use contraception/birth control with your partners. In your opinion…

Do people your age hear messages about how not to get pregnant? If so, from where?
*Prompts: friends, TV, movies, teachers/school, parents/family, church, doctor's office,*

Do you know what "emergency contraception" is? (Otherwise known as EC, morning-after pill, day-after pill)

How much do you think your family relationships effect whether someone your age becomes a father or not? How? *Prompts: religion, parent's relationship, strict/not strict*

How much older or younger should your partner be? How much younger is too young?

Are you, or were you, comfortable talking with your girlfriend or partner(s) about having sex or using birth control?

Whose responsibility is it to provide the birth control in a relationship? Why?

What do you think are some of the reasons that some people your age don't use birth control and/or condoms?

Why? What stories have you heard about other people using birth control?

Do you think birth control doesn't work sometimes? Why do you think that happens?

When is it a good time for a woman to go on birth control?

Why do some men engage in sex without using birth control and/or condoms?
*Prompts:*

- *Can't afford birth control*
- *Don't know how to use birth control*
- *Don't like using birth control*
- *Partner doesn't like using birth control*
- *Overwhelmed by the urge to have sex*

Do you know what kind of birth control your girlfriend uses? Could you talk about it with her, and decide what would work for you?

What kind of support do you think people your age need in order to avoid getting someone pregnant?

Do you think men should be encouraged to use birth control all the time?

Did you and your partner agree on whether to have a baby when you did?

What do you think is different between guys that become fathers at your age and guys that don't? *Prompts: Is there something different that helped them prevent becoming a dad before they wanted to?*

**Mental Health Aspects of Unintended Pregnancy:**

Thinking about your life before you became a dad, what was different for you? *Prompts: where you lived, school, what you spent time doing (how you spent your free time), relationships with friends.*

How did you feel when you found out you were going to be a dad? Were you glad, or sorry or terrified, or all of them at once?

And how did you cope with all these feelings? *Prompts: depression, anger, substance abuse/cigarettes*

How did family and friends act towards you after you became a father?

What kind of things did people say or do that were helpful?

What kinds of things did people say or do that really made you feel bad?

How did you feel after your baby was born?

What do you do when the baby cries a lot? How do you make yourself feel better when the baby is having problems?

Tell me how being a dad has changed your relationship with your girlfriend/partner? *Prompts: better, worse, we're together more, we fight all the time*

Do you feel different now compared to before you became a dad? *Prompts: more grown up, more stressed out, more tired, happier, lonelier because my friends get to go out all the time*

How has having a baby changed or impacted your plans for the future?

Are you as involved with your child as you would like to be?

**Wrap-up:**

If there was one thing that could be done to help other young men from becoming dads if they don't want to be, what would it be?

What else would you like to say about being a father that you think we should know?

**Summary: Thank you for sharing your thoughts and taking the time to participate.**

# APPENDIX F
# Focus Group Analysis Codes

# Boulder County Unintended Pregnancy Research Project
# Focus Groups Codes

Literature review identified areas to explore in focus groups with women and men aged 13-28 who have experienced an unintended pregnancy carried to term:

**IMPACT OF PREGNANCY AND PATERNITY**
Emotional/psychological
Overall effect/impact of pregnancy on:
- Family
- Friends
- Boyfriend/husband (baby's father)/Girlfriend/wife (baby's mother)

**DEFINITION OF PREGNANCY:**
Planned
Unplanned
Unintended
Attitudes toward pregnancy

**KNOWLEDGE AND USE OF CONTRACEPTIVES**
Discussing sex/prevention with partner
Contraceptive Responsibility
Facilitators/Barriers to contraceptive use
First choice of contraceptive
After pregnancy

**EMERGENCY CONTRACEPTION**
General awareness/knowledge

**SOCIAL CONSEQUENCES (POSITIVE AND NEGATIVE) OF CHILD-REARING, AS A RESULT OF AN UNINTENDED PREGNANCY, ON:**
Mother (self)/Father (self)
Friendships
Family
Relationship with child's father for females/Relationsip with child's mother for males
Education attainment/job
Emotional/psychological

**BOND/RELATIONSHIP WITH CHILD AND CHILD REARING PRACTICES**

**LIFE CIRCUMSTANCES POST-BIRTH**
Living arrangements
Stress relief
Hopes, dreams of future for self/children

Receive public assistance
Financial

**SOURCES OF SUPPORT**
General
Emotional
Social
Financial
Programs

**PREVENTION SERVICES**
Primary prevention programs
Secondary prevention programs

# APPENDIX G
# Focus Group Analyzed Transcripts

**BOULDER COUNTY UNINTENDED PREGNANCY RESEARCH PROJECT**
**ANALYZED TRANSCRIPT - FEMALE FOCUS GROUPS**

**Focus Groups:**
Females (1), May 12-Lafayette (18-24 year old)
Females (1), May 22-Boulder (18-24 year old)
Females (7), May 19-Longmont (18-24 year old with two 17 year old)
Females (7), May 19-Longmont (18-24 year old with two 17 year old)
Females (5), May 26-Longmont (18-24 year old with one 17 year old)
Females (5), May 27-Longmont (18-24 year old with one 15 year old)

## DEFINITION OF PREGNANCY:

*Conventional measures of pregnancy intendedness distinguish pregnancies that happened at about the right time from those that were mistimed (i.e., they happened sooner than desired) or unwanted. Pregnancies in the first group are classified as intended, whereas those in the other groups are classified collectively as unintended. Some recent studies have measured intendedness by measuring pregnancy desirability.*

*Women often informally discuss their personal feelings about the timing of the pregnancies they have had—whether a baby came just a bit too early, whether a pregnancy occurred at a time when it interfered with future plans but would have been wanted at a later time, or whether a pregnancy was not wanted at any time. Some women feel ambivalent or may disagree with their partners, one wanting a pregnancy and the other preferring to wait.*

*During focus groups with women and men, the participants were asked what they thought a planned, unplanned and unintended pregnancy are. Most felt that a planned pregnancy was just that, planned and that unplanned pregnancy was one that was unexpected or mistimed but most felt that using accidental to describe an unplanned pregnancy was negative and the term unintended was not even on the participant's radar and they didn't know what the term meant.*

### Planned

**Quotes:**
"When people already have their shit set like an apartment or married. I got married when I was twelve or thirteen but it wasn't a planned pregnancy for us"

" When someone that actually sits down with their partner and says, 'Let's have sex'."

"Someone who is planning their pregnancy means their trying to conceive. You're expecting to be pregnant."

### Unplanned

**Quotes:**
"I wanted to get pregnant someday, but not now."

"We didn't talk about getting pregnant. I think if we talked more in depth about having a child our pregnancy wouldn't have been an unexpected pregnancy."

"Unplanned means more like it happened to me but I don't know how it happened to me. That is what happened to me…"

"Accidental pregnancy sounds terrible too. When someone says you were an accident, its like 'oh thanks, you really wanted me here'."

"Unplanned sounds better because you just weren't planning to get pregnant."

**Unintended**

**Quotes:**

"They don't really know the man and they're like, 'Oh yeah, I'm pregnant'. 'Oh shit that baby isn't mine'."

"To me unintended sounds like I didn't want my baby."

**Attitudes toward pregnancy**

*Before they were pregnant some participants viewed pregnant teenagers as hoes and sluts. Their opinions changed after they discovered that they were pregnant because they realized they couldn't say those things anymore. They no longer gossiped about other pregnant girls.*

**Quotes:**

"Nah, at first you're like 'damn, what a hoe or little slut." But when it's you you're like 'shit, can't say that anymore'. When you go to school and see the girls are pregnant, you used to be like 'did you see who was pregnant' and now you can't do that because you're like 'so am I'. So you're like 'fuck'."

"When I look at younger girls who are pregnant, I just hope they will stick with it, even though it's hard being pregnant and it will be hard having a baby and focusing on school and stuff."

"That's one thing that I would tell pregnant girls in school, stay in school and your education is so important to have a good life for your kid."

"I didn't see it coming from my sister, even though it had happened to me. I was kind of hoping she would have learned from my experience."

"You want to say congratulations but then you know they aren't ready because they are always doing drugs or out there with different guys."

## SOCIAL CONSEQUENCES OF PREGNANCY:

### Emotional status

*Unintended pregnancy takes place within a complicated web of peer pressure, life aspirations, and notions of romance that shape an individual's decisions about sex, contraception, and pregnancy. Certain groups of adolescents, such as those who are in the foster care system or suffer from depression, have particularly high rates of unintended pregnancy. Additionally, there is research that shows that many unintended pregnancies were preceded by sexual abuse or nonconsensual sex.*

**Quotes:**

"I took, like 4 pregnancy tests, I couldn't believe it. I just kept looking at it and then put it away. I'd wake up in the morning and look at it again and that little line just didn't go away."

"And then you start showing and you're like, oh wait!"

"I had an interesting emotional problem. I ended up in a mental hospital for being suicidal."

"My son is not my husband's, I was raped for my first son."

"Scared. Scared of what people would say. How my parents would react."

"If you don't have a job, or you're not very educated, and you're still in school, you think, 'how am I going to take care of a baby.'"

"Where am I going to go for help. You have a lot to think about."

"I never thought it would happen cuz I really didn't want a kid. I wasn't ready to give up my way of life. I wasn't thinking about nothing else but that."

### Overall effect/impact of pregnancy:

*Not being able to do the same things they were used to. It was hard to even go outside to talk to their friends because of the baby. Some women who experienced a feeling of isolation and depression during their pregnancy, particularly if the pregnancy was a result of non-consensual intercourse.*

**Quotes:**

"Not being able to get high, drugs. Not being able to do the shit that you do. You know, it's different when the baby's still in your stomach because you carry him everywhere, but after you have him it's like 'damn, you can't do nothing.'"

"I didn't want to be pregnant. I didn't know anyone who was pregnant. I didn't know what to expect. I kept to myself a lot, didn't want people know what happened.

Everything turned out for the best. When I was pregnant I was sad all the time, I was suicidal."

"I'd be having fun."

"I probably would have been done with school. I would have graduated with my class."

"I was a party type of girl. I really didn't want a baby. I wasn't ready to give up my way of life. I was just thinking of myself."

**Family**

*There was some disappointment from family members. Some had family that had gone through unexpected pregnancies and they were happy for the participants.*

**Quotes:**

"A lot of disappointment, mainly from family. And then they grew into it, like after you have the baby it's a different story. They love you and they love the baby."

"His dad was really angry. He was really mad cuz he thought because my husband [boyfriend at the time] had just turned 21 and I was 17 that he might get in trouble."

"My stepdad didn't talk to me until I was 4 months pregnant. We lived in the same house and wouldn't talk. I'd say 'good morning' and there was no response. He wouldn't say one word back."

"Surprised."

*Other participants expressed that their families were supportive and provided a good deal of help through their decision to continue their pregnancy.*

**Quotes:**

"When I got pregnant, my boyfriend's family wanted me to give my baby up for adoption because they didn't want to have part of it. But my mom was very nice and supportive about it and she said she would never tell me to give my baby up. It's just different for every girl in their different situations."

"My mom told me I'll be behind you no matter what you decide to do. If you decide to get an abortion or keep the baby, I'll be there for you to help you through it. But I'm not the parent, you are, so you aren't just going to leave your baby with me. She helped me a lot through it."

"My dad actually helped me when I got morning sickness."

## Friends

*Friends were disappointed that they could no longer party with them.*

**Quotes:**

"Most of my friends have babies already, so pretty much it was just like 'whatever'."

"Sometimes when you're pregnant you lose all your friends. I mean, if they are your real friends you won't lose them."

"You do lose them to a point."

## Boyfriend (baby's father)

**Quotes:**

"I wasn't happy about it. He [her partner] was ok with it."

"I have a loving husband who takes care of me."

"My boyfriend was there at first and went to all the appointments with me. But then after a while he's stopped being into it and it was really hard for me."

# KNOWLEDGE AND USE OF CONTRACEPTIVES

## Discussing sex/prevention with partner

*Most thought that if they were comfortable being naked in front of their partners then they could talk about sex with them. However, they mentioned that guys were easily excited and once they were at that point the girls couldn't talk to them.*

**Quotes:**

"Well if you're comfortable being naked in front of them then it's not even an issue."

"I don't know how comfortable he is!"

"Yeah, we talked about it. And I was on Depo but then stopped."

"I was like, "no I'm not going to get pregnant." I didn't believe it could happen."

"For me, the more we got into our relationship, the more we were like, 'eh whatever'."

## Contraceptive Responsibility

*Both. Girls can go get birth control but guys need to be aware if their girl has birth control or not so they can get condoms. It should not be just the girl that provides it; most guys don't know much about birth control so it was harder for the girls to talk to their partners about which one they were using. Most girls didn't talk to their partners about birth control before hand and some admitting to not using any birth control.*

**Quotes:**
"Well girls they can go get birth control, but guys they should be aware if their girl has birth control or not. They could have condoms or whatever. So it could be on both of them. Like I hate it when guys blame it on the chick like 'Oh you should have had birth control', well you should have provided it! It goes both ways."

"They really don't know nothing about it."
"Guys don't even know. They are bunch of horn dogs."

"Both of us. I mean it's each person's responsibility; so both parts."
"I've never left it to a guy."

"I think that people just need to do it; it's easy just to go get a shot to keep yourself from getting pregnant."

"At first we always did use condoms but then I think we just got too comfortable with each other. And then we stopped and for a while I didn't get pregnant. I was like, maybe I can't even have kids. Whatever."

"I feel like it's our responsibility."

"Men feel like it's inconvenient because most guys don't go to the doctor's, right?"

"It makes it convenient for them because most guys don't like condoms, so they figure if you're on birth control than they don't have to worry about it."

"I think for the guys, they just need to know them know more that they have a big responsibility. It's not in their belly for 9 months and they don't have to push it out. And so they don't physically realize what they are in for. Yeah, mentally some of them may be like, yeah I see what she's going through. But really they don't. It's very different for them."

"But it's not just up to the guys. Because it could be the girls too. What if the girls don't remind him, 'hey dude where's the condom at?' I think it's 50/50. It takes two."

**Facilitators/Barriers to contraceptive use**
*Most girls stated that money was an issue when getting birth control so the Teen Clinic was a very useful asset. All the participants had heard and/or used the Teen Clinic.*

*Other resources that the girls had heard of or used was the sex education classes taught in high school, though most admitted to not taking them seriously.*

*Parent's attitudes about birth control and sexual activity were sometimes barriers to getting birth control.*

*A lot of the participants expressed the desire for contraceptive choices be explained in more detail to them in terms of the advantages, disadvantages, and side effects of the various methods so t hat they can make an informed choice.*

**Quotes:**
"The Teen Clinic should make their name more heard of because I didn't know about it until my Genesis worker told me. So I think it should be more known, cuz if it's for free why not do it? You don't even need insurance."

"If it was always free. Because it's not free after you're 21 – at least at the teen clinics. They need more ads on TV."

"A lot of things make it difficult; having to follow up with your parents. You have to pay everything for it that can make it pretty difficult."

"My dad doesn't believe in birth control because obviously it means you're whoring around and it just gives you the chance to whore around and not get pregnant. I wanted birth control when I was 13 in case I went to a party and something happened. But he said 'No'."

"If you can get a birth control that your parents don't know about, it's free, and you can get it, get it! That's why a lot of girls don't go in to get birth control, because they are scared of their parents."

"When I went on this birth control, they didn't tell me that I was going to get bleeding. Nobody explained to me the symptoms or anything."

"They want you to read it. And you should and I read it but it's always nice for people to explain it too. I mean, it says that you're going to have changes. But they need to explain it to you more."

"Yeah, if it's your first time they should tell you more."

"But more information on what the side effects are and how well they work because a lot of people are thinking of what they are going to get and how busy they are and much time it's going to take…. So depending on how busy you are helps you decide what to get."

"It's easy to get. For both of my kids, I got pregnant with my second on the Patch and was on birth control both times … Depo for the first one. But I think the best kind of birth control is getting fixed. That way you don't have to worry about getting pregnant. That's the best way to go."

"Before I got pregnant, I was seeing it as harder to get birth control. I didn't know exactly where to go, or I didn't want to go there, and it was hard for me to get there transportation-wise."

"I got pregnant on birth control twice, but the second time it was my fault I think because on the pill, it says that if you miss a pill in your second week then you can just take two and continue regularly, but if you miss in your third week you gotta start a new pack. But nobody ever told me, so I don't know if it's my fault or what, 'cuz I was on the pill and ended up pregnant."

"And with the patch, the first time I got pregnant, it fell off in the shower and I called them and was like, it fell off, what do I do? Because I didn't want to get sick. And they asked me if it still sticks and I was like, "yeah, it sticks" so they said to just put it back on, you'll be fine, because it hadn't been off for 24 hours. So I put it back on and ended up pregnant."

**First choice of contraceptive**

*The general consensus was that everyone in the group was able to get their first choice of birth control if they were currently using any. It was common to hear the girls talk about the different birth control methods they had gone through before finding the one the worked best for their lifestyle. There was limited knowledge to the newer forms of birth control (e.g. Yaz) and the girls admitted to having heard of ones that were being advertised more heavily.*

**After pregnancy**

*Once the girls had their babies they were all very adamant about using birth control. One girl stated that she knew about some forms of birth control before she got pregnant, just not the one she's on now that she likes the best. The Teen Clinic was where most of the girls heard about or received their birth control.*

*The participants were familiar with Depo, IUDs, Implanon, condoms and the pills. Two girls claimed that they were on the patch when they got pregnant but one forgot to change it once. She actually blamed the patch for getting her pregnant because her hormones "were raging". Most of the girls that were on longer-term birth control liked it (Implanon, IUDs). Several stated that they had friends or relatives that had had their tubes tied and still got pregnant.*

**Quotes:**

"Oh I got birth control right away. Well I knew about birth control but I didn't about the birth control I've got. Cuz I've go the Implanon and I went to that Teen Clinic and I didn't know that you could get it for free because when I got pregnant I was up in Alaska and they didn't have nothing like that; nothing was free."

"Yeah, I heard you could get it for free there too. I just barely had her [the baby] so I'm not thinking about having sex right now. But yeah, I'm thinking about getting on birth control…I don't know what it's called."

"At the end, I'll still to using condoms and the pull-out method. We always use condoms."

…"But once I had her I thought it was way easier because they tell you at the clinic at your check up to think about what birth control you want and you just do it."

## EMERGENCY CONTRACEPTION

### General awareness/knowledge

*Yes, all participants knew what that pill was however most did not know about it before they were pregnant. At least two women had used EC. There was confusion over whether the pill prevented a pregnancy or terminated a pregnancy. Also the time-frame in which the pill has to be taken was not clearly known to the participants.*

**Quotes:**

"Yeah, is it 'Plan B'? It's where you take that pill and it stops anything from forming."
"I've used it before. I would pick this method of birth control. I've never had side effects."

"People don't know how to get it. I know that for sure. None of my friends knew about EC. I know a lot of girls that have no idea about it."

"It's not hard to get. But it's expensive."
"There's info in the restrooms at the clinic. They have posters in the bathrooms and little cards everywhere."

"I don't pay any attention to those posters."

"I think doctors should mention it more."

## LIFE CERCUMSTANCES POST-BIRTH:

## *(*SOCIAL CONSEQUENCES (POSITIVE AND NEGATIVE) OF CHILD-REARING, AS A RESULT OF AN UNINTENDED PREGNANCY, ON)

### General

*It's hard to do whatever they want whenever they want. They have to think about how decisions will affect their kid. The participants were often told that they were young or that they were doing the wrong things.*

**Quotes:**

"I think the hardest thing was going from the point of being a teenager and having no responsibility to jumping in to being a mother and providing the meals and taking care of someone else. All this before you even had to really take care of yourself."

"You sometimes feel alone knowing you are the only one there taking care of that baby."

"Wanting to do a lot of things."

[lack of ]"Freedom."

"You're just tied down."

"And having to grow up faster then you normally would. Now you have to be grown-up and an adult. So you have to figure it out."

"I did want to get my life back to where it left off. But it's really hard to get stuff done. Child care is hard."

"For me, it was hard I was 18 when I had my baby and sure, I felt mature but I also felt like I was still a kid. People would look at me different and sometimes I still felt like a baby myself. But people were like, don't feel bad – you actually made it 'till you were 18. But even though I felt like I was mature and had responsibility, I also felt like people were just putting me down because I was young."

"If I had waited 5 or 10 years, I think I would have a lot of soccer moms to hang around with. Like, that's cool."

**Living arrangements**

*Living situations varied for the women after having their babies. For some their living arrangements were tenuous and changed quite often but for others, they were able to find a stable situation.*

**…."**And that's what sucks - when you live with your family or their family and don't get along with them because you can't say nothing about it 'cuz you don't want to hurt their feelings and there's nothing else you can do. You have to live with it."

**Friendships**

*They can no longer go out and have fun with friends*

**Quotes:**

"I don't have the same friends as before."

"Not the same friends. Of course, hey are still doing their thing and you're in your own little world with your boyfriend or with your family. For a little bit it was just me and my partner and close friends, but then I went to a teen parenting program and that's where I was able to meet other girls who were pregnant."

**Family**

*The girls stated that during and especially after they had the baby it wasn't about them; the baby seemed to take priority to those around them. Some of the girls didn't appreciate their parents telling them that their baby was going to treat them the same way they had treated their parents.*

**Quotes:**
"I remember when you're pregnant too; they're always like "Well, you've got to think about the baby."

"My parents, my mom, were not close before, we are closer now than we were before…"

**Relationship with child's father for females**

*The baby changed their relationship with the baby's daddy. Before they could fight and leave each other but now they know they have come to back to one another and work it out. Some said that it made their relationship stronger. One girl said that the pregnancy made her relationship worse with her partner because her hormones made her a 'bitch and then he started hitting me, so everything went downhill." Most girls stated that the pregnancy brought out a different side of their partner and put a lot of responsibility on both of them. One participant stated that the pregnancy made both her and her boyfriend settle down and she really appreciated the way he stuck by her even when her hormones were all over. A few girls mentioned that they thought their boyfriends were going to start cheating on them because of the erratic way they were acting. They also admitted to being angry over how the guys still wanted to go hang out with their friends and were less willing to change their lifestyles.*

*A sensitive issue was when people would tell the girls that their baby's dad wasn't going to stick around. While they knew it was a possibility they didn't want to hear it from someone else.*

**Quotes:**
"So I think there's more of an open opportunity for guys not to be involved."

**"….i**n a way I did and I didn't know that my husband was going to be involved there and involved with the baby because I'm there and I'm like, 'Hey honey, do you want to change the diaper?' and he's like 'No, I don't want to do it.' I'm like, 'Do you want to hold him and feed him?' and he's like 'No, I don't want to do those things.'"

"Well, for me I had a bad experience. He was great at first. But we got into domestic violence and that ruined a lot of things even for my baby."

**Education attainment/job/financial**

*Some wouldn't have graduated if they hadn't got pregnant. Many participants agreed that the baby pushed them harder. While being pregnant and then a parent pushed them to do the best that they could, most still expressed that it was difficult to finish school or attain their educational or financial goals once they were parents.*

**Quotes:**
**Positive impact:**
"I don't think I would have graduated if I hadn't got pregnant. Because when I wasn't pregnant I didn't go to school, I didn't care about it. When you're pregnant you realize you need to do something with your life."

"It's [school] just going to take longer than I wanted it to. I mean, eventually I hope to go to the art institute."

"Having my kids has opened me to other things. I want to be a neonatal nurse. It has opened my husband to other things too."

"I think, for me, it is way better that I got pregnant cuz I wouldn't have stopped, you know, doing what I was doing; getting in trouble and all that stuff. So now I think about my daughter first, more than anything else."

"If I didn't have my boy then, I wouldn't be where I am now. I would still be drinking and partying and being a teenager."

"Not getting in trouble as much. More responsible."

**Negative impact:**
"I'm still pregnant and trying to catch up on school 'cuz I didn't go for a while."

"When you don't have a good job, I mean, I'm getting paid $9 an hour and that's still not good enough."

"I'm not working right now so things are tight, but hopefully I'll be working again soon."

"It would be easier to graduate (high school). Now I'm always tired. I wake up in the morning and am so tired."

"It takes forever to move up from measly pay up to something bigger."

"It's stressful and hard. I definitely don't want to be working at Chuck E Cheese the rest of my life."

"Certain opportunities aren't there."

**Emotional/psychological/stress [relief]**
*The baby had a positive affect on many of the girls; they would not have stopped doing what they were doing if they hadn't become pregnant. They described their actions as having been driven out of boredom and keep trying to find new things to do which were getting out of hand. Now they think about their children first.*

**Quotes:**
"I'm like, really emotional. I just cry about the dumbest things. And my boyfriend is like, why are you crying? And I'm like 'cuz you said something."

…"Because sometimes you get stressed out, especially when you first have them."

"I have to put my baby in the crib, sometimes when my husband is out and my baby is just crying, I can't handle it."

"I got a little stressed afterward because we were like, ok we gotta get a job and take our jobs more seriously."

**Hopes and dreams for future and self/children**
"By the time I got pregnant I was already behind in school because of being truant. So I'm still behind. But now I have a plan to finish. I'm more motivated because of my baby."

"When I was in high school, I didn't know what I wanted to do after that. I was a stoner and a party girl. My main goal was finishing high school, but I'm in an internship right now. I'm just trying to make my life better for my baby. That's all that matters to me. That's my focus."

**BOND/RELATIONSHIP WITH CHILD AND CHILD REARING PRACTICES:**
*The unconditional love and knowing that the baby was theirs was a huge positive for them. When they felt the baby kick it was a 'wow' moment and now that they could hold the baby it's even better. Some girls stated that having a baby at their age is a huge responsibility that they don't think they're ready for but when it arrives they hope they'll learn.*

*The fear of anything happening to their baby was difficult for the girls. Being able to support the baby financially and providing a good life for him or her are challenges. Having to grow-up so fast and become adults. The participants often compared themselves to older mothers or aunts that they would see at the pool or grocery store. These older mothers were viewed to have their lives more together but also as having their kids' schedules take over their own schedules.*

**Quotes:**
"The love."

"Just knowing that it's yours."

"I'll be able to relate to my children when the get older."

"It's just hard now 'cuz you're always thinking about your baby. Like, what if something happens to it? It's like, now that I'm here I'm wondering, "is my baby okay?" I know she's fine with my mom, it's just a feeling of more responsibility."

…"But when your baby comes, it's like "I know what I'm doing" but whoa, does someone want to take the baby for a little bit? It's way harder than you thought."

"My oldest acts like she's 20. She's only 4 but she's got a mouth on her. She talks back. She wants to pick out her own clothes. She's got attitude. Every day is a different thing with her. It takes her all day to pick out one outfit. Yeah, it's hard."

"When I'm depressed and stuff I just sit there and talk to my daughter."

## SOURCES OF SUPPORT

### General

*The Genesis program, husbands, parents, the partners, boyfriends, siblings were all mentioned to be helpful during and after the pregnancy. A couple of the girls stated that the baby's daddy was helpful in the beginning but has since either decreased his help or left the picture all together. One participant stated that you need to know where the resources are.*

Another participant asks group, 'Do you know about Life Choices here in Longmont?' "You can get milk, diapers, books, clothes for your baby. You can get free counseling. It something is bothering you inside and you need to go talk to a counselor, it's free, like anytime you can just walk in and there are really nice ladies there. They aren't judgmental. It's Christian-based and I don't know if you guys are, but if you need some support, because sometimes it's hard, you know?"

"Some days you might not have money or something. You never know what's going to go wrong. And you need to know where your resources are."

### Emotional

**Quotes:**

"My mom and my man."

"At first it was my boyfriend but now it's just my mom."

"My mom helped me raise my son for a good 6 months."

"My friends were very supportive."

### Financial

"I was very lucky because my husband's family supported us the most, more than my family was. Now we've been supporting ourselves for a very long time. And now we both have good stable jobs and it's really hard to get that."

## PREVENTION:

*All the girls had heard about Genesis through the Teen Parenting Program, WIC, a sister, or a case worker. "If I could see myself right now" is what one participant said would have helped her wait to get pregnant. Condoms and knowledge were also mentioned to have been helpful. Most of the girls said that when people came to talk to them at school and give them condoms they didn't really listen and thought "how stupid would I have to be to need this" They stated that they would just throw the information in the trash. Most also didn't believe a teenage pregnancy would ever happen to them. Also knowing the consequences would have helped them not become pregnant.*

### Primary prevention

### Parents

"More encouragement from my parents. I was in school and they could have said stuff like 'hey you're almost done, hang in there'."

"I'm not blaming my family for my mistakes. But I think they should have shown me more love and shown me that they cared. They should have told me that they loved me."

### Education

**Quotes:**

"Tell them to keep their legs close, for real."
"More education. And the fact that you shouldn't be taking certain antibiotics while you're on a certain birth control."

"Sex education classes where it's mandatory and not optional. I remember ditching health class a lot of times. Abstinence curriculum is not good. No one wanted to hear that…" …"If parents knew what they can prevent through sex ed, they would want it taught in schools."

"Birth control, not just condoms."

### Social Services

**Quotes:**

"If I wasn't pregnant I would definitely take advantage of all the programs that are out there to help me. There's a lot of help out there", one girl stated. Another stated, "I would tell girls that it is possible to get pregnant because so many think that it won't happen to me. Take advantage of the birth control that's available, there's no reason not to."

"How stupid would I have to be to need this"…..[condoms given at school during sex ed]

"Maybe a class at school that would tell the girls about all the methods and what this does and what that does – that would be cool - so girls would know what they are doing. And it school, the girls are right there."

**Healthcare providers**

"I think doctors should spend more time talking about birth control. Even if it's just 15 minutes, like this is what it is, this is what it's going to do to you, this is what it may cause for you. Because for them, what's that? What's 5 minutes to them for a lifetime to someone else? That right there could change someone's life. They're getting paid good money, why don't they sit there for another 10 minutes? It's not going to hurt."

"I think they should talk about when girls are younger. And the doctor should bring it up first instead of waiting for the 12 year old to ask about it. A younger girl is not going to bring it up with her doctor."

**Secondary prevention**

"I think they should just make it more available. Like, you know, what they do for you right after you've had the baby, how they talk to you about birth control? Even just at a regular check-up, when girls go for the high school soccer team physical, they should talk about it right there. You know, do you want birth control? You might not be sexually active yet, or maybe you are, but think about it. They should push it on you as much they do right after you've had your baby. Because obviously right after a girl has her baby she's like 'yeah I'm getting on birth control'. Because they are motivated then."

Well, for me my mom was too comfortable with my relationship with my boyfriend. He moved in when I was just 14 and she didn't mind. My mom, and maybe me too, should have limited myself a little more. He had just gotten out of detention and I had missed him so much and just wanted to be with him all the time. Don't get me wrong, I don't regret it at all, but if my mom had put more limits on me, that probably would have helped.

I think my parents didn't care what I was doing. I was the party girl who always had friends in my car. It was party car and there were people in the front, in the back, and in the trunk. I cut class all the time and just wanted to party with my friends. All I thought about was, cool we're going to go drink, we're going to go get high. So I was just headed down a bad path.

For me I don't think that's necessarily what made me get pregnant young, but in the beginning that's what got me where I wasn't going to school. And that affects who you end up with.

**BOULDER COUNTY UNINTENDED PREGNANCY RESEARCH PROJECT**
**ANALYZED TRANSCRIPT - MALE FOCUS GROUPS**

**Focus Groups:**
Male (1), May 12-Lafayette (18-24 year old)
Males (10), May 26-Longmont (18-24 year old with one 16 year old)

## DEFINITION OF PREGNANCY:

### Planned

*Participants agreed that a "planned" pregnancy means they're ready for a kid and that they are trying to have a baby.*

**Quotes:**
"You're planning on having a child. You've talked about it."
"It's actively trying."

### Unplanned

*Some participants stated that an "unplanned" pregnancy means that a couple didn't want to have kids, including not having even discussed having kids.*

**Quotes:**
"I don't believe that there is a planned pregnancy. If it's your first baby, no two people are ever really ready."
"Unplanned pregnancy is they didn't want to have kids, they haven't even talked about it."
"Unplanned is you wanted one, eventually."

### Unintended

*Participants indicated that an "unintended" pregnancy is not wanting a baby.*

**Quotes:**
"The unintended is yeah, they may have talked about it, but it happened so soon."
"It was like 'oops'."

## KNOWLEDGE AND USE OF CONTRACEPTIVES

### Contraceptive Responsibility

*Although, the majority of participants stated that it was their responsibility to provide the birth control in a relationship, some participants stated that it was a responsibility of both people involved.*

**Quote:**
"I feel it's more of the responsibility of the guy to do it because it is a lot easier for him to go out and get condoms than it is for a woman to go out and get the various types."

**After pregnancy**
Some participants stated that their girlfriends are now on an IUD or some other form of birth control.

**Quote:**
"As soon as she had the baby she got one of those IUDs."
"I told her that I'm not having sex with her unless she got the IUD."

## Emergency Contraception

*The majority of the participants stated that they know what emergency contraception is.*

**Quote:**
"Yeah, I had to buy it once, $50."

## RELATIONSHIP WITH CHILD'S MOTHER

**After pregnancy**
*The consensus among participants was that being a dad has been challenging, especially for some that indicated that their relationship with their girlfriend was not going well. Most participants recognize that the time with their child is very important especially since children grow up fast and if they are not part of their child's life, they will miss out on special moments. Nevertheless, some participants indicated having no regrets about becoming a dad and have become closer to their girlfriend. .*

**Quote:**
"You know there's no regret; like the first year after the baby was born it was hard. And then we split up and I didn't see him for a while, like 6 months. And then we talked and everything and now I get him every weekend now."

"Being a kid is short man, so you're going to miss all that stuff; you're going to miss their first world, their…I don't know. That's the cool shit, I think, to hear them talk and everything."

## Social consequences of child-rearing, as a result of an unintended pregnancy, on: Education attainment/job

*Some participants stated that they had to change their priorities and get a job in order to be there for their baby and have some money to provide for their baby. In addition, some participants stated that they do want to be there for their child.*

**Quote:**
"I had to drop out of school and get a job. I didn't have to technically drop out, but I had to work at Burger King, McDonald's or anywhere that would hire me, to start making money."
"I wanted to be there for my kid like my dad was there for me."

"My dad wasn't really there for me but I want to change that with my kid."

**Bond/relationship with child and child rearing practices**

*The consensus among the participants was that as young fathers they would be able to relate to their children better than if they were older and they would also be able to have more fun with their children.*

**Quote:**

"I think it's easier to relate to them as opposed to parents who are 20 to 25 years apart, so that's an advantage; easier communication, kind of show them the ropes."

**LIFE CIRCUMSTANCES POST-BIRTH**

**Hopes, dreams of future for self/children**

*Participants stated that they now have plans for the future, despite not having them before they became fathers.*

**Quote:**

"I have plans for the future now. I never had them and now I have them. I plan to keep working."

**Sources of support**

*Focus group participants stated that in many instances much attention is not given to the concerns and feelings of the male partner, but rather the attention is given to the female partner. In order to deal with it all, participants stated that they go hang out with friends and play ball to get their mind off of what's going on.*

**Quote:**

"I feel like we don't even get that kind of concern for our side because we're guys and don't show anything."

"You can go play ball to get your mind off that. I mean if she's going to be giving me all this nonsense and stressing me out then I'm going to do my own thing, you know?"

**Social**

*Some participants expressed that people have been encouraging or have provided good advice.*

**Quote:**

"'You can do it. You can take care, it's all about communication.' My brother always told me I just had to be there for her."

**Prevention**

*Participants agreed that using condoms should always be a must. They also noted that it is important to get to know their partner and to think before they act. One participant suggested putting weekly goals on a piece of paper as a reminder to what he needs to accomplish that week. Another participant said that they shouldn't be afraid to ask their partner if they are using any type of birth control. It was also stated that the there should*

*be more forms of birth control for guys and not just condoms. On participant simply stated that one should wait because they have their whole life ahead of them.*

**Quotes:**
"Don't do the baby's mom. Think before you act man, because once you have a baby it's over. You're going to be the one taking care of it."

"Take her yourself too, ask that question. Don't be afraid to ask because you're going to be protecting every guy."

"Just wait, because if you have plans or not, just go to school and finish school. You've got your whole life ahead of you."

**Primary prevention programs**
*Suggestions among participants on what could be done to help other young men from becoming dads included starting pregnancy prevention education in middle school, videos in schools, family communication, and having conversations with other people who have gone through a similar situation..*

**Quote:**
"You have to pretty much hit them by middle school because that's when I first had sex."

# APPENDIX H
# Key Informant Interview Guide

**Proposed Key Informant Interview (KII) Guide**

***Boulder County Un/intended Pregnancy Research Project: Stakeholder Interview***

**Brief overview and review of the purpose of the KII**

*Hello, my name is _____, and I am calling on behalf of the Boulder County Public Health, Administrative Services Division. I work with an independent consulting firm named JSI (John Snow, Inc.), and we are working with the County to research the local issues and factors associated with unintended pregnancy in Boulder County. As part of this project, we are talking with people to get their knowledge and opinions about factors associated with unintended pregnancy/paternity among Boulder County residents aged 13-28 as well as identify best practices in primary and secondary prevention of unintended pregnancy/paternity in Boulder County. You were selected as a provider or agency who might be involved with efforts to prevent unintended pregnancy/paternity or provide support services to those who have an unintended pregnancy/paternity. I was wondering if you had 40 to 60 minutes, either now or at a later date, to go through a confidential phone interview.*

*Yes: Great, what time is most convenient for you?*
*No: Thank you for your time.*

*BEGIN INTERVIEW:*
*Thank you for participating in this interview. It is important for us to note that the information you provide us will not be aligned in any way to you individually or a specific organization within the county. This interview should take roughly 40- 60 minutes of your time. As I mentioned before, I work with an independent consulting firm, JSI. Will protect your confidentiality and will be reporting your responses in summary form. Do you have any questions before we get started? Great, Let's begin.*

*If you have any questions regarding this interview, please contact Namino Glantz at BCPH at 303-441-1167 or nglantz@bouldercounty.org, or Christine Duclos at 303-262-4300 or* ***cduclos@jsi.com****. or Yvonne Hamby at JSI at 303-262-4304 or yhamby@jsi.com.*

**Introductory/General Questions**

1. Please state your job/role:

2. Please state where you work or deliver services:

3. Tell me about the organization:

*Prompts:*
What is the primary mission of your practice/organization?
(Health Services-Reproductive Health, Abortion, Prenatal Care, Mental Health/ Substance Abuse, Educational, Parenting Support, Social Services)

4. Tell me about your role in the organization:

5. How long has the organization been in the area?

6. How do you define your organization/community/service area?

7. What are the demographics of your clients?
*Prompts:*
Percent Race/ethnicity, Age (teens, older), Percent Chip, Medicaid Uninsured, Homeless

Do you provide services to pregnant teens?
Yes No

Do you provide services to pregnant adults?
Yes No

What is the proportion of teens to adults?

8. How are clients referred to your practice/program?

**Defining Unintended Pregnancy**

9. What do you think "unintended" or "unplanned" pregnancy means?

*Prompts:*
Trying hard not to get pregnant
Didn't want to be pregnant yet, maybe later
Never wanted to be pregnant

10. Do you think teens and young adults would define it the same way as you do?

**Reproductive Health Services**

11. Where do people go for reproductive health care or prenatal?

12. What resources are available now that are useful?

13. How does a person's coverage such as Medicaid, uninsured or private insurance affect where they go for care?

14. What gaps do you see in services for women and men?

15. What solutions would you offer?

16. What overlap/duplication do you see in services for women and/or men?

17. What solutions would you offer?

18. What resources might be available in the future that could be useful?

19. What are the biggest concerns as you see them for reproductive health and/or pregnancy prevention today?
*Prompts:*
Concerns for the patient's welfare
Concerns about the sustainability of the program,
Other concerns

20. What is currently done that hinders, instead of helping reproductive health and/or pregnancy prevention in Boulder County?

**Access to Emergency Contraception**

21. Who do you think accesses these services most and why?

22. What are the barriers currently?

23. What could be solutions?

24. How can the visibility of EC be increased?

25. What else should be done to increase availability and use of EC?

**Prevention and Parenting Programs**

26. How could unintended pregnancy prevention be integrated/coordinated with other public health/ prevention programs?
*Prompts:*
What other programs/agencies do you regularly interact with?
What makes programs/agencies easy to work with?
What makes programs/agencies hard to work with?
What overlap do you see in programs?
What programs are needed?

27. Challenges to program:
What are the challenges you face as a program?

How have you tried to address these challenges?

28. Besides yourself who [else] in your area provides services for pregnancy prevention, or parenting support or care for pregnant women?

29. Who provides pregnancy testing?

30. Who provides pregnancy options counseling?

31. How adequate do you feel your referral network is, if you want to refer someone for some aspect pregnancy prevention or care?

| Not Very Adequate | | | | Very Adequate |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

32. Why did you rate it the way that you did?

**Barriers to Prevention**

33. What do you see as the main barriers to providing primary and secondary prevention services for unintended pregnancy (financial barriers, cultural barriers, language barriers, structural or logistical barriers, personal barriers?)

34. What would you say is the most important prevention barrier to overcome?

For providers (either health, social, parenting)?
For clients?
For the county?

35. Are there any major legal or policy issues which affect unintended pregnancy prevention in Boulder County?

**Gaps in Services (whether it is health, social, parenting)**

36. In what areas does the community lack capacity to adequately prevent unintended pregnancy?
*Prompts:*
Public awareness, screening, access to treatment, case management, professional training or education

**CLOSING**

37. Is there anything else we should know about unintended pregnancy in Boulder County?

***Thank you for your responses to these questions and your time. Your knowledge and insights will be very helpful to us.***

# APPENDIX I
# Key Informant Interview Summary

**BOULDER COUNTY UNINTENDED PREGNANCY RESEARCH PROJECT**
**KEY INFORMANT INTERVEW SUMMARY**

28 Key Informant Interviews were conducted as part of the Boulder County Unintended Pregnancy Research Project. The organizations, agencies and programs interviewed as part of this research included the following:

**HEALTH SERVICES**

Boulder Valley Women's Health Center - Contraceptive Services
Boulder Valley Women's Health Center - Abortion Counseling
Clinica Campesina: People's Site - Administrative Services
Planned Parenthood Boulder
Planned Parenthood Longmont

**SOCIAL SERVICES**

Boulder County Public Health - Community Health Division
Boulder County Public Health - Family Health Division
Boulder County Public Health - GENESIS , Case Management
Boulder County Public Health - GENESIS, Parent Education
Boulder County Public Health - Health Planning
Boulder County Public Health - Health Programs
Boulder County Public Health - Nurse Family Partnership Program
Boulder County Public Health - Unintended Pregnancy Prevention Program
Boulder County Public Health - Women, Infants and Children (WIC) Program
Girls Incorporated of Metro Denver

**PARENTING PROGRAMS**

Faireview High School - Teen Parenting Program
Florence Crittenton School - High School and Child Care Center
Parent Pathways - Young Fathers Services

**OTHER**

Boulder County Commissioners Office - County Commissioner
Colorado Department of Health & Environment - Health Statistics
Colorado Department of Health and Environment - Family Planning Program
Colorado Department of Health and Environment - Family Planning Expansion
Colorado Department of Health & Environment - Maternal and Child Health
Colorado Department of Health & Environment - Pregnancy Risk Assessment Monitoring System
Colorado Department of Health & Environment - Vital Statistics
Colorado Organization on Adolescent Pregnancy, Parenting, and Prevention
NARAL Pro-Choice Colorado
Pueblo City-County Health Department - Community Health Division

Across all the interviews that were conducted, some consistent themes emerged, including:

- It is challenging to define *unintended pregnancy* among a teen and young adult population.

- Despite the wide range of reproductive health services available in Boulder County, prevention efforts are hindered by the fact that many young people are not worried about pregnancy or simply do not think it will happen to them.
- While there is a great deal of collaboration among programs and agencies in Boulder, there is always room for improvement in this regard.

The interview questions and responses are tabulated below, as well as suggestions from interviewees for potential improvements to prevention services.

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**DEFINING UNINTENDED PREGNANCY**

Questions:
*What do you think "unintended" or "unplanned" pregnancy means?*
*Do you think teens and young adults would define it the same way as you do?*

Responses:

The event is often defined as unintended/unplanned interchangeably.

Unwanted is not a term that is used because that may infer that abortion or adoption is being considered. Mistimed is probably more appropriate.

Most people who work in this field refer to the event as unintended pregnancy, which mirrors the way it's referred to in the literature. However, this term doesn't resonate with young people.

Certainly there are differences between how a clinic defines it and how a patient might define it. For them, as soon as it happens to them it's not "unintended" because that has negative connotations to it and adds a dimension of shame. They don't want to feel they did anything wrong.

I was a teen mom myself and when a pregnancy is unintended or unplanned, it is like it's not even on the radar. It's as if it's not possible for it to happen. For me, the thought hadn't crossed my mind. The belief is that it can't happen because we're smarter than everything else. At that age we can control everything, including when we get pregnant. We think it takes more work than it actually does and that we have to actively be trying to get pregnant.

For guys, having sex may be part of their identity of becoming a man. Intent to get their partner pregnant is probably not a part of the equation for them.

A lot of women talk about how it "was meant to be."

Getting at pregnancy intention takes some digging. It also depends on the interviewers' interpretation. It's more based on clinical assessment.

There is a significant ambivalence factor and what I see most is "if it happens it happens" and "I just wasn't thinking about it."

## ACCESS TO REPRODUCTIVE HEALTH SERVICES

Questions:
*Where do people go for reproductive health care or prenatal?*
*What resources are available now that are useful?*
*How does a person's coverage such as Medicaid, uninsured or private insurance affect where they go for care?*
*What gaps do you see in services for women and men?*
*What solutions would you offer?*
*What overlap/duplication do you see in services for women and/or men?*
*What resources might be available in the future that could be useful?*
*What are the biggest concerns as you see them for reproductive health and/or pregnancy prevention today?*
*What is currently done that hinders, instead of helping reproductive health and/or pregnancy prevention in Boulder County?*

Responses:

Boulder County is very fortunate to have Planned Parenthood (in both Boulder and Longmont), Boulder Valley Women's Health Center (in both Boulder and Longmont), and multiple Community Health Centers (Clinica, Peoples, and Salud). There is good access to health services and a great referral network to/from these organizations.

The wait time for an appointment at BVWHC has greatly improved over the past year, where it used to be a month or longer for an initial appointment.

The free teen clinics are a great way to break down the barrier that otherwise having to access a parent's insurance might pose. The CHCs are another story because of the volume of calls they receive. Often a caller is asked to leave a message, but for young people who may not have cell phones, can't keep their phones with them in school, and don't want their parents to know they are calling – this process can cause a barrier to making the appointment.

There seems to be the greatest "mismatch" of resources when looking at Salud in Longmont.

I think Nederland's community health center closed.

We offer a lot of resources in Boulder County, so it tough to say where any gaps in services may be.

Some appointments are easier to schedule than others. But when a teen has to wait for an appointment, and then change their minds [about birth control] by the second, it's difficult to tell them their appointment isn't right away. Once they get in, the services provided are great. But more availability of appointments would help.

People from the mountain communities do seem willing to travel for services.

There are a lot of places for people to go. I think that where information is inadequate is in knowing the range of birth control methods available. Without that knowledge, young women can't always make an educated choice about the best method for them.

**EMERGENCY CONTRACEPTION**

Questions:
*Who do you think accesses these services most and why?*
*What are the barriers currently?*
*What could be solutions?*
*How can the visibility of EC be increased?*
*What else should be done to increase availability and use of EC?*

Responses:

There seems to be a lot of young girls who know what EC is. But they don't all know the proper way to use it or how to access it. And until just a couple of years ago there were lots of people who still confused this with the abortion pill.

Access to EC remains an issue because either girls don't know where they can get it, or some pharmacists won't stock it or dispense it. And cost is also an issue, as it's about $60 per prescription, unless you get it from one of the clinics that have a sliding fee scale (in which case it would probably be free.)

Some parents object to EC being advertised or talked about because they too don't know enough about it to differentiate it from the abortion pill.

Girls need to understand that taking EC only helps in an isolated incident. If they have another situation of unprotected sex, the EC won't help all instances. And the success rate is about 80%, so it's not full proof.

The age limit is 17, so that still leaves no access for the younger girls.

There is a belief that even if they knew where to get it and that it could also be free; most girls still think that they won't need it because they won't get pregnant.

The most common time it's requested is after a condom breaks.

Kids are educated about EC, but one obstacle for them is having to call someone to tell them they need it. They feel like they are being judged for having unprotected sex, which makes them feel shameful. If teens had an easier way to access it, without having to make that call – it would be very helpful. And the only way to get it proactively is to pay full price (close to $60) which is not possible for some young people.

There is some resistance to using it, which may indicate a lack of education around what it really is/does. Or influence from the partner. The Latina community in particular has a lot of myths around birth control.

There needs to be more education it because I still hear it being referred to as the abortion pill.

There's still some shame around needing it because with Plan B, there's a feeling that something went wrong.

More availability would increase the use of it. Some places that could provide it don't. Others may roll their eyes or make the person feel uncomfortable for asking for it.

## COORDINATION / INTEGRATION OF PREVENTION SERVICES

Questions:
*How could unintended pregnancy prevention be integrated/coordinated with other public health/ prevention programs?*
*What are the challenges you face as a program?*
*How have you tried to address these challenges?*
*Besides yourself who [else] in your area provides services for pregnancy prevention, or parenting support or care for pregnant women?*
*Who provides pregnancy testing?*
*Who provides pregnancy options counseling?*
*How adequate do you feel your referral network is, if you want to refer someone for some aspect pregnancy prevention or care?*

Responses:

There is much coordination and integration of prevention services in and around BCPH. Programs such as WIC, Genesis, Unintended Pregnancy, NFP refer to each other, as well as to outside these programs. However there can be more/improved integration because it can be a "rocky road" sometimes.

More program staff are starting to participate in cross-program discussions of the issues and how each program can help the other. Sometimes just physically being in different locations/buildings adds to the challenges of collaboration. Another issue is recognizing cultural differences between communities.

**BARRIERS TO PREVENTION**

Questions:
*What do you see as the main barriers to providing primary and secondary prevention services for unintended pregnancy (financial barriers, cultural barriers, language barriers, structural or logistical barriers, personal barriers?)*
*What would you say is the most important prevention barrier to overcome?*
*Are there any major legal or policy issues which affect unintended pregnancy prevention in Boulder County?*

Responses:

For kids, there is shame in going for birth control b/c it's not spontaneous. Kids also need more education around birth control myths/facts.

A lot of girls have no idea how they got pregnant or how they could have prevented it. They also don't know what resources are out there.

Boys don't feel birth control is their responsibility. Girls do.

Kids separate between being sexually active and being a mom. There is a "super-hero" effect that makes them think it won't happen to them.

Pregnancy doesn't change future plans when there are no future plans. The pregnancy becomes their default plan.

Must dispel the myths around birth control, such as no risk of pregnancy when the guy pulls out.

Pregnancy is sometimes seen as a path to something else: having someone to love, keeping a partner.

Boulder Valley Women's Health Center is still struggling with reaching more men…particularly since the term "women" is in their name.

Staying in touch with teens when their phone numbers change all the time.

Even girls who have ability to make smart decisions will often engage in risky sexual behavior just to experience it. They don't want to be seen as "nerd virgins" anymore, so they get sex out of the way.

Very few kids are willing to admit that they need [pregnancy prevention] information.

Need more community awareness around healthy pregnancy intervals, Plan B, and how to make decisions on having more kids. Some people think it's terrible to have only

child, so they go on to "give" their child siblings. We could do more education around these topics.

## CAPACITY OF COMMUNITY RESOURCES TO PREVENT UNPLANNED PREGNANCY

Question:
*In what areas does the community lack capacity to adequately prevent unintended pregnancy?*

Responses:

There needs to be more comprehensive sexual health education in schools. This will require a balancing of roles between parents and schools. Prevention efforts could focus more on tools that parents could use to help them talk to their kids about sex. Most parents don't get the wake-up call until a pregnancy has occurred. Get parents to talk to sons as much as daughters. Parents may assume that schools are taking the lead in that discussion.

The SHAPE program is a peer education program that seems to work well, where fellow students go into community groups and do presentations, as well as hand out condoms at places like the Pearl St Mall.

There is a lot of confusion (among schools) about who has final word on sexual health curriculum. Some school principals think it's their role, while other school districts think it's theirs.

## SUGGESTIONS FOR IMPROVING PREVENTION SERVICES

Start small and expand on successes. By reaching too broadly the impact could be diluted.

Identify the primary population that has influence with teens and work through that population to get the message across. But don't dilute the parental influence, rather create awareness about its power and teach parents how to apply it.

School-based health centers.

Make it so young people would have to choose to become pregnant (i.e., remove birth control method) vs. choosing not to be pregnant (by taking a pill or using a condom.)

Provide comprehensive sexual health curriculum that talks them through what is happening with their bodies, as well as understanding values (vs. teaching values), peer pressure, assertiveness, role playing "what if" scenarios, and healthy relationships.

Gain a better understanding of peer networks and letting young people know there are places to talk about things that they don't want to talk to parents about.

Don't just tell people what they should do. Train people who are internal resources and they can be an agent of change.

Figure out a way to change the mind-set so that young people consider what a pregnancy would really mean to them.

Develop a Life Skills Program around saying "no" to things you don't want and learning how decisions can be made about things that are important, including family planning.

Try and identify "best practices."

More case management type positions because young people tend to move around a lot or have a change in circumstances, so having someone helping to keep track of birth control methods/availability would be helpful.

Remember the continuity aspect. Providing birth control options that women can use throughout their life.

More programs in schools teaching kids that it can happen to them. Also providing other activities for them to get involved in.

Getting kids to be open about their sexual activities so that they don't feel isolated.

Increasing self-esteem for girls. Some girls will tell you they were sexually active because there was nothing else for them to do or because everyone else was doing it.

There is a need for more mental health services. Recognizing that pregnancy is not the end of the line and that are still options available. What is needed is a widening of perspectives.

It would be nice to have re-education or re-training opportunities for those of us in the family planning world so that we're all on the same page. Also, contraception updates would be helpful in keeping up with the latest methods.

Create a general family planning campaign of what it would mean in their life to have children.