The Family Planning Project Social Marketing Study / May 2001

what women are saying

We worry about our children, our hu
bands, but we don't take care of ou
as women because we have so man
roles... My life is like a teeter-totter t
balances between work and childre
Everyday is a struggle just to get wh
you're going... With every contracep
there are so much more cons than t
are pros... Sometimes I get in a rage
on Depo now because I kept forget
take a pill. I don't like getting shots,
now I only have to worry about birth
trol four times a year... I would defin
recommend emergency contracept
you didn't want to have a baby and
had a accident, but not just if you're

what women are saying

The Family Planning Project Social Marketing Study / May 2001

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executive summary

The Family Planning Project Social Marketing Study

Background

"Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic status of women."

—CENTERS FOR DISEASE CONTROL AND PREVENTION *ACHIEVEMENTS IN PUBLIC HEALTH, 1900-1999,* DESCRIBING FAMILY PLANNING AS ONE OF THE GREAT PUBLIC HEALTH ACHIEVEMENTS OF THE 20TH CENTURY.

The relationship between increased availability of contraception and improved maternal and infant health is unquestioned. So is the fact that, as we begin a new century, contraceptives are more available, more varied and more effective than ever. Still, unplanned and mistimed pregnancies continue to exact their associated health, social and financial costs on families in our state and across the country. In 1998, 30,693 Oregon women experienced an unintended pregnancy, resulting in 12,727 abortions and 17,966 births. Medicaid paid for more than half of these births (9,881) at a cost of $4,463 per birth, or a staggering $44 million in 1998 alone (*1998 Vital Statistics* and first year of *PRAMS* survey of August 1988 through September 1999 births).

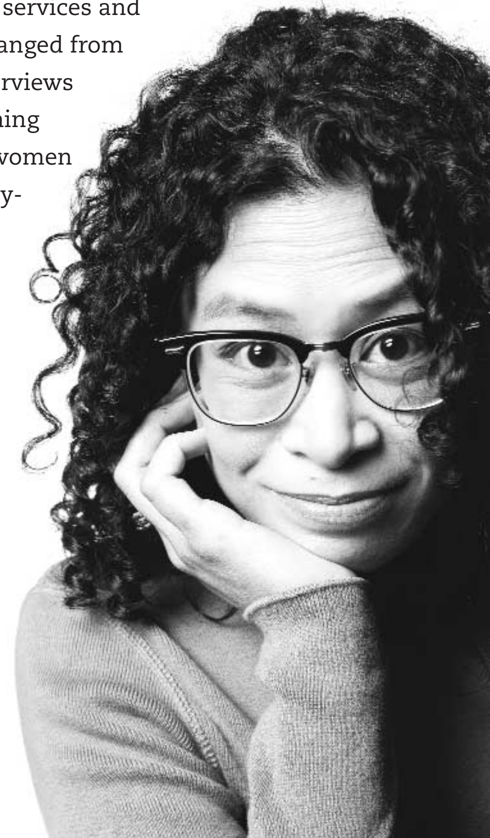
The Family Planning Project (FPP) is Oregon's response to this complex and costly problem.

"We worry about our children, our husbands, but we don't take care of ourselves as women because we have so many roles..."

Description

The Family Planning Project, a Medicaid benefit program, provides clinical and counseling services related to contraception for economically disadvantaged Oregonians. The FPP goal is to reduce unintended pregnancy and increase the well-being of women and children in Oregon. An FPP key component is a statewide social marketing initiative (SMI). The SMI supports the Project's goal by promoting access to newly-available family planning services and improving consistent use of effective contraceptive methods among individuals at risk of unintended pregnancy.

The FPP Social Marketing Study was initiated in June 1999 as the first stage in the development of this initiative. Eight independent studies using qualitative and quantitative research methods offered program managers an in-depth understanding of the factors impacting women's use of family planning services and birth control. Studies ranged from informal, in-depth interviews with local family planning staff and low-income women to structured, ethnically-specific focus group discussions. A telephone survey of 600 women with recent Medicaid births concluded the research. We gleaned additional information from a review of published literature, state and national research data and Oregon client services data.



What We Learned

In Oregon and across the nation about half of all unintended pregnancies occur among women who report not using contraceptives at all. The other half, however, occur among those who report some level of contraceptive use. In other words, even among women who use contraceptives, many are doing so unsuccessfully. Clearly more is required than simply making contraceptives available. What more can be done to help women achieve their reproductive goals? How can we ensure that every pregnancy is planned and every child wanted?

To that end, this study sought to identify the factors that influence women's contraceptive behavior. The answers from women revealed **five factors** that, when present, *motivate and encourage* women to take action to avoid pregnancy through the use of contraception:

1. A desire to delay pregnancy until a later time in their lives;
2. The availability of caring and supportive family planning clinic staff who are responsive to their individual needs;
3. Clinic services that are easy to access, with timely and convenient appointments of reasonable length in a clean, professional, respectful clinic environment;
4. The perception that using birth control has emotional and physical benefits such as peace of mind and regulation of their menstrual cycle;
5. A satisfying experience with use of a birth control method.

We identified **ten factors** that *discourage and prevent* women from actively seeking or effectively using contraception:

1. Limited knowledge—about their reproductive cycles, when they are at risk for pregnancy and about birth control methods and correct use;
2. Real and perceived side effects associated with hormonal contraceptive use;
3. Difficulty finding a birth control method that works for them;
4. Inability to access services and/or use birth control when they are ready, willing and able;
5. Previous negative experiences with family planning services;
6. Lack of awareness about the availability of clinic services;
7. Monetary expense of obtaining birth control supplies;
8. Competing life priorities;
9. The attitude that although a pregnancy is unintended, the consequences would not be severe enough to overcome other obstacles;
10. Lack of support from their male partner.

For some women in the study, the encouraging factors outweighed the discouraging factors, allowing them to successfully access family planning services and effectively use birth control. For the majority of women studied, however, the costs of trying to access services and use birth control far outweighed the benefits, deterring them from using services and/or birth control on a consistent basis.

Implications for Social Marketing

Findings from this study confirm those from other studies with important implications for reproductive health policy, program and service delivery. These findings led to the following conclusions about the development of Oregon's Family Planning Project Strategic Marketing Plan:

- **Women need more information about their own bodies, conception and contraception. They need better skills for correct and consistent use of contraceptive methods.** Contraceptive risk-taking and unintended pregnancies are higher among women with incorrect knowledge of their fertility cycle or women who lack knowledge about contraceptive methods. Strong evidence indicates lack of knowledge is widespread, even among those who have previously received family planning services. *Counseling and education messages must be reconsidered in light of the evidence of misinformation among both current and new clients.*

"If you go to a low-income place...you kind of get treated like you can wait because you are not really paying your money, so they kind of disrespect you more."

- **A specific event or experience often triggers birth control decisions.** Many opportunities are lost when women cannot get appointments quickly or do not succeed in taking action at the time they are motivated. Referral and service strategies must facilitate quick access to services at the time of decision-making. *Key opportunities for contraceptive decision-making include after childbirth, abortion and at the time of a negative pregnancy test.*

- **African American, American Indian and Asian women are under-served by the Family Planning Project, specifically, and by public family planning services, in general.** Study findings indicate an interest among women in these populations, presenting an opportunity to remedy service disparity. *We need to develop marketing messages and outreach strategies to reach women at risk of unintended pregnancy from under-served populations.*

- **Many women have strong issues with real and/or perceived side effects from hormonal birth control methods.** Hormonal side effects translate into a price that is too high to pay for women. *Marketing and counseling strategies must work to improve the cost-benefit ratio of hormonal methods by actively assisting clients with side effects and by providing education on hormonal benefits.*

- **Many eligible women perceive public family planning services as a government program designed to serve teenagers and welfare recipients.** They do not see themselves as belonging to either group, and consequently, do not seek family planning services at public clinics. Other women have had negative experiences with public clinics in the past and do not want to risk subjecting themselves to similar experiences

again. *Policies, services and marketing messages must mitigate the negative "welfare" stigma women associate with publicly funded programs such as the Family Planning Project.*

- **Even women who currently use contraceptives or express interest in using them do not regard unplanned pregnancy as a wholly negative event.** As we provide family planning services, we must understand and address this ambivalence. *Both birth control marketing and counseling messages must reflect an understanding that pregnancy, particularly in the future, is a positive concept for most women.*

- **Women's decisions regarding use of family planning services and contraceptives are neither uniform nor static.** The vast majority of women in this study expressed the desire to avoid pregnancy or have control over its timing. However, their willingness and ability to commit to consistent action varied widely from woman to woman and even with the same woman over time. *Family planning services must be individualized* and *offered continuously to be effective.*

- **The strategic marketing plan reflects an understanding of the similarities between women who are current and potential clients of family planning services.** As women move in and out of using services, they also move back and forth in their status as current and potential clients. *Strategies must contain elements that address client retention and ongoing maintenance as well as new client access and outreach.*

Conclusion

This market study sought to identify factors influencing women's use of family planning services and contraceptives for the purpose of developing a strategic marketing plan. Among the factors identified are universally basic needs for: accurate information; accessible services; safe, effective and affordable birth control methods; and supportive partners.

Women's attitudes and reproductive health needs intertwine with other aspects of their lives. Attitudes and needs are diverse and ever-changing among women collectively and individually. They represent unique clinical and marketing challenges: tapping into women's inner motivations by reaching them with the right services and messages in the right place at the right time.

The information shared by women in this study further our understanding of the myriad and complex factors that determine women's ability to realize their reproductive health goals. As reproductive health professionals consider the implications of these findings for their program areas, this study should mark the beginning of an on-going dialogue among all individuals who have a stake in reducing unintended pregnancy and in improving the well-being of women and children in Oregon.

what women are saying

Background

To Fill an Unmet Need: The Oregon Family Planning Project

Following two years of intensive planning, the Oregon Health Division, in partnership with the Office of Medical Assistance Programs (OMAP), county health departments, local family planning agencies and the Health Care Financing Administration (HCFA), embarked on a 5-year demonstration project designed to expand access to family planning services. The Oregon Family Planning Project is part of an overall strategy to increase access to family planning services and reduce unintended pregnancies in Oregon. Implementation of the Family Planning Project began in January 1999.

The Family Planning Project provides free contraceptive services to people who do not have public or private insurance covering family planning and who have incomes at or below 185% of the U.S. Federal Poverty Level (FPL).

Low-income Oregonians who do not qualify for free services under the Family Planning Project benefit indirectly.[1] The increase in Family Planning Project-covered clients free family planning providers to focus grant funds and other resources toward low-cost services for others on a sliding fee scale. Otherwise these clients may have been left out of low-cost services.

The current network of family planning providers served 80,984 Oregonians in 1999. By 2001, the Family Planning Project and continued federal family planning grant support will provide free or low-cost family planning services for 100,000 Oregonians annually.

Further, the Family Planning Project demonstrates that investments in family planning reduce overall state and federal Medicaid costs by preventing unintended pregnancies. And finally, the project reduces financial and other burdens on families who are not ready to support unplanned children.

[1] Oregon's family planning services to low-income individuals are supported by a combination of public health and Medicaid programs working together. For a description of these programs, please contact the Family Planning Program at the Department of Human Services, Oregon Health Division (phone: 503-731-4018, web: www.oshd/org/fp).

"We're all young and most of us didn't do it the right way and it is not something to be ashamed of, or it is not bad because I'm sure we all love our children. But next time... plan it."

A Customer-Centered Approach: The Family Planning Project Social Marketing Initiative

The Family Planning Project Social Marketing Initiative is a key component of program success. This comprehensive statewide initiative supports Family Planning Project goals by promoting:

1. Access to and full utilization of publicly-funded family planning services.
2. Effective use of contraceptives among Family Planning Project-eligible individuals at risk of unintended pregnancy.

The initiative involves a continuous process through four major stages:

1. Research
2. Strategy development
3. Implementation
4. Evaluation.

Information from Stage 4 is cycled back to inform earlier stages. Each stage is thus driven by research and customer feedback to make real-time program adjustments for continuous quality improvement; i.e., improvements and enhancements over the course of the project and beyond.

A social marketing approach emphasizes understanding and response to customer needs. Public information and client education components of social marketing coordinate with policy development, service delivery, and outreach activities to avoid promotion of inaccessible services or creation of unrealistic expectations. For this reason, an effective initiative begins with the formative research stage.

Behavior Change and *The Stages of Change* Model

Social marketing focuses on voluntary behavior change as the bottom line. The *Stages of Change Model* developed by Prochaska and DiClemente is one theory of behavior change that has been particularly useful for and popular with social marketers.[2] It classifies individuals by their progression toward a desired behavior, which in the case of the Family Planning Project is two-fold:

1. Use of Family Planning Project services
2. Use of effective birth control.

According to the model, individuals progress through five main stages of change in moving toward a behavioral goal, the final stages being *Action* and *Maintenance*. Depending on the behavior, however, people don't usually move directly to *Action* and stay there. Some individuals cycle back and forth many times between earlier stages before arriving at *Action*; others arrive at *Action* only to relapse back to an earlier, inactive stage.

Applying this model to actions regarding the use of birth control and family planning services allows messages and/or marketing strategies to be more effectively tailored to what will move women from one stage to another. This model provides the theoretical framework for formative research and may be useful in the strategy development stage.

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[2] Prochaska, J.O., Velicer, W.F., Rossi, J.S., et al. (1994) Stages of change and decisional balance for 12 problem behaviors. *Health Psychology*, v.13, 1, 39-46.

learning opportunities

Description of Research Activities

About the Women Who Shared Their Time and Thoughts

Social marketers only recently began to apply what commercial marketers have known and used for years: when it comes to marketing and outreach, one size does not fit all. Successful marketing messages and strategies target well-defined groups. If more than one group is identified, we tailor strategies for each group—a concept known as *target audience segmentation*.

The broadest target audience segment for this marketing study was low-income women of childbearing age and at risk of unintended pregnancy—that is, women who are eligible for the Family Planning Project. Women statewide participated in this study and we made special efforts to include women from diverse racial/cultural groups. Most of the marketing research activities (see table, page 9) targeted women in the 18–29 year age range. We based the decision on the following factors relating to the 18-29 year age group:

1. Among women of reproductive age, the highest proportion at risk of unintended pregnancy (70%) are in this group.[3]
2. This age group has the highest proportion of Medicaid pregnancies (81%, *Poverty Level Medical Telephone Survey*).
3. 64% of current family planning clients fall into this age group (*Family Planning Project Client Data, 1999*).

We further divided women participating in this market research into groups according to their use of Family Planning Project services:

1. Women who are current Family Planning Project clients
2. Women who are interested in the Family Planning Project (i.e., potential clients)
3. Women who are not interested in the Family Planning Project.

The first two groups are the focus of this study.[4]

"I feel more like if we aren't supposed to have any more kids, we aren't going to. I don't want to do anything to make us not have kids. If it's going to happen, it's going to happen. Then it's God's choice that it's going to happen."

[3] Institute of Medicine, Brown, S.S., Eisenberg, L., eds. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families.* National Academy Press, Washington, D.C. 1995.

[4] Only one study examined women not interested in the Family Planning Project. Over half of this group were not interested because they were currently covered by the Oregon Health Plan or had insurance or other providers with whom they were happy; others were not interested in contraceptive services for other reasons.

About the Research Activities

The principal research focus was to develop an in-depth understanding of women who make up the Family Planning Project target audience. Research ranged from qualitative to quantitative in nature; from interviewing a handful of participants in convenience samples to a cross-sectional survey of women with a recent Medicaid birth (i.e., PLM women). Individual research reports include descriptions of populations in each study and parameters and limitations on conclusions.

A review of published literature, state and local client data, and state population survey results provided contextual information. Oregon surveys referenced include the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment and Monitoring System (PRAMS). The Oregon Health Division conducted both public health surveys. Additionally, local Family Planning Project providers and other health and social service agency providers shared their perspectives on complex issues influencing low-income women's use of contraceptives and family planning services.

Other Data Sources

Region X Data System client data (Ahlers & Associates), Portland State University Population Research Center population data, and data from Oregon Health Division surveys of adults (BRFSS) and women who recently gave birth (PRAMS) were analyzed for use in the social marketing study. (For a more detailed description of the two surveys, see sidebar).

A Guide to the Acronyms

BRFSS (Behavioral Risk Factor Surveillance System)
National representative survey, including Oregon, and with special family planning questions for Oregon beginning in 1998.

EC (Emergency Contraception)
A special combination of birth control pills used to prevent pregnancy up to three days after unprotected sex.
(Note: This is not the same as the recently approved RU 486.)

FPP (Family Planning Project)
Oregon's Medicaid waiver for a family planning demonstration project, begun in 1999.

FPL (Federal Poverty Level)
The basis for State and Federal income guidelines used to determine eligibility for many publicly funded program services, including the Family Planning Project.

HCFA (Health Care Financing Administration)
Federal Medicaid agency.

OHP (Oregon Health Plan)
Oregon's Medicaid waiver for a managed care demonstration project, begun in 1994.

OMAP (Oregon Medical Assistance Program)
Oregon's Medicaid agency.

PLM (Poverty Level Medical)
Oregon Medicaid program for pregnant women with incomes between 100% and 170% of the Federal Poverty Level.

PLM Survey
A telephone survey of women who had a recent Medicaid birth (and who were not on Medicaid immediately prior to their pregnancy). Conducted for the Family Planning Project Marketing Study in 2000.

PRAMS (Pregnancy Risk Assessment Monitoring System)
Oregon's representative survey of women who have recently given birth, begun in 1998.

Title X (Title X of the Public Health Services Act)
The Federal legislation that established a Federal program and authorized grants for family planning.

For Further Reading

Henshaw, Stanley K. "Unintended Pregnancy in the United States." *Family Planning Perspectives*, 1998, 30(1):24-29 & 46.

IOM (Institute of Medicine) 1995. "The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families." National Academy Press, Washington, D.C.
(To purchase, call 1-800-624-6242.)

Research Activities

***SECONDARY REPORT: REVIEWING THE LITERATURE AND OREGON DATA*, July 22, 1999 (PSI)**
We reviewed and analyzed national and local literature on family planning and contraceptive use among low-income women at risk for unintended pregnancy.

***FAMILY PLANNING PROJECT FOCUS GROUP DISCUSSIONS*, November 30, 1999 (PSI)**
We conducted eight focus groups in several Oregon locations with low-income women, ages 18–29, who were not using Family Planning Project services but were interested in getting free services and birth control (i.e., potential Family Planning Project clients). We conducted two groups with each of the following racial/ethnic groups: Caucasian, African American, Latina, and American Indian.

***HEALTH PROVIDER AND HEALTH AND SOCIAL SERVICE AGENCY INTERVIEWS*, November 30, 1999 (PSI)** We conducted 32 interviews with medical providers (including five PLM providers), health and social service agency staff, and community organization representatives who work with potential Family Planning Project customers.

***FAMILY PLANNING PROJECT CUSTOMER SATISFACTION SURVEYS*, November 30, 1999 (PSI)**
We conducted 100 one-on-one surveys with women between the ages of 18 and 44, utilizing Family Planning Project services at 12 county health departments and 5 Oregon Planned Parenthood clinics.

***GEODEMOGRAPHIC ANALYSIS: FAMILY PLANNING PROJECT CLUSTERS IN OREGON*, November 30, 1999 (PSI)** We utilized a computer database to profile individuals eligible for the Family Planning Project and gain insight into their lifestyles and behaviors. We examined demographic characteristics, health care attitudes and use, media habits, activities, and product and financial preferences across eight Family Planning Project clusters.

***CLINIC OBSERVATIONS AND STAFF INTERVIEWS*, November 22, 1999 (Ann Sola)**
We conducted a combination of 15 semi-structured and four casual interviews with clinic staff (administrators, providers, receptionists and assistants) and observations of all aspects of six clinics (e.g., interactions in the waiting room and reception area, prep work prior to exam, physical exams, and casual time with staff).

***POVERTY LEVEL MEDICAL (PLM) TELEPHONE SURVEY REPORT*, May 1, 2000 (PSI)**
We conducted 606 surveys over the telephone with women who had a Medicaid-funded birth (PLM women) between January 1 and June 30, 1999.

***IN-DEPTH INTERVIEWS*, April – June, 2000 (Ann Sola)** We conducted 19 in-depth, face-to-face interviews with Family Planning Project-eligible women between the ages of 19 and 29 in both urban and rural areas of the state. The women were not enrolled in the Family Planning Project nor were they currently accessing family planning services and supplies effectively. All participants were at risk for unintended pregnancy.

what we heard

Understanding Women's Use of Contraceptives

Almost half (49%) of all pregnancies in the United States are unintended, either mistimed or unwanted altogether.[5] In 1998, over half (53%) of all pregnancies in Oregon were unintended (PRAMS and Vital Statistics data).

Moreover, national data shows that half of all unintended pregnancies occur among women who report using contraception (IOM, 1995). The Family Planning Project social marketing research found this to be true in Oregon as well: In the PLM survey, half of women who described their most recent pregnancy as unintended reported also that they were using some form of contraception just before they got pregnant. We cannot determine whether pregnancy resulted from inappropriate or inadequate contraception or whether the birth control method failed. It is clear, however, that many women trying to use contraception still become pregnant.

We talked with Family Planning Project providers and the women in this study to gain insight into why so many women have problems using contraception effectively (i.e., consistent and correct use of an effective birth control method).[6]

Interestingly, Family Planning Project providers don't always see Family Planning Project clients the way clients see themselves. When asked to distinguish between family planning clients who use birth control effectively and those who do not, Family Planning Project staff consistently described the former as women who are able to clearly state they do not want to get pregnant, have a plan for the future, are organized and responsible. Ineffective users were characterized as women who have unorganized lives and no plans or hope for the future. They further characterized ineffective users as not taking advantage of the preventative services offered, but rather using pregnancy test services when it was too late.

Interviews with current and potential clients revealed a somewhat different perception. Both groups in this study see themselves as having busy but not necessarily unorganized lives. They see themselves as responsible and having plans for the future. Most clients have high school diplomas, and many are attempting to improve their status in life by attending college. Other clients struggle to raise children they already have. Most clients are either married or co-habiting. Most perceive themselves as being somewhat secure financially, and many express determination that they don't want to be part of the system, i.e., on public assistance. In summary, the women see themselves as responsible individuals wanting to make a better life for themselves and their families.

It is important to listen to women talk directly about their birth control experiences. When we listen, we find that most women have used one or more methods of birth control at some time in their lives. However, their behavior is characterized by intermittent, inconsistent and even incorrect birth control use. In this report, we explore factors that influence this behavior.

[5] Henshaw, S.K. (1998). Unintended Pregnancy in the United States. *Family Planning Perspectives,* v. 30 (1), January-February, 24-49.

[6] For the purpose of this study, effective birth control methods are defined as hormonal methods, such as Norplant, Depo-Provera, oral contraceptives and the IUD, and sterilization.

"With every contraceptive, there are so many more cons than there are pros."

Past Experience with Contraceptives

Women's past contraceptive experiences are a significant determinant of current contraceptive behavior. This study confirmed that women in our target audience have had very mixed experiences in using contraception.

Out of the 606 women who participated in the PLM survey, 356 stated less than full agreement with the statement "I wanted to get pregnant." However, they reported mixed use of contraception in the month before they got pregnant: birth control pills (28%), condoms (38%) or nothing (29%). Moreover, use of a method did not mean consistent use. Some of the women also agreed with statements that they forgot to get or use birth control (27%), had side effects from their birth control method (25%), could not pay for birth control (21%) or that it was too much trouble to get or use birth control (19%).

Inconsistent contraceptive use was found in other parts of the research as well. Focus group and in-depth interviews with potential Family Planning Project clients found that most clients were able to cite examples of times they had successfully used a birth control method. At the same time, most clients cited examples of times when they (or others) got pregnant while using a birth control method. A number of women had used contraceptives for a period of time after a negative pregnancy test result or following an abortion. Others had obtained and used contraceptives following a visit with a health care provider for another issue. However, few of these events resulted in long-term contraceptive use among the women in this study. Having discontinued the prescribed method, the women did not seek or receive follow-up services. It appears, then, that women are trying to use contraceptives, but they experience difficulty finding a method that works for them.

Knowledge About Contraception

Ignorance is a major factor inhibiting women's consistent use of effective contraceptives. Misinformation, misunderstandings and anecdotal stories from friends and family members all contribute to a basic lack of knowledge regarding birth control methods (including proper use and side effects), fertility and conception, and other reproductive health issues. As a result, many women rely on ineffective methods (douching, herbal remedies, etc.), less effective methods (rhythm method, barrier methods, etc.) or improper use of effective methods. Published literature supports this conclusion, as does t he Oregon research.

Lack of accurate information may explain some conflicting responses described in the previous section. Almost half (46%) of women in the PLM survey who reported using birth control but got pregnant anyway, had obtained it at a drug store rather than from a medical provider. At the same time, about one-quarter (26%) of women using a method had obtained it at a public clinic (14% from a health department clinic and 12% from Planned Parenthood). Use of family planning services, therefore, does not assure that clients are provided with effective counseling and education about their birth control method.

Other responses from women in the PLM survey revealed mistaken beliefs about their ability to get pregnant. About half of those with unintended pregnancies thought that their birth control method would prevent them from getting pregnant, even though some clearly had not used their method at the time. More than one-third mistakenly thought they could not get pregnant (41% didn't think they were in the fertile part of their cycle; 38% thought they or their partner (18%) had a medical problem that prevented them from getting pregnant).

These findings confirm information gathered in focus groups and in-depth interviews, where women repeatedly expressed confusion over the proper use of birth control methods, particularly birth control pills. Some women believed that hormonal methods would stay in their system and prevent pregnancy for some time after they stopped taking them. In stories they told about themselves and friends, they cited the inability to get pregnant after stopping these methods as significant information affecting their own decision-making.

Many women interviewed and in focus groups expressed a desire to have partners be more involved in and supportive of birth control use. Specifically, women felt that if their partners were more knowledgeable, they would be more supportive, especially when women experienced difficulties with birth control methods (side effects, use of a back-up method, etc.). They emphatically stated that education is key: men need to know "how male and female bodies work" and how birth control affects women. They suggested birth control classes for guys/couples, videos and partner inclusion in their exams as ways to increase men's knowledge and involvement. At the same time, women emphatically stated that they want to make the ultimate decisions regarding birth control.

In addition to a general lack of accurate information about fertility and birth control, women lack information about many contraceptive technology changes that include lower-dose birth control pills with fewer side effects, safer IUDs and emergency contraception (EC).[7]

Again, findings are consistent among women who had been family planning clients as well as those who had not. In Family Planning Project interviews, providers reported that they too see these same issues among clients and try to address them during clinic counseling.

Observations in Family Planning Project clinics and interviews with Family Planning Project staff revealed that clinicians want and need assistance with providing more effective client education. Some clinicians expressed frustration that although they give clients birth control information, the clients come back with positive pregnancy tests.

[7] Only one-third of the women in the PLM survey and about half of the women in the other studies were aware of EC, and for many, there was confusion about how it works.

"None of my children were planned. I had my first one at 16. I was having sex because I thought that's what you were supposed to do... My second one I was on pills. My third one was on Depo. I also had a miscarriage after having my tubes tied. I pretty much think birth control sucks."

Attitudes About Pregnancy

Attitudes about pregnancy play a critical role in contraceptive decision-making. An overwhelming majority of women in this study expressed the desire to avoid pregnancy at this time in their lives, but most want to have children in the future. The capacity to be a mother, and a good one, is still important, even when women want to delay pregnancy.

Focus group participants who had children described their children's welfare and their own ability to provide for them as strong motivators for delaying or avoiding a subsequent pregnancy. They discussed the importance of spacing births and planning when and how many children to have. In the PLM survey, 86% of women agreed with the importance of spacing births and 82% agreed with the importance of planning when and how many children to have.

Although they agreed that delaying pregnancy was desirable, the women did not feel that an unexpected pregnancy would be a crisis. The PLM survey indicated that 58% of women thought that a pregnancy would interfere with the other things in their lives right now, but 64% also agreed "it would be OK" if they found out they were pregnant today. Eighty-one percent of women in the survey agreed with the statement that if they got pregnant, it was "meant to be." Women of all ages expressed this same sentiment throughout the research.

Women described very specific beliefs about what makes a good home and the ideal conditions for having a child, including social, economic and emotional readiness. Although most of the women had reasons why they should not get pregnant at this time, many also described themselves as possessing the very qualities they described as advantageous to having children. Consequently, a woman who perceives herself as having these characteristics would not consider it disastrous if she were to become pregnant. This perception may contribute to an ambivalent or lax attitude towards contraceptive use and feelings of "if a pregnancy happens, it was meant to be." Again, this apparent duality in attitudes is a common theme among all women throughout the market research.

Even current contraceptive use, particularly condom use, may or may not represent a strong commitment to avoiding pregnancy. Findings from the in-depth interviews suggest that fear of AIDS may be a much greater incentive for condom use than concern about pregnancy. Women discussed using condoms consistently with new relationships or multiple partners, and then relaxing or even discontinuing condom use when they establish a more permanent relationship. It may be that a segment of the Family Planning Project-eligible population is less concerned about pregnancy than about disease prevention.

"When I was single, avoiding pregnancy was really important. But now that I'm married and in a happy, stable relationship, avoiding pregnancy is not a top priority."

Attitudes About Birth Control

Birth control attitudes can impact an individual's willingness to consider contraceptive use, and attitudes are decidedly mixed among market study women. They easily described both benefits and drawbacks of using birth control in general and using specific methods in particular.

Women in the PLM survey revealed the following positive attitudes toward birth control use. Women surveyed agreed to statements such as:

They are not too busy to use birth control.	91%
People important to them think using birth control is a good idea.	89%
Using birth control gives them a sense of control over their lives.	78%

Likewise, over three-fourths of women who participated in the clinic customer satisfaction surveys reported they are satisfied or very satisfied with their birth control method. Women using birth control pills and Depo-Provera reported the highest level of satisfaction.

Women described many benefits of hormonal birth control methods in the focus groups and confirmed similar satisfaction in the PLM survey: 81% rated peace of mind as an important benefit, 71% said hormonal methods and IUDs had the advantage of not interrupting sex, 64% saw period regulation as an advantage of the pill and 45% stated the pill clearing a woman's complexion as a benefit. Peace of mind was the most frequently mentioned benefit: women said the sexual experience would be more relaxing and fun if they did not have to worry about pregnancy.

Negative attitudes centered overwhelmingly on the side effects of hormonal birth control methods: both physical and emotional aspects were discussed at length in focus groups and in-depth interviews. Side effects were mentioned as the main reason for not using or discontinuing birth control among women in the PLM survey. In fact, of the surveyed women not currently using birth control, 25% cited side effects as the primary reason. Among those who said they were not likely to start using one of the more effective methods in the future, 50% cited side effects as their reason.

> "I don't want to put chemicals into my body because they've screwed with my body too much and I don't feel comfortable with that."

Those who had used less effective methods, such as withdrawal and barrier methods, described disadvantages. Many said they worry about their partner's willingness to use condoms or failure to withdraw in time. Some expressed anxiety that they had not inserted their diaphragms properly.

Barriers to Contraceptive Use

FINANCIAL BARRIERS

One of the obvious barriers women face in successful contraceptive use involves the cost of contraceptives. In fact, the Family Planning Project seeks to address cost as one of the main barriers to accessing family planning services. Cost was mentioned throughout this research as one of the main reasons women didn't use, stopped using or still don't use effective contraceptive methods.

When asked about birth control use in the year prior to unintended pregnancy, many women in the PLM survey cited cost as an influencing factor. More than one-fifth of women (21%) indicated that they had not been using an effective method of birth control prior to pregnancy because they could not pay for it. Among those who had been using an effective method, 12% stopped because of the cost. Among those whose pregnancies were unintended and who had considered using an effective method of birth control prior to pregnancy but did not use one, 21% cited expense of the method as the main reason. When PLM women with unintended pregnancies were asked about their current use of contraceptives, 9% said "none" of these, 14% indicated cost as the main reason.

"I'm on Depo now because I kept forgetting to take a pill. I don't like getting shots, but now I only have to worry about birth control four times a year."

In focus group discussions, participants mentioned cost as one of many disadvantages of birth control pills and one of several elements that contributed to negative clinic experiences.

Women in in-depth interviews also identified cost as a barrier to contraceptive use. Several women related stories in which they could not afford the method of their choice. Still others could not afford to refill their prescriptions for birth control pills or could afford only to refill them on a monthly basis. In more than one case, inability to afford the prescription refill or to remember to refill the prescription each month led to unintended pregnancy.

SIDE EFFECTS

Extremely negative attitudes that some women expressed about hormonal birth control side effects clearly represents a barrier to use. Beginning with the focus groups, women described extreme symptoms such as weight gain, emotional difficulties, and headaches. Every study included some women who had given up on birth control, either temporarily or permanently, because of side effects.

THE HASSLE FACTOR

Throughout the studies, women consistently discussed missed opportunities and frustration because of the difficulty of having quick access to birth control.

Delayed Appointments

It was clear that for some women, it's important to begin using a birth control method *while they are interested*. If they can't get a quick appointment for family planning services, they either forget the appointment made months in advance or they become distracted and lose momentum to act, resulting in a lost opportunity.

Unfilled Prescriptions

Several potential clients mentioned that they frequently leave birth control prescriptions unfilled for a variety of reasons (cost, difficulty remembering, dissatisfaction with the method, procrastination, etc.)

Difficulties with Method Use

Several women said it was nearly impossible for them to remember to take the pill every day or go back for their next Depo-Provera shot. Others had difficulties using barrier methods, ranging from not knowing how to use them properly to not feeling confident that they had done so.

Examples of the variety of reasons women do not use birth control methods effectively can be found in PLM survey responses. Table 1 (see page 18) summarizes the reasons given by 164 women who confirmed that they were not using birth control at the time of their PLM pregnancy, although they did not want to get pregnant.[8] The themes of cost, hassle and negative side effects come through loud and clear.

[8] In this group, women had either used contraceptives before and stopped, had considered using them but didn't, or had never considered using birth control.

Other Serious Social and Psychological Issues Affecting Contraceptive Use

Critical barriers to contraceptive use faced by some women are not likely to be addressed effectively through marketing strategies without the development of specifically targeted programs. Although the scope of this research project could not extend to an extensive exploration of addressing these issues, the following findings should be noted:

DRUG ABUSE AND MENTAL ILLNESS

Two women who identified themselves as former substance abusers blamed their lack of contraceptive use on drug-using attitudes and behavior. Three women who revealed they have mental illness expressed concern about the compatibility between their illness and hormonal methods of birth control.

ABUSIVE PARTNER

An abusive partner can be a barrier to a woman's attempts to prevent pregnancy. Two women who described themselves as being in abusive relationships said their partners would not let them use anything to protect themselves from disease or pregnancy.

Current and Future Contraceptive Behavior

From a marketing perspective, it is important first to know where women are in relation to the desired behavior—that is, preventing unintended pregnancies through consistent and correct use of effective contraception. We have described several key factors that influence contraceptive behavior. But what do we know about women's current and future intentions for contraceptive use?

Statewide data show that among Oregon's low income women at risk of unintended pregnancy, 83% report using a birth control method and 51% report using one of the more effective contraceptive methods (BRFSS, 1998). We know from findings presented earlier in this report, however, that this data represents only a snapshot in time for these women. The data may not reflect effective use of birth control now. Some key findings of these studies regarding women's intentions are as follows:

- Women who use public family planning services are more likely to be using more effective methods of birth control than are women who use other types of health services (60% vs. 43%) (BRFSS, 1998).

- While most clients are satisfied with their method, a significant portion (22%) are not. The PLM survey also indicates that 23% of pill users and 18% of Depo-Provera users are likely to change methods in the next six months.

- A pregnancy or pregnancy scare appears to be a significant motivator for changes in birth control use. One-third (33%) of women in the PLM survey reported using more effective methods of birth control after their delivery than before.

- Additionally, the PLM survey shows an increase in birth control pill use (20% to 34%), a decrease in no use of a birth control method (45% to 9%) and a decrease in condom use (23% to 19%) among women following their pregnancies.

- Women who gain access to family planning services at critical times are even more likely to take positive action. While 27% of women identified as potential Family Planning Project clients in the PLM survey reported they are still using condoms as their main birth control method, only 5% of current clients still rely on condoms.

- Condom users who have had a pregnancy are an important potential market: more than half (53%) of condom users agreed they are likely to change to another method in the next six months. The readiness of these women for change represents a service opportunity.

- Another opportunity appears to be in the area of emergency contraception (EC). About half of the women said that they are aware of EC and would likely use it if they had unprotected sex and wanted to prevent pregnancy.

Again, the main barriers stated by potential Family Planning Project clients for not using more effective birth control methods include:

- incomplete/inaccurate information,
- side effects,
- hassle, and
- financial cost.

Women who participated in focus group discussions made the following suggestions of what might persuade them to use a more effective method in the future:

- new safe methods without side effects,
- improved access,
- more information about options and individualized counseling,
- confidentiality,
- free or low-cost birth control, and
- involvement of partners in discussions about birth control.

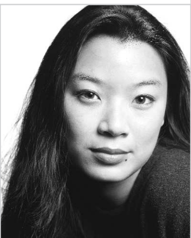
Table 1
Reasons for Not Using Contraceptives Among Women in the PLM Survey Whose Pregnancies Were Unintended (164 women responded)

	WOMEN WHO DISCONTINUED THEIR USE OF AN EFFECTIVE BIRTH CONTROL METHOD (16%)	WOMEN WHO CONSIDERED USING A MORE EFFECTIVE BIRTH CONTROL METHOD BUT DIDN'T (47%)	WOMEN WHO NEVER CONSIDERED USING A MORE EFFECTIVE METHOD OF BIRTH CONTROL (37%)	TOTAL (100%)
Side Effects	44%	20%	17%	23%
No Time, Didn't Get Around to it, Inconvenient, Got Pregnant Before Able to Use	0%	22%	7%	13%
Financial Cost	11%	17%	5%	12%
Didn't Want to Use Hormones	4%	5%	13%	8%
Don't Know	0%	8%	12%	8%
Not Sexually Active/ Didn't Plan to Have Sex	0%	14%	0%	7%
Wanted to Get Pregnant or "Didn't Care"	15%	0%	10%	6%
Other	4%	8%	3%	6%
Didn't Feel Confident in Birth Control	0%	7%	3%	4%
Health/Medical Conditions	11%	0%	3%	3%
Didn't Think About it	0%	0%	8%	3%
Didn't Think Could Get Pregnant	0%	0%	7%	2%
Use Other Method	0%	0%	5%	2%
Prescription Ran Out	7%	0%	0%	1%
Breastfeeding	0%	0%	3%	1%
Refused to Answer	0%	0%	3%	1%
Wanted to Take a Break	4%	0%	0%	1%

Understanding Women's Use of Family Planning Services

Our research examined women's use of family planning services separately from their use of birth control because both outcomes are goals of the project. However, the direct relationship between the two behaviors is clearly evident in this study. Published literature reviewed for the study emphasizes that patient satisfaction, quality of care and client provider interaction are all inextricably linked to client choice of family planning services and continued adherence to a contraceptive regime. Just as knowledge and attitudes about birth control affect women's use of family planning services, family planning services can provide a positive impact on women's knowledge, attitudes and successful use of birth control.

Current Family Planning Project clients reported high satisfaction with the quality of services they receive, with a few exceptions. Potential clients provided information about specific clinic/service characteristics, including access barriers, that they view as important to their decisions to use services. These and other issues determine women's use of family planning services, as described below.



"My visit there was very uncomfortable... she made me feel guilty for being sexual that early. She was very rude and cold. It was not a good experience."

Past Experience with Services

Most women have received family planning services—often in a variety of settings. Their use of services is similar to their use of contraceptives; they tend to cycle in and out. Predictably, women who have had positive experiences are more likely to be either currently using services or more interested in using them than are women who have had negative experiences.

When asked about specific aspects of their clinic experience, almost all current Family Planning Project clients gave the clinics high ratings for cleanliness and access, including 90% who agreed that making an appointment was easy. When asked specifically about providers' skills and treatment by staff, almost all women rated them excellent or good. When asked in an open-ended question what they liked most about their experience that day, 39% said clinic staff friendliness. Current clients also rated information they receive from the provider as excellent or good.

In contrast, potential clients surveyed through focus groups and in-depth interviews indicated a number of negative experiences with family planning services—some of which kept them from seeking services again. Descriptions of negative experiences had one or more of the following characteristics: difficulty making an appointment by phone, long wait for an appointment, rude or disrespectful treatment (on the phone, in the reception area or by the clinician), lack of privacy or confidentiality, cost of services, clinic appearance, ill-informed staff, insufficient or inaccurate information provided regarding their birth control method, and lack of trust. Focus groups participants also expressed dissatisfaction when they were required to have an annual exam as a prerequisite to getting their birth control, especially when they recently had one somewhere else. A number of potential

clients related incidences of not showing up for an appointment because it was made so far in advance. They either ended up with a conflicting commitment or simply forgot. Knowing that they would have to wait several more weeks for another appointment discouraged them from trying again.

Some current clients repeated negative themes in the customer satisfaction survey. When asked what one thing could be changed to make the experience better, 17% noted extended clinic hours, better phone access and more staff; 13% wanted a shorter waiting time. Over one-third (35%) of women rated waiting time in the reception area as fair to poor. Ten percent indicated that making an appointment was not easy. Some women said they did not receive enough information—they were seeking more information about Depo-Provera and other types of birth control that would have fewer or less severe side effects and more information on tubal ligations. Eighteen percent said they would have liked additional information about EC.

It should also be noted that clinic observations and staff interviews revealed significant problems with appointment no-show rates. It is worth further investigation to determine whether or to what degree no-shows indicate service problems not currently reflected in customer satisfaction surveys.

Knowledge About the Availability of Free or Low-Cost Family Planning Services

Family planning program managers often felt that the existence of their services is not well known. Are women aware of the availability of low-cost family planning services? Research results are mixed.

When surveyed by the BRFSS in 1999, 81% of women at risk of unintended pregnancy said they knew about free or low-cost services available at local health departments and Planned Parenthood clinics (BRFSS, 1998). Subgroups of women have different levels of knowledge, however. Among women using methods such as barrier or withdrawal for instance, only 77% reported that they know about services. The first year of Oregon PRAMS data suggests that women with recent Medicaid births are less likely (69%) to report that they knew of such services before their pregnancy.

The PLM survey asked women in many different ways to indicate barriers to getting birth control. None of the responses indicated that they do not know where to go to get birth control or that this is a problem. However, many women getting contraceptives from drugstores or other sources may not know of other access opportunities in their communities.

"I wouldn't mind going there (a clinic) but everything they have is like a sample. You can't go there and say, "I need this and I need that."

When current Family Planning Project clients were asked how they heard about the clinic, most reported that they learned about it from a friend. Other referral sources for current Family Planning Project clients included: relatives, phone book, school or private doctor.

Most of the potential Family Planning Project clients in this research are aware of family planning services available through Planned Parenthood, county health departments and other providers. Many had previous experiences with service providers, however, none of the women had been aware of free Family Planning Project services and supplies. Social service providers reported that women they serve do not know about the Family Planning Project and expressed interest in disseminating Family Planning Project information.

"This place was great. Like the whole fact that they have to buzz you in at the doors, very private, and like everybody in there was nice. It was very clean and all the nurses and staff were wearing nurse clothes. At the other place I used to go to the women were not even dressed up. It didn't feel professional."

Attitudes About Family Planning Services

Our research found that attitudes about services clearly arise from specific and/or accumulated experiences. But a slightly different attitudinal dimension was tapped when women were asked to identify specific important features of family planning services that they want.

Focus group participants identified features related to clinic environment, clinic staff, access and service components. The PLM survey quantified these features and explored them in more detail during the in-depth interviews. With few exceptions, there was a high degree of consistency in the priority and importance women placed on these features. A brief description follows:

- Women are happiest when they can make an appointment easily over the phone and get one quickly. Younger women and potential clients in particular express a desire for evening or Saturday appointments. Women don't want to have to wait more than 15 minutes in the waiting room to be seen.

- Women want to know what to expect, including services and all costs. An atmosphere of privacy and assurance of confidentiality is important. They want to be treated respectfully by professional-appearing staff who take the time to talk with them and respond to their individual needs. They want verbal information and printed material about all birth control options and they want their choice of method. If they don't know what they want, they want assistance in selecting a method that is right for them.

- Women want a clinic facility that is clean and pleasant both inside and out.

- Some women want clinic staff to remind them of their appointment time with a phone call or

postcard. They want to be given 12 months of birth control pills at a time. They want to know about possible side effects, including what side effects to expect and how to deal with them. Some women want a follow-up phone call to see how their method is working for them. Some women want the opportunity to include male partners in appointments; others just want information to give to their partners.

As noted above, results from the customer satisfaction survey show that Family Planning Project clients were quite happy with services they received. In addition to rating existing services, clients were also asked about what service features they want.

Women rated the following clinic hours as convenient:	
Weekday mornings	39%
Weekday afternoons	34%
Weekday evenings	35%
Saturday mornings	29%
Saturday afternoons	24%

Women expressed a preference for receiving their health information:	
One-on-one with their provider	68%
With their partner and provider	25% of all women
	43% of women of color
With brochures	20%

Preferences for giving feedback about their clinic experience included:	
Short survey	43%
Comment box	40%
Book in the lobby	12%

Each service area/feature is important and contributes to overall attractiveness of the service. Still, some features stand out and some features are evidently more important to one group than to another. For instance, evening or Saturday appointments, a clean clinic, and respect are more important to potential clients than to current clients in the PLM survey. With changes in the ways clinics function, this may present an opportunity to move some potential clients into the current client category. In other instances earlier negative experiences are of parallel importance for both potential and current clients, such as the ability to make appointments easily over the phone and appointment reminders with a phone call or postcard. Other features stand out because they relate to our understanding of women's contraceptive use—for example, the importance of staff taking the time to talk with clients and respond to individual needs, talking about possible side effects and how to deal with them, and making follow-up phone calls to see how clients' methods are working for them.

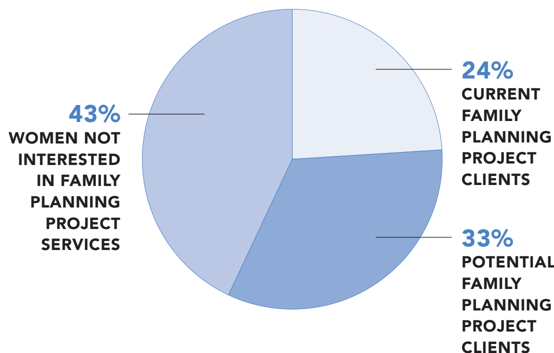
Another facet of family planning service attitudes surfaced in focus groups and in-depth interviews—the belief that county health departments and, to a lesser extent, Planned Parenthood clinics, are places that serve poor people and teens. Clients thought that these clinics provide welfare or government type programs to people more impoverished or otherwise different from themselves. Although most clients surveyed were low-income women, they do not perceive themselves as being economically disadvantaged enough to make use of these services. Moreover, in-depth interviews revealed that women associate family planning services with teen pregnancy prevention combined with a perception that pregnancy prevention is more important for teens than for other groups—including their own age and income groups.

Current and Future Family Planning Utilization Behavior

The 1998 BRFSS survey shows that among low income women at risk of unintended pregnancy in Oregon, 46% reported using a public family planning clinic for women's health services. An additional 19% either obtained public family planning clinic services in the past or have low levels of insurance suggesting they might need to use clinic services in the future.

The PLM survey asked follow-up questions about future intention to use Family Planning Project services. Using the *Stage of Change* model described at the beginning of our report, women were placed into three groups:

1. Current Family Planning Project clients (24%, defined as women who have received services within the last year and are very sure they will continue using services),
2. Potential Family Planning Project clients (33%, defined as either women who have not been using Family Planning Project services but intend to use them in the near future or women who have been using Family Planning Project services but are only somewhat sure they will continue to use them), and
3. Women not interested in Family Planning Project services (43%, includes women with Oregon Health Plan (OHP) or other insurance as well as those without).



Future intentions of potential clients are of obvious importance if the project is to meet its goal, but future intentions of current Family Planning Project clients are of equal importance. Information gathered from current clients reveals numerous opportunities for increasing client retention and improving or maintaining clients' consistent use of effective contraceptive methods.

Among the 80,984 family planning clinic clients, half are new clients—that is, new to surveyed clinics. However, an estimated 12% of new clients come in for the purpose of getting a pregnancy test, not necessarily with the intention of using contraceptive services. Further exploration is needed to determine which clients whose pregnancy tests turn out to be negative have the potential to be appropriate future and continuing family planning "consumers." Clinic data show that while only 2% of all current clients report not using contraceptives because they are seeking pregnancy, 18% of all visits include negative pregnancy tests. Moreover, in-depth interviews indicate that women may be taking advantage of free pregnancy test services available at locations not offering contraceptive services, most notably crisis pregnancy centers.

Family Planning Project Staff described challenges of attracting new clients and retaining current clients. Family Planning Project staff in rural areas described transportation challenges (especially in winter), confidentiality in small communities, staff recruitment, community norms not supportive of family planning and fear of repercussions from conservative political and religious groups. These issues represent challenges for Family Planning Project staff, current clients and potential clients alike. All Family Planning Project staff interviewed as part of our marketing study expressed the desire to make family planning services readily accessible and available for all sexually active persons.

Based on staff experiences with low-income men and women, providers of other health and social services described difficulties of sexually active individuals in accessing and using family planning services. Providers feel that some difficulties could be alleviated by increasing the number of locations where family planning services are provided and initiating changes in the provision of services. Specifically, they recommended increasing the time providers spend with individuals and couples to teach clients about birth control methods and options, improving client follow-up and tracking, and incorporating family planning concerns into other non-family planning-related medical visits.

Providers see the Family Planning Project as an important link to improving access and continued use of family planning services. Some medical providers expressed interest in becoming Family Planning Project providers to allow continuity of care for clients. Health and social service providers and community organization representatives all view family planning as important to clients and to the improvement of economic and social conditions. Providers feel that Family Planning Project promotion and referral can and should be done through several varied avenues to reach our diverse populations.

Understanding Critical Differences Between Groups of Women

Our report describes consistent themes found across the entire population of women who participated in this market study. However, there are two areas where it is important to note differences between groups of women studied: demographics and stages of change.

Demographic

RACE/ETHNICITY

Since race, culture and ethnicity have important influences on people's attitudes, beliefs and behaviors, we made an effort to include women from many diverse groups. Overall, about 21% of market study participants were women of color. Out of eight focus groups, two were conducted for each of the following racial/ethnic groups: Caucasian, African American, Latina and American Indian. In-depth interviews also followed up with some of the African American women.

Still, the research did not always result in statistically significant numbers of women of color needed to make all comparisons. However, studies identified some significant differences. State level data provides some context:

In Oregon, Latinas constitute 12% of the female population below poverty and 23% of current family planning clinic clients overall. In the first year of the Family Planning Project, however, Latinas represented only 7% of Family Planning Project clients. Medicaid requirements that exclude nonpermanent residents from participating in the Family Planning Project may be a contributing factor. However, women in other communities of color also make up a lower proportion of Family Planning Project clients compared to their proportion in the total population of females below poverty: African Americans 1% vs. 4%; Asians 2% vs. 5%; and American Indians 1% vs. 3%. (Population data sources: 1990 Census and 1999 PSU population data. Client data, 1999.)

Data strongly suggests that women of color are underserved by family planning services. This may be due to language and other social, economic and cultural barriers that have important implications for our marketing initiative.

We noted differences in unintended pregnancy rates among different racial/ethnic groups. Literature review information suggests an association between contraceptive failure and race, ethnicity and poverty status.[9] While we don't know the exact nature of the association, we do know that national data shows the following percentages of unintended pregnancies by racial/ethnic group (Henshaw, 1998):

Total	49%
Caucasians	43%
African Americans	72%
Latinas	49%

Oregon PRAMS data and vital statistics data show the following percentages of unintended pregnancies among racial/ethnic groups:

Total	53%
Caucasians	53%
African Americans	72%
Latinas	50%
American Indians	64%
Asians	56%

Contrary to these findings, PLM survey women of color reported a lower portion of unintended pregnancies at 33% (compared to all women at 44% and Caucasian women at 48%).

[9] Fu, H., Darroch, J.E., Hass, T., Ranjit, N. (1999). Contraceptive failure rates: new estimates for the 1995 National Survey of Family Growth. *Family Planning Perspectives*, v. 31 (2), March-April, 56-63.

RESEARCH DIFFERENCES IN BIRTH CONTROL EXPERIENCES

According to literature review information, African American women and English-speaking Latinas are more likely to use condoms and Caucasian women are more likely to use oral contraceptives. Spanish-speaking Latinas are more likely to use long-acting contraceptives such as Depo-Provera.[10] Focus group discussions with Latinas revealed that they are more likely than other racial/ethnic groups to associate a variety of health problems with birth control methods (e.g., toothaches, headaches, varicose veins, and heartburn).

Partner issues appear to be more prevalent among women of color. PLM survey women were more likely to cite as a benefit of using Depo-Provera the fact that it can be used without their partners' knowledge (28% vs. 13%). In the customer satisfaction surveys, however, women of color were almost twice as likely as Caucasian women to express more interest in including their partners at family planning clinic visits (43% vs. 22%).

In rating the importance of clinic features, the following were small but statistically significant differences in PLM survey responses between Caucasian women and women of color:

- Women of color were twice as likely as Caucasian women to rate public transportation accessibility as the most important access feature (16% vs.8%).
- 33% of women of color rated being treated respectfully by staff as the most important staff feature, compared to 22% of Caucasian women.
- Privacy and confidentiality were also more often the most important staff feature for women of color (29% of women of color vs. 18% Caucasian women).
- In the customer satisfaction survey, women with limited English-speaking skills identified the availability of a provider who speaks their language as very important.

As noted earlier, women of color are currently underserved by the Family Planning Project. However, research indicates an opportunity to overcome this disparity with appropriate modifications to service delivery components and outreach. Data do not indicate that women of color are not interested in services. In fact, when comparing women in the PLM survey by race/ethnicity and stage of change for the Family Planning Project, both current and potential clients are more likely to be women of color. Women not interested in Family Planning Project services are more likely to be Caucasian (24% and 21% vs. 14%).

AGE

The clear majority of Family Planning Project-eligible women in the PLM survey are young; 81% are 18–29 years old, with almost two-thirds between the ages of 18 and 25. This could be significant for marketing purposes, especially since compared to the women not interested in Family Planning Project services, both the current and potential clients are more likely to be under 25 (71% vs. 58%). A higher portion of younger women indicated that their PLM pregnancy was unintended (55% vs. 36%). The PLM survey also found that younger women are less likely to say they believed in pregnancy planning before their PLM birth (68% vs. 83%).

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[10] Forrest, J., Frost, J. (1996). The family planning attitudes and experiences of low-income. *Family Planning Perspectives*, v.28, November/December.

CHILDREN

Data indicates that motivation to prevent pregnancy may be higher right after the birth of a first child than after subsequent births. Almost two-thirds (60%) of women in the PLM survey had no children before their PLM pregnancy. Prior to their unintended PLM pregnancy, women with no children were more likely than women with one or more children to agree with the statement that it is "too much trouble to get or use birth control" (22% vs. 14%).

EDUCATION

The education level among women in the PLM survey ranged from 23% with less than a high school diploma, to 44% with a high school diploma or equivalent, to 33% with at least some college education. In the Family Planning Project customer satisfaction survey, more women had some college education (43%), with fewer women in the other two groups (29% with a high school diploma and 17% with less than a high school diploma).

"Stages of Change"

We made an effort to closely examine women in the *Stages of Change* categories of readiness to use contraception consistently and to avail themselves of family planning services in that effort. Some important specific differences emerged between women who are interested in Family Planning Project services versus those who are not, and between women who are currently using family planning services versus those who are potential users. The differences may be useful in designing more targeted marketing strategies.

INTERESTED IN FAMILY PLANNING PROJECT SERVICES VS. NOT INTERESTED

To confirm the obvious, current and potential clients in the PLM survey were more likely than women not interested in services to say they couldn't pay for birth control (28% and 32% vs. 15%). Current and potential clients were also more likely to be under 25 years old and to have only one child.

Differences Between Potential Clients and Current Clients

POTENTIAL CLIENTS

A significant number of woman are potential Family Planning Project clients. One-fifth of all low income women (19%) could be classified as potential clients (BRFSS, 1998), and an even higher proportion (one-third) of women with a recent Medicaid birth identified themselves as potential clients (PLM survey).

In the PLM survey, potential clients were more likely than current clients to report:

1. An inability to afford birth control in the year prior to unintended pregnancy.
2. Using condoms as a main method of birth control.
3. Intentions to change to a different method in the next six months.

This result indicates opportunities to intervene and facilitate women's access to family planning services, particularly with women who have just given birth.

The desire to have evening or Saturday appointments is greater among potential clients, indicating that adding hours might help to draw in these clients. Clean clinics and respect by staff are desired most strongly by potential clients compared to other groups.

CURRENT CLIENTS

It is difficult to use data to isolate one key difference that sparks action among current clients and not others. Not surprisingly, current clients hold more strongly to the belief that it is important to space births and to plan how many children to have.

Current clients provide insight into what is important about clinic services (see above information). Current clients in the PLM survey are more likely than potential clients to feel that the ability to make appointments easily over the telephone is the most important access feature of a good clinic, suggesting that the service experienced by these clients was something less than optimal.

"My first one was an accident... I guess the factor was that I didn't use protection. But my second one was planned... and it was a totally different experience. It was cool because financially, emotionally, mentally, I was a lot more well-off than I was with my first."

conclusion

This market study sought to identify factors influencing women's use of family planning services and contraceptives for the purpose of developing a strategic marketing plan. Market study results contribute to our understanding of the myriad and complex factors that determine women's ability to realize their reproductive health goals. These findings confirm results from similar studies and experiential information from local family planning providers. When we listened to the women participating in this study, we found that almost all share the same basic need for ability to successfully access family planning services and use effective methods of birth control consistently. Basic needs include: accurate information; accessible services; safe, effective and affordable birth control methods; and supportive partners.

Women revealed a diverse and often dichotomous array of attitudes toward pregnancy, family planning and contraception. Of particular note is the almost universal concern over real and perceived side-effects of hormonal birth control, representing a major barrier for contraceptive use among many women. Throughout this study, many women voiced a "fateful" attitude toward pregnancy: on the one hand, they expressed a desire to delay pregnancy until they're ready to have children, and at the same time, they expressed acceptance in the event of an unintended pregnancy.

Women's attitudes and reproductive health needs are intertwined with other aspects of their lives. Attitudes and needs are diverse and ever-changing among women collectively and individually, representing unique clinical and marketing challenges: tapping into women's inner motivations by reaching them with the right services and messages in the right place at the right time.

As reproductive health professionals consider the implications of these findings for their programs, this study marks the beginning of an on-going dialogue among all individuals who have a stake in reducing unintended pregnancy and improving the well-being of women and children in Oregon.

and not using anything—that's ridic lous... When I was single, avoiding p nancy was really important. But now I'm married and in a happy, stable r tionship, avoiding pregnancy is not top priority... None of my children w planned. I had my first one at 16. I w having sex because I thought that's what you were supposed to do. I wa living at home. I was living on my ow Every-body else was doing it, so wh not? My second one I was on pills. M third one was on Depo. I pretty muc think birth control sucks... I don't wa put chemicals into my body becaus they've screwed with my body too m

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