

MORE INFORMATION AND BETTER CHOICES:  
WHAT LOW-INCOME WOMEN SEEK FROM FAMILY PLANNING SERVICES

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## EXECUTIVE SUMMARY

In the State of California, family planning services are available to low-income women at nominal cost or free of charge, yet substantial numbers of such women do not utilize formal family planning services. Why don't more low-income women avail themselves of family planning services? Is there anything that can be done to encourage and facilitate their use of such services? These are the central policy questions motivating this report.

Data were gathered through 20 focus groups conducted with an ethnically diverse sample of low-income teenage and adult women (excluding sterilized women) in three California counties. Focus group discussions covered a variety of topics relating to family planning and reproductive health care, and participants also completed a questionnaire on these topics. Findings and policy implications are summarized below.

## FINDINGS

### **Attitudes Toward Childbearing and Pregnancy Prevention**

Teen and adult women alike did believe in planning (both to have children and to prevent pregnancy), and also believed that the timing and spacing of one's children are important. At the same time, however, they were also skeptical about the possibility of controlling fertility with certainty. Many related personal stories in which methods had failed, careful plans had not worked out, or the women had themselves simply failed to take control (particularly in their younger years). For about a third of the participants, abortion was an important form of *post hoc* control.

With respect to possible changes in welfare policy (capping family grants), women felt that although some recipients were irresponsible enough to have additional children for higher levels of aid, the change would not affect most women's behavior. The result would be penalizing children and those families who are struggling to make it.

### **Birth Control Experiences and Perceptions**

Among adult women there was a great deal of dissatisfaction with birth control methods, based in many cases on first-hand or close-to-hand experiences. Many teens also had negative perceptions of particular methods, but their impressions were often less concrete, deriving from more general stories about birth control problems. In both groups, there was a great deal of misinformation and uncertainty about both the safety and effectiveness of different methods.

In terms of current use patterns, a substantial number of women in both groups report

using condoms (27% among adults--their most common current method; 33% among teens), the awareness of which has clearly been influenced by AIDS prevention campaigns, at least among adult women. Teens rely most heavily on the Shot (36% using), followed by withdrawal (29%); adults--after condoms--rely on the Pill (18%) and female sterilization. (Note that the adult participants were selected from a sample of women who had *not* been sterilized as of mid-1995. The proportion of all AFDC women who use sterilization is roughly one-fourth in California.) There are some racial/ethnic differences in use patterns; for example, condoms are more popular among white and African American women than among Latinas.

Among the adult women in our focus groups, almost one-third (31%) were not currently using any method of contraception; asked for their reasons, 44% said they were not sexually active (with men), 20% that they wanted to be pregnant or it would OK to be pregnant, and 16% were currently pregnant. Among the non-pregnant teens, 18% were not using a method; most of these women also cited sexual inactivity as the reason. Very few adults or teens cited reasons having to do with access to birth control.

### **Experience with Service Providers**

The primary source of reproductive health care among adult women was private physicians or HMOs, but there was substantial evidence of clinic use as well, particularly for supplies and special needs. There were some racial/ethnic and geographic differences, with heavier clinic use among Spanish-speaking Latinas, and among women residing in San Joaquin County. Among teens, fewer used private physicians or HMOs and more were clinic users (both family planning and other types of clinics). Both groups of women would prefer to receive family planning services in the same setting where they received other health care, from a provider who knows their health history and social circumstances. Women and teens alike believed that regular gynecological care was important and for themselves would not choose to obtain birth control without an examination.

Almost no one reported encountering significant barriers to obtaining contraception when it was actively sought, with the exception of women denied tubal ligations because of young age. There were some difficulties, though, for women seeking a particular method, and also problems arising from lack of awareness (particularly noted by adult women reflecting back on their teenage years). In discussing communication with providers, one of the primary criticisms expressed by some women was the tendency of some providers to emphasize a particular method--often the Pill--to the exclusion of other methods in which the woman herself might be more interested. Women expressed an unmet need for information specific to their own concerns--not necessarily for more information about family planning in general, but for answers to their own questions.

In reporting what they liked and didn't like about services, both teens and adults highlighted staff characteristics: personal attention, sensitivity, and competence on the part of the clinician and other staff members are highly valued. In addition, clinician continuity (seeing the

same clinician at each visit) is also very important. Similarly, the most serious complaints raised had to do with poor or disrespectful treatment by providers, though there were occasional reports of other problems, such as lengthy office waits.

### **Suggestions for Improving Information, Education, and Services**

Among teens, the meaning of the phrase “family planning” was often unclear or unfamiliar. To many adult women, it is understood to refer specifically to birth control or pregnancy prevention, though they thought it *should* mean something broader and more consistent with the actual idea of planning a family (having as well as preventing children). In general, adults and teens would like to see contraception situated in a larger medical and social context--linked to other services and taking into account other life plans.

Asked about how family planning services could be improved, both groups emphasized the need for sensitive, considerate, respectful staff members. All teens and many adult women prefer female clinicians, and Spanish-speaking Latinas would like to see more bilingual providers. Almost all women want to see family planning services provided in a larger health care setting.

Assistance with child care and transportation were noted by some adults and many teens. In terms of convenience issues, shorter office waits are desirable, and there was some call for drop-in appointment availability and more convenient locations. Low-cost services and supplies were mentioned more often by teens (fewer of whom may have been on Medi-Cal consistently) but also occasionally by adult women who had experienced difficulties obtaining foam and condoms.

Adult women felt a need for better education--of themselves, of younger women, and of men--not just on birth control and reproduction, but on sexually transmitted diseases, substance abuse, child and sexual abuse, family life and child rearing, and life opportunities for study and work. They felt that family planning information should be *everywhere*--as prominent as beer ads, said one. Teens agreed that more media attention should be paid to these issues, but also felt that schools and in many cases parents were important potential sources of information, assuming that parents could be educated in how to talk to their adolescents about family planning issues and could be nonjudgmental. Teens felt the public messages should be quite specific: services are free, confidential, and do not require parental consent.

Teens focused on the need for information, but adult women also felt that an effort should be made to change attitudes and expectations, particularly among young people and men. Young women need to understand how difficult it can be to care for a family, and men need to see their own role as a responsible one. It should also be noted here that a number of the teenage participants reported that their mothers had talked to them about sex and even taken them for family planning, but they had become pregnant anyway. For them, sexual pressure from boys and men, peer norms that support childbearing, and an absence of appealing alternatives to early

motherhood propelled them into pregnancy. A substantial investment in social, educational, and employment programs is needed to address these concerns.

## **IMPLICATIONS FOR POLICY**

### **Social Marketing and Informational Campaigns**

To be successful, social marketing campaigns must take into account the needs of different audiences and the self-perceptions of those the campaign is trying to reach. In particular, it should be noted that although a sizable proportion of women are either not contracepting or not using very effective methods, most of these women do not see themselves at high risk for pregnancy. Many are not currently sexually active or have sex only intermittently; others are using methods that may not be reliable but which women feel are their best option. Women in these groups are at risk and should be aware of the option of post-coital, emergency contraception (hormonal pills, emergency IUD insertion).

There is a great deal of misinformation and uncertainty about birth control methods, and in particular, disproportionate suspicions about some of the most effective methods. Some of this could usefully be countered through public information campaigns, though these will not be a panacea. Specific information needs to be more narrowly targeted and better timed to be of use; rather than using television ads to tell women about particular methods, it should be used to make them aware that they have options and rights to both information and services, and where they can go to find out more. A social marketing campaign can and should help women to become more assertive and informed consumers of reproductive health care.

Men are conspicuously absent from discussions about family planning, and yet male behavior cannot be ignored by policymakers concerned about the problems of unintended pregnancy. Male awareness and supportive involvement in the use of contraception are rare but potentially very powerful and should be encouraged. Men themselves need to take responsibility for their own roles and policymakers and the public need to think of family planning as something that happens in relationships.

### **Delivering Family Planning Services**

Very few problems with access were reported by the women in these groups (though if family planning clinics were reduced, a more significant problem might well appear, and there were greater constraints for teens than for adult women). They did, however, have strong feelings about the best ways to provide services, including the following: respectful, personalized care; providers who are knowledgeable about birth control *and* willing to take seriously women's concerns and questions; family planning services in the context of other medical care; clinician continuity; female clinicians (for teens, especially); and bilingual staffs. A "fast food" model of service was not well received; in fact, this is the opposite of what most women were seeking.

As the State moves toward both managed care for Medi-Cal recipients and the “State-Only Plan” for family planning services, a number of concerns need to be kept in mind, to ensure continued or expanded use of these services. First, though private physicians may offer a form of care that is in many ways appealing, they may also be inadequately trained in the provision of family planning services. This problem can be addressed in several ways: through enhanced training of primary care physicians, through continued inclusion of specialty providers (clinics), and through improving women’s knowledge and assertiveness as consumers. Second, as managed care plans cover increasing proportions of the AFDC population, the possibility of decreased utilization of family planning services may increase if these plans either intentionally or unintentionally erect barriers to use. The plans themselves should be carefully examined for such barriers, and in addition, clients should be fully informed of the benefits of family planning and their rights to receive these services, even outside the plan. Finally, because family planning clinics are an important source of care for some groups of women and in some locations, a strong effort should be made to ensure the incorporation of these clinics into managed care plans.

### **The Role of AFDC**

As noted, women did not believe that the maximum family grant policy would be likely to have much influence on behavior, and it would hurt children and families who are making an effort to behave responsibly.

With respect to the role of the AFDC offices in providing information, women were very receptive to the idea that such offices would make family planning information available to clients (in the waiting room, through written hand-outs, videos, posters, even a consulting RN available to answer questions). They did not, however, think that eligibility workers should talk with clients about family planning; these workers are extremely busy already and any conversation about birth control would be seen as both detracting from other worker responsibilities and invading the client’s privacy. It would be acceptable for a worker to make brochures available--without comment--but not to advise a client about family planning without the client’s explicit request.

Finally, the point was made that any information that is provided--about methods, providers, options available to low-income women--must be accurate and up-to-date. Many women have received information in the past that was not, and as a result they may have limited confidence in the AFDC office as a source of valuable information or referrals.

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## SECTION I: BACKGROUND AND RESEARCH QUESTIONS

The research described in this report was conducted under contract to the Office of Family Planning (OFP) in the California Department of Health Services, and to the California Department of Social Services (CDSS) to inform policy-makers about the utilization of family planning services by low-income Californians. National data indicate that a significant number of women who are at risk of unintended pregnancy are not using contraception, and that the proportion is even higher among poor women (Zill, 1996; Forrest and Singh, 1990; Silverman and Torres, 1987; Mosher, 1988). With respect to California residents, a 1994 Lou Harris survey found that among clients, only one-fifth (22%) had received family planning services in the 12 months preceding the survey (Harris, 1994). Given these findings, the present study was developed to answer two central policy questions:

Why don't more low-income women, and Medi-Cal beneficiaries in particular, use family planning services?

What can be done--in terms of both service improvements and educational efforts-- to encourage and facilitate the use of family planning services by low-income women?

Answers to these questions will be used by OFP to develop a social marketing that can better target information about family planning services to low-income Californians, and by CDSS in its efforts to design an effective way for the AFDC program to provide family planning information to AFDC recipients.

Additional literature review and discussion among agency personnel, project staff members, and consultants, produced a series of more specific research questions. These included the following:

Among study respondents, what are their attitudes and practices with respect to family planning/ pregnancy prevention? What are the perceived benefits of family planning?

What do these women know about family planning methods and services?

What are their perceptions (including concerns about safety and effectiveness) of different

methods?

Where and from whom have women learned about family planning?

What are effective mechanisms for the dissemination of family planning services and methods?

What might be the roles of the Department of Social Services and Department of Health Services in an information campaign?

What do respondents imagine will be the impact of the "family cap" ("maximum family grant") AFDC policy on childbearing behavior and family life?

What should be the role of AFDC eligibility workers in disseminating family planning information?

These particular questions were used in the development of the data collection instruments described in the next section.

## SECTION II: METHODS

Data were gathered through in-depth discussions as well as questionnaires administered in the context of two-hour focus groups (see Krueger, 1994; Morgan, 1988; Stewart and Shamdasani, 1990). Thirteen focus groups were conducted with a total of 86 "older" women (ages 21 to 44, average age 30) and seven "teen" focus groups were conducted with 54 young women and adolescents (ages 15 to 22, average age 18). The focus groups were held between March and May of 1996 in Los Angeles, Stockton, Hayward, Oakland, and Berkeley. The individual groups included between four and ten participants and were ethnically and linguistically homogeneous (with the exception of one diverse group of older women, and five younger women who participated in groups designated primarily for another ethnicity). In all, there were six African-American groups (three of older women and three of teens); four English-speaking Latina groups (three older and one teen group); four Spanish-speaking Latina groups (three older and one teen group); five non-Latina white groups (three older and two teen); and one mixed older group. It was not possible to construct groups of Asian American women because there are too few of them within any single national or linguistic group on AFDC to do so.

The participants in the older groups were paid \$50 for participating and up to \$25 for child care, while the women in the younger groups were paid \$25 for participating and had their child care costs reimbursed. Transportation to groups was either paid for or provided directly. All materials in the Spanish-speaking groups were translated into Spanish.

The instruments used (discussion guides and questionnaires) are appended to this report (Appendix B). The questionnaires used in both teen and adult groups included personal demographic questions (e.g., age, number of children, pregnancy, and marital status) as well as items regarding knowledge, attitudes toward and use of birth control, and experience with providers. In both teen and adult groups, the discussion guide covered the research questions listed above, in the context of four discussion sections: 1) attitudes toward childbearing and pregnancy prevention; 2) experiences with and perceptions of birth control; 3) experiences with

service providers; and 4) suggestions about improving services and information. In addition, the teen group discussion guide also included a set of questions specifically relevant to younger women, covering attitudes toward teenage pregnancy and childbearing, challenges adolescents face in using contraceptives once they receive them, and communication patterns with partners and parents regarding contraceptive use.

Groups were led by skilled facilitators who matched the groups ethnically and linguistically. In most groups, three project staff members were present, one to facilitate, one to take detailed notes and one to assist with refreshments, the tape recorder, latecomers, and so forth (as well as take notes). Before discussion began, the study was introduced and participants were asked to sign an informed consent form, which was reviewed aloud. Participants then completed the questionnaire (which was also read aloud)--using clipboards to protect the privacy of their answers to these somewhat personal questions. Facilitators then led the discussion using the open-ended topic guide questions, encouraging group members to participate actively and shape the discussion. Discussions lasted approximately two hours.

## **RECRUITMENT OF WOMEN FOR ADULT FOCUS GROUPS**

The groups of older women were recruited from a sample of people who are already participating in a longitudinal study of AFDC policy. This sample of 2214 household heads was randomly selected from households who were on AFDC in December 1992 in three counties: Alameda, San Joaquin and Los Angeles. Using this roster (which had up-to-date telephone numbers and addresses) as the basis for focus group recruitment offered three important advantages. First, it permitted us to exclude women who were using tubal ligation as a method of birth control. The first wave of interviews for the AFDC research included the question "Have you had a tubal ligation", to which 27% of AFDC recipients answered "yes". These women were excluded from the focus groups because they do not now need birth control services. (Further detail on the use of sterilization in this sample is presented in the Findings section. A few women in the focus groups had been sterilized since the first AFDC research interview.) Second, while focus group participants self-selected into the research by agreeing to participate in a group, they were not selected on the basis of their prior utilization of services (as a clinic-based

sample would have been). Third, because we already knew each woman's ethnicity and language, it was easy to generate homogeneous groups.

These focus groups were drawn from a list of women on AFDC in December 1992; by design, all were on Medi-Cal, and it turned out that virtually all (95%) of them were still on AFDC as of the most recent interviews conducted for the AFDC research (May 1995 or later).<sup>1</sup> Table 1 (see Appendix A for all tables) compares the 86 adult women participating in the focus groups to a random sample of California AFDC recipients (these latter data are from the "Characteristics Survey" for April 1994 released by the Department of Social Services). In terms of language and marital status our participants match the AFDC population quite closely, but there are some differences: our respondents include more women in the middle age brackets (85% are between 25 and 39, compared to 57% of all AFDC recipients; our respondents also have more children and a few more years of education. The age difference is consistent with our having designed the research in order to differentiate between the attitudes and needs of younger and older AFDC recipients.

The data collection procedures were tested on a "pilot" focus group of adult women recruited through word-of-mouth. A few changes were then made to the discussion guide and the questionnaire. The remaining twelve adult groups (drawn from the larger AFDC study sample) were recruited over the telephone by UC Berkeley Survey Research Center personnel.

## **RECRUITMENT OF ADOLESCENTS AND YOUNG ADULTS FOR FOCUS GROUPS**

Participants for the "teen" groups were recruited in each of the research counties (Alameda, San Joaquin and Los Angeles) through the Women, Infants, and Children (WIC) program, which serves low income pregnant and parenting women. Flyers explaining the study were posted in waiting rooms at these sites and distributed to caseworkers. Interested women contacted their caseworker who maintained a log of potential participants. The caseworker notified interested young women of the purpose, location and time of the session and reconfirmed their attendance close to the meeting itself.

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<sup>1</sup>The "pilot" group of five AFDC participants was not generated from the AFDC research list but by word-of-mouth recruitment.

## **DATA ANALYSIS**

Most of the teen sessions and all of the adult sessions were tape-recorded, and in addition, detailed notes were taken during the discussions. Immediately following focus group sessions, facilitators and note-takers jointly reviewed the discussion and elaborated or corrected notes that were taken. For the adult groups, one staff member also prepared a detailed summary of the group process and discussion (a “debriefing”).

Data from the groups were coded using thematic analysis procedures, in which participant statements were categorized by topic area and then analyzed for general themes. In the case of the adult groups, a senior staff member also reviewed all debriefings and listened to all tapes of English-speaking groups (Spanish-speaking groups were debriefed by a Spanish-speaker who provided an English version of the debriefing). Direct quotations (with no names attached) are included throughout the report both to summarize common experiences and to illustrate particular points of view.

Data from the questionnaires were analyzed on personal computers using either StatView or SPSS. Frequency distributions and cross-tabulations with independent variables of interest formed the bulk of the analysis of the quantitative data, which are reported along with qualitative findings in the following section.

### **SECTION III: FINDINGS**

In this section of the report, we report data from our focus groups and, as relevant, findings from other research. The section is divided into four major substantive areas: Attitudes Toward Childbearing and Pregnancy Prevention; Birth Control Experiences and Perceptions; Experience with Service Providers; and Suggestions for Improving Information, Education, and Services. Each section begins with a brief introduction and highlights certain findings, including some of the similarities and contrasts between adult and adolescent women. Next, findings from the adult groups are described along with references to relevant research, followed by findings from the teen groups.

#### **ATTITUDES TOWARD CHILDBEARING AND PREGNANCY PREVENTION**

Other research strongly suggests that reasons for nonuse of contraception may be less “structural” (i.e., supply-side difficulties such as cost and lack of information about providers) than attitudinal or motivational (i.e., women may have serious reservations about birth control methods and/or be ambivalent about pregnancy prevention) (O’Campo, et al., 1993; Silverman and Torres, 1987). In the opening sections of our focus groups we asked women to tell us about their feelings and beliefs about family planning, about the importance of timing and family size, and about the likelihood that changes in welfare policy (e.g., the maximum family grant or cap) would affect women’s behavior.

Most women did believe in planning, but they were also skeptical about the possibility of doing so with absolute certainty; this was true among both teens and adult women. Both groups cited examples of method failures as part of the argument that control is limited. Denial of one’s own susceptibility to unplanned pregnancy was particularly apparent among teens, though it may be present--simply less obvious--among adult women. Teens and adult women agreed that timing mattered, and ideal timing of childbearing was when a woman was financially secure, in a stable relationship, and not too young. Among adults, high school age childbearing is too young; among some teens, it is junior high school age childbearing that is “way too young.” The teen

groups spoke more extensively than did adults about the benefits of pregnancy and childbirth in terms of attention, the sense of being “grown up”, having someone to love; African American teens also mentioned the social norm of early childbearing in their community.

There was some evidence of ambivalence with respect to possible pregnancy among both teens and adult women. This is an important result because given the high level of motivation required for pregnancy prevention (IOM, 1995), there is no room for ambivalence. In a study of adolescent girls, Zabin (cited in IOM, 1995) found that those who were ambivalent were just as likely to get pregnant as those who definitely wanted pregnancy. Another study found that consistency of condom use was higher among women who were certain they did not intend a future birth than among ambivalent women (Peterson, et al., 1994).

Fewer teens than adult women had heard of proposed welfare changes (capping aid). The two groups had many of the same reactions to the plan, but more teenagers seemed to think it was a good idea than did adult women. Both groups noted, though, that many recipients would not change their behavior and that the policy would be a burden to some families. Both groups also spoke with frustration of how difficult it was to get off welfare even when making a serious effort. The distinction adult women commonly drew between “deserving” women and those who might have children for extra money was less prevalent among teens.

## **Planning**

Successful use of contraception requires--among other things--a commitment to planning: an understanding of the benefits of planning one’s family and the belief that it is possible to do so. Although our adult participants generally stated that it is both wise and possible to plan for one’s childbearing and family life,<sup>2</sup> their personal stories often contradicted this notion and suggested that the picture is much more complicated than the ideal model would suggest. Personal histories illustrated three types of experience in which planning was problematic: (1) simple failure to plan--especially as teenagers and younger women; (2) failure of birth control

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<sup>2</sup>A few women throughout all the groups seemed to feel that a woman’s control was very limited, and, in the words of one Latina participant, the final outcome is in the hands of God (“Eso esta en las manos de Dios”).

methods, (or in the case of women planning to get pregnant, failure to conceive); and (3) circumstances changing so that apparently reasonable plans themselves went awry.

*Failure to plan.* Many adult women who believe that it is possible to plan, and that timing of childbearing is important, reported first pregnancies that were unplanned. In some cases, women got pregnant as young teenagers before they knew anything about birth control. As one Latina woman commented, "I always wanted to be financially set, before I had kids. Didn't really turn out that way. . . . if I'd had sex education before . . . I know definitely that I would have not gotten pregnant when I was 16." In other cases, young women were aware of birth control, may even have used it, but simply failed to exercise what they now see in retrospect would have been good judgment. A white woman explained, "I got pregnant when I was 19 years old. . . I'd stopped taking birth control, my son's father and I--had we had better sense, we would not have had a child [then] . . . But as young as I was at the time, I didn't have enough knowledge to make a healthy decision . . ."

*Failure of method.* A number of women who had made an effort to control their fertility had experienced serious birth control difficulties or failures. After agreeing with the general idea that one can control the timing and number of children, one white woman qualified her assent by saying, "Not everything is for sure, though. I got pregnant with two of my children *on* birth control." Two other women in the group immediately reported the same experience (the method was low-dose birth control pills in all three cases). Women in other groups reported personal experience of pregnancies occurring despite the use of IUDs, condoms, and birth control pills.

The experiences of these women illustrate the very real difficulties women face; they also discourage other women from pursuing birth control. Almost none of our respondents ignored birth control altogether, but many were skeptical about its effectiveness, based on personal and vicarious experience. A black woman's comment expressed the tensions nicely: "Well, I have to be careful 'cause I'm real fertile . . . so I got to take precautions, make sure that does not happen . . . [but] I've known quite a few people at where I work . . . where women had their tubes tied, got pregnant, they were on the pill, got pregnant [laughs]. They were on Depo-Provera shot, which I take, and got pregnant . . ." Another African American woman summarized the problem: "No birth control method is foolproof, so if you're not ready to have no kids because of a financial

situation, then don't--I mean, do every--you can, like I say, do everything to prevent it, but the only thing you can do to prevent it is not have sex.”

*Plans fail.* Finally, some women told of careful life plans simply not working out as expected, making the point that there is far more to family planning than the use of birth control. Some women reported that all of their children had been planned; nevertheless, their lives hadn't worked out as hoped. Believing themselves to be in a solid relationship and stable financial circumstances, they went ahead and had children, and then the relationship fell apart, the partner left, got arrested, lost his job, or fell seriously ill--and everything changed. A white woman got pregnant at 18 with a man a few years older and had an abortion. Then at age 20 she met another man, 28, who wanted to have kids. They were getting along really well, “So I went ahead and got pregnant . . . [had the baby] and then a year went by, and I deliberately got pregnant [with my second son]. . . And I don't regret my children at all, but at this point I wish I would have waited because if you knew . . . [had the benefit of hindsight]. . . because when I was just 6 weeks' pregnant . . . their dad got arrested and then I got divorced . . . So it's been really tough on me with them . . .”

Sometimes the failure seemed in retrospect to be predictable--something the woman now thinks she should have seen coming, so that the failure of plans seems more like a failure to plan. As an African American woman explained, “So like, in my case I thought I was gonna get married twice, and I didn't, and I came out of both relationships with two children. But then again, I didn't have very strong self-esteem or else I woulda saw like the *bs* comin' before I got pregnant.”

In line with the idea that there's more to planning than birth control, women--Latinas in particular--emphasized that men need to be part of the equation. The Latina women noted that men often proved their masculinity by filling their women with children, and also used pregnancy as a way of controlling women, sometimes coercing partners into avoiding birth control. One Latina woman told a story of struggling through difficult pregnancies, of being on the pill, of her partner refusing to use condoms, and her deciding despite his opposition and her own youth (she was only 23 at the time) to have a tubal ligation. “I can't keep having babies just 'cause you don't

wanta get sterilized. . . . And he still wanted more kids . . . it just made him change, feel different towards me. I still went ahead and did it. I don't regret it. And well, here I am, single but with my own decisions." An African American woman said she'd been reluctant to tell her most recent partner (father of her seventh child) that she planned to have a sterilization because she knew he'd be angry with her--despite the fact that he was having a child by another woman at the same time. Few women had partners who were willing to take responsibility for birth control and many married women encountered resistance when they suggested vasectomy to their husbands.

*The role of abortion.* Given the difficulties and ambivalence that characterized their experience with family planning, abortion was sometimes the only way in which a woman could exercise unequivocal control over her reproductive life. A few women in all but the Spanish-speaking Latina groups spoke of having had one or more abortions--often despite great personal misgivings or familial opposition--when faced with pregnancy at a completely unacceptable time. For most of these women abortion was a difficult choice, some vowed they would never do it again, and a few said they might make the decision differently if they had it to do over again. Among Spanish-speaking Latinas, abortion was not openly considered an option, though there were some abortions among this group, as reported in questionnaire data. As a whole, almost a third of the participants reported (on the questionnaires) having had abortions (Table 2), though a smaller number spoke of this in groups. What is significant about abortion in the context of the planning and control question, however, is that it is strong evidence of women taking steps to control their reproductive lives, albeit after the fact of conception.

*Planning also means having children.* Women's responses to questions about the benefits and possibility of "planning" also revealed that planning could mean either pregnancy prevention or intentional childbearing, and for many women the first thing that came to mind was *success in getting pregnant* rather than success in preventing pregnancy. For example, an African American woman commented, "When you plan, it takes longer than you really want to--and it's like when you least expect it--that's when it happens." And another said, "When you make plans, they never come through. And if you *don't* want it, it happens." A white woman put it this way, ". . . you can plan and you can take precautions not to plan." (In other words,

“planning” meant planning to have a child.) Another white woman told a story of wanting to be pregnant but not succeeding until she was 35: “I don’t think you *can* plan it. When it’s your time, it’s your time.”

### **Planning as a Concept Among Teens**

Teen group participants were asked what they thought about the general concept of planning when to have children. In each discussion group, there was at least one person who stated that one had some control over when you became pregnant - that you could or should plan. However, participants also expressed the idea that despite one’s desire to plan, “It [pregnancy] just happens.” Each group expressed opposing feelings that though it is possible for a person to plan when to have children, this is very difficult to accomplish and among their peers seldom occurred. These views were held consistently across all ethnic groups, although Latina adolescents tended to place the issue as part of an overall plan influenced by God.

There was frequent mention of method or usage failure, such as condom breakage or forgetting to take the pill, as a reason for not being able to control when pregnancy occurred. Some participants expressed that they had personally experienced such a failure themselves and all participants across all groups seemed knowledgeable that contraceptives had limitations in their ability to fully protect against an unintended pregnancy.

Participants were asked if they ever had thought they were pregnant when they weren’t. In all groups, with the exception of one, there were participants who had experienced a false pregnancy. However, few expressed that it had motivated them to become more adherent contraceptors. Only one or two participants shared that it had changed their contraceptive choices or contraceptive seeking behavior. Thus, even when a pregnancy scare occurs, few responded to the potential risk in which they placed themselves. Denial continued to be a factor, though in most groups there were at least a few women who said that now that they had a child, they felt more motivated to use birth control.

There were also conflicting thoughts regarding the likelihood of becoming pregnant. For example, in one group only a few participants said they had thought about the possibility of becoming pregnant when they started having sex. While a small number of participants had

gotten pregnant soon after they started having sexual relations, there were many more adolescents who were at risk of pregnancy, but who did not get pregnant. Yet, when asked if they thought they had a high or low chance of getting pregnant, all but one participant said that she thought she had a high chance of getting pregnant. Some adolescents had been sexually active as long as two or three years before obtaining contraceptives or becoming pregnant. A few were even becoming concerned that they could not become pregnant and thus were relieved when they did. Some participants, especially African-American and white respondents, mentioned that some girls will try to get pregnant thinking that it would help to keep to keep their boyfriends with them. Many soon found out that this reality was not going to occur and many were struggling to raise their children on their own, often relying on their parents for support.

### **Timing and Family Size**

One hypothesis about early childbearing among low-income women is that such women ultimately would like to have the same number of children as nonpoor women but they have them earlier. In other words, for these women, timing--in the sense of delaying childbearing until adulthood--is less important than simply the number of children one has (or timing *is* important and they prefer earlier childbearing). The data from our focus groups are not entirely consistent with this hypothesis: most adult women did express the belief that timing was important, and conversely, a number of women did not seem to have strong feelings about total family size--for example, they weren't seeking pregnancy but would have another child if the circumstances were right.

In terms of timing, two issues were raised repeatedly: maternal age and financial stability. Most felt a woman shouldn't be either too old (late 30s) or too young when she has her children. In particular, being too young was associated with being financially unstable and emotionally unprepared for the responsibilities of parenthood. It also meant truncating or deferring one's education and career opportunities. As noted earlier, a number of women regretted having begun childbearing as early as they had, recognizing the negative effect this had on their economic and career opportunities. A Latina woman who had her first child at 15 cautioned, "You should wait until you get out of school and have a good job and have some money saved, and things like

that.” A white woman explained that it's hard when you have kids before you get an education and are settled financially: “Once I'm already in this position, with children, it's just tougher to get out.”

Even for adult women, however, the respondents felt timing was important in the sense that one should be prepared to care and provide for a child. An African American woman noted, “. . . it's a matter of finances, whatever time it is, I think if you're going to have a child I think it's important to be able to know that you can take care of that child and--no matter what time that they come. . . . [you might want and be prepared to love a child, but:] that's the bottom line, is finances.”

But while almost all women acknowledged the importance of timing and planning, their own efforts--as a group--were uneven. In this respect as in many others, the respondents were an extremely diverse group: some had done everything they could to prevent an ill-timed or unwanted pregnancy whereas others were far less diligent. In all groups were women who had obtained tubal ligations--though sometimes later than they wished (several women's initial requests for sterilizations were denied because of age or postponed due to partner's resistance). In addition, there were women who had one or two children, wanted more but not now, and reportedly were using effective means of contraception. On the other hand, there were also women who were not seeking pregnancy now--either because the timing wasn't right *or* because they had all the children they intended to have--but who appeared not to be taking serious steps to prevent pregnancy (relying on rhythm, condoms alone, or abstinence--with unclear answers about what they would do if they did become sexually active).

### **The Timing Question Among Teens**

The clear majority of participants recognized that the opportune time to get pregnant was when they were economically stable and thus better able to provide for the child. A smaller number of women mentioned the advantage of being married so that there would be someone to help them both financially and with the care of the child.

When asked about the advantages and disadvantages of having a child while being in school, most adolescents across all ethnic groups reported that it was not good to have a child

this young. Their reasons included not being prepared to care for the child, boyfriends not wanting to accept responsibility, not being able to finish school, having to come home early and missing out on things, and not being able to think solely about yourself anymore. Among the three ethnic groups, white teenagers were more likely to mention that they actually wanted to become pregnant and that they saw clear advantages of having a baby. A few did report that having the baby helped to motivate them to improve themselves or forced them to grow up faster.

This group also mentioned that girls might desire babies to be grown up or receive attention from others. One participant shared that she knew of girls who pretended to be pregnant in order to get the attention of others and then would have a convenient miscarriage. African-American participants also shared that having a baby among their friends was a frequent event and that they could count on "one hand" the friends in their circle who had not gotten pregnant. While a community clinic was in close proximity to the housing project, there was a clear indication that there was a strong social norm influencing childbearing and adolescents comparing themselves to each other.

In two groups, having someone to care for and love you in return was mentioned as a positive aspect of having a baby. These women either stopped using drugs or applied themselves more in school, including returning to school as a result of becoming a mother. Several adolescents discussed that relationships with their mother actually improved after they became pregnant. In contrast, some adolescents expressed that having a baby had made it significantly more difficult to return to school. Several African-American adolescents expressed that as long as the teenager is going to school or working to support her child that teenage mothers should not be condemned.

In contrast to childbearing in high school, there was the universal feeling that having a child while in middle school "was way too young." Included in their reasons was the lack of services available at the middle school level to help the mother, being too young and immature, and not having an opportunity to "be a child themselves".

## Welfare Policy Changes

Focus group participants were asked about the proposed plan to put a ceiling on cash aid (not increase welfare aid with more children) and its probable effects on behavior. Almost all adult women had heard something about the proposal, and not surprisingly, there was general concern that capping aid would hurt innocent families and children *and* would not have a significant effect on contraceptive behavior.

Most of the adults (95% of whom were on AFDC) saw themselves as responsible individuals whose childbearing behavior would not be affected by the presence or absence of the small amount of money currently allotted for an additional child. "I'm not gonna get pregnant just so I can get more money," said one Latina; and an African American woman asserted, "I don't think anybody here in their right mind would have another one for an increase in the check." But most women *did* believe that there are *some* AFDC recipients (perhaps even "lots" of them) who do behave irresponsibly, and the respondents resented being lumped together with such people. One black woman who wanted another child but wasn't planning it because of her financial situation said, "I know this one lady she said she's gonna keep having babies until she has a little boy, and I just looked at her 'cause she already has ten kids or something like that . . . Those are the people that make them want to say . . . cut welfare payments." A Latina woman recounted a story of seeing a very young teenager at the welfare office who was pregnant a second time; the girl's mother told her she couldn't have another child, but the girl insisted, "No, but, Mom, I'll get more money." The respondent said, "She didn't look at that baby as a baby, she looked at her baby as a dollar sign." Such people might deserve harsher treatment, some women felt, and if there were a way to target the policy it might be all right. As one white woman put it bluntly, ". . . cut *them* off welfare. Leave the rest of us that are doing right alone."

Others believed that even though some recipients might be behaving irresponsibly, the policy change would do little to change contraceptive behavior. "I don't think it'll change people's behavior," said one white woman. "I think there's gonna be more children that are out there on the streets that don't have nowhere to live, I think there's gonna be more women having abortions when they really don't want to 'cause they can't afford the kid . . ." Many women saw

teenagers as among those likely to behave in an irresponsible fashion, and they were critical of them for doing so, but at the same time they acknowledged that teenage behavior was unlikely to be influenced by policy changes. A Latina woman said, "I don't think it's gonna make any difference, because kids . . . they don't listen. You look at now teenagers that--they're partying and having fun, I mean they're not gonna think about what welfare's gonna--I mean, heck, they're gonna go ahead and do what they're gonna do and get pregnant . . . and then they're gonna think about getting help."

Many women were concerned about how welfare caps would affect children and families who were doing their best, but had circumstances get away from them. They felt the money is little enough now; how would people survive with less? A Latina woman said, ". . . when I had my first divorce, if it wasn't for welfare, my kids wouldn't have had a home." Another said, "I think it's going to hurt the children. Because women are still gonna get pregnant. I don't think that by them setting up the rules it's gonna stop anybody. The only thing it's gonna do is it's gonna hurt children." And a white woman argued, "A hundred dollars isn't gonna make you have more, when you think about it. And if you're gonna take that away anyway, the only one suffering is gonna be all these kids, because they're still gonna be havin' babies--I think. I think it may stop a small percentage, but I don't think in the long run it's gonna do what they want it to. All it's gonna mean is more children not eating, and more children not having some of the things they need."

Though this did not seem to be the majority viewpoint, a number of women did think that welfare caps might cause some women to take birth control more seriously. One white woman said, "If there was no welfare--'cause both my pregnancies were not planned, and I've never been married, so I knew that their father was not gonna get a job . . . but if there was no program like welfare to where I knew I could support myself somewhat financially, I would have made sure I wouldn't have got pregnant, you know?" When asked if the welfare policy change would make a difference, a Latina woman said, "I think it would" Then she added, "You know, you'd think about it twice." Another said, "A lot of people are having babies just to get money." She thought it would "definitely" make a difference in a woman's remembering to take her birth control pills. And an African American woman stated flatly that she agreed with the idea of capping aid,

“because there’s a lotta people out there who are just havin’ babies . . . just to get more money.”

### **The Teen Reaction to Capping Aid**

The facilitator explained the possibility that welfare policy might change under the family cap program, in which recipients would receive no additional financial support for having additional children while they were on welfare. Approximately half of the white teenagers, almost all of the black teenagers, and a small number of Latina adolescents had heard of this proposal. For the most part, participants felt that this was a good idea. They felt that it would encourage the woman to work which was considered positive. A few said they did know of women who had more children to get more money. Several mentioned that it would probably cause other people to use family planning services more and one participant stated that the proposed change would definitely make a difference in how she used birth control. However, a high proportion of recipients felt that people would not change and would go ahead and have additional children whether or not financial support was made available. In none of the groups did all of the women currently receive AFDC, thus it was not clear how many of the participants would be directly affected by the proposed change.

There was also mention that for those adolescents who cannot work, the family cap policy would be a burden. Several commented that the funds that they currently receive are urgently needed and do not cover the basic costs of living. There was a deeply held sense of frustration that even when someone gets a job, that their financial base from welfare is decreased and that food stamps and medical care is not available to them. Thus, several expressed that you "could never move ahead" because one would always be hampered. Incentives to work were off-set by the negative perception that the types of jobs that were available did not provide enough to replace their current situation. While adolescents across the groups, especially white and Latino adolescents, expressed that they wanted to work and felt great pride in having a job, that they felt trapped by the situations in which they lived. In two groups, participants discussed that additional job training programs, such as Cal Learn, were helpful because they provided opportunities and incentives to return and stay in school. Eventually, this was seen as a help in finding better paying jobs.

Difficulty in finding child care was also frequently mentioned. Without adequate day care, the adolescents felt it was difficult to get a job or go to school. Yet, many expressed deep concerns about the quality of child care available to them and expressed a strong sense of distrust about available care. Adolescents, particularly Latina and African-American teenagers felt that they could not feel comfortable leaving their children to the care of strangers and were concerned about potential physical abuse.

## **BIRTH CONTROL EXPERIENCES AND PERCEPTIONS**

Other research has found that a woman's attitudes toward specific methods of birth control as well as birth control in general are an important component of her decision-making with respect to family planning (IOM, 1995; Silberman and Hamilton, 1994; Silverman and Torres, 1987; Keith, et al., 1991). Women with unsatisfactory experiences or negative beliefs about certain methods may generalize to all methods and be reluctant to pursue other options. In addition, some of the more effective methods have problematic reputations in terms of their overall safety that discourage women from using them (IOM, 1995; Silverman and Torres, 1987). In addition to asking women for their opinions and experiences with specific methods, we asked about how they had learned about birth control and the roles of partners, family, and friends in their decisions; relevant findings are summarized below.

Before offering comments on the specific methods, two overall points should be made. First, among adult women there was a great deal of dissatisfaction with methods, based in many cases on personal experience or the experience of close associates. Stories of satisfaction with methods were by far the exception. Second, a strong articulation of the costs of pregnancy was strikingly absent from these discussions (though there must have been some sense of it, because virtually all (95%) of the adult respondents *had* engaged in birth control). In part, this was an artifact of our discussion guide, because women were asked about birth control experiences and not asked directly about the experience of pregnancy and childbirth (though they talked of it). But it is noteworthy that on the rare occasions when a woman did favorably compare birth control--despite its drawbacks--to pregnancy, the comment was not echoed or elaborated upon by others.

Among both adult women and teens, there was an apparent lack of knowledge regarding the safety of some birth control methods, and awareness of effectiveness was also somewhat uneven. Among adult women, Spanish-speaking Latinas in particular stand out in their lack of knowledge about the safety and effectiveness of methods. These findings point to the necessity of considering the types of information that are needed within the community and developing effective mechanisms for communicating the information in a manner that might help to overcome negative perceptions or strongly held beliefs regarding a method even though the woman had not had a direct experience with the method in question. In both adult and teen groups, negative stories about methods have great power and women are often not convinced by the reassurances of medical providers.

In terms of use patterns, the Shot is much more popular among adolescents, and withdrawal is also more common in this group. A substantial number of women in both groups currently reporting using condoms. A small number of adult women but no teens reported having ever used Norplant.

## **Experiences and Perceptions of Specific Methods**

### **The Pill**

There was widespread experience with the Pill and also widespread dissatisfaction with it, though there were some cases of satisfied, long-term users among all groups. As shown on Table 2, 83% of these women (76%-95% of different groups on Table 3) had used the pill at some time, but only 18% were current users (slightly higher among Latinas, lower among whites and blacks). In the discussions, numerous side effects and other drawbacks were mentioned, drawn from both personal experience and the experiences of friends and family members. Reported side effects included nausea, bloating, weight gain, cramping, headaches, depression, moodiness, nervousness, anxiety, hair loss, leg pains, and breakthrough bleeding. Women were concerned about the need to remember to take the Pill at precisely the same time every single day, and some reported that even though they might like to use the pill they could not do so because of medical contraindications.

In addition to these reports based on personal and vicarious experience, there were also

some less grounded negative assessments, from women who simply felt that “there are health issues involved with the Pill” or that it wasn’t good for your body to take something that made you feel pregnant. In one or two groups when the question was asked, “Is it safe?” several women simply said “No.” General fears about the pill included blood clots and cancer; one woman said she felt it simply hadn’t been studied enough and that it had lingering effects long after a woman had stopped using it. These comments are consistent with findings reported elsewhere that women may tend to exaggerate the risks and underestimate the benefits of birth control, most particularly the Pill (IOM, 1995; Silverman and Torres, 1987).

Questionnaire responses were slightly less negative (see Table 4) in the sense that at least as many women think the Pill is “mostly safe” as think it is “mostly harmful” within virtually all racial/ethnic categories.<sup>3</sup> There are, however, differences between groups in opinions about the Pill’s safety: the proportion who believe the Pill is “mostly safe” is highest among whites; it is lowest among Spanish-speaking Latinas primarily because such a large percentage of them are unsure (as they are about most methods), and next lowest among African Americans, who have the highest proportion believing the Pill is “mostly harmful.”

At the same time, the Pill is also universally known and as noted, has been used by a great many women, often as their first form of prescription birth control. Some white women recalled that as teens, they and their friends had gone on the Pill at the same time (“it was the popular thing to do”). Other groups also commented on the Pill’s prevalence: that it was the first thing “they” (family planning authorities) told you about; that providers stress the Pill even if they tell you about other methods; that it’s often first thing a woman herself thinks of). Most participants saw the Pill as an effective method, though there were some who had become pregnant while taking low-dose pills, and some whose friends had become pregnant while on the Pill. In questionnaire responses (Table 5), a majority of whites and Spanish-speaking Latinas thought the Pill was “very effective”; English-speaking Latinas were evenly divided between “very” and “somewhat” effective, but African American women were more doubtful: only 14% said the Pill is “very effective” and 73% said “somewhat effective.” Larger proportions of Latinas than of

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<sup>3</sup>The difference between the two figures among Spanish-speaking Latinas is insignificant, given the small group size.

other women were unsure.

In terms of the relationship between beliefs and discontinuation, the questionnaire data reported on Tables 4 and 5 suggest that discontinuation is not strongly influenced by safety fears, though complete avoidance of use may be. Forty-four percent (44%) of those who have discontinued Pill use say it is “mostly safe” while only 29% of those who now use it say this; 42% of current users are unsure of Pill safety. However, current users are considerably more likely to believe the Pill is “very effective” (67%) than those who have discontinued the Pill or never used it either (32% and 20% respectively). The more common belief of nonusers that the Pill is “somewhat effective” may actually be realistic given reported problems with use (taking it every day at the same time, especially with low-dose pills).

### **Teens and The Pill**

Forty-four percent (44%) of teenage participants had used the pill at some point in their reproductive histories (Table 6). African-American participants were more likely (55%) to have used the pill than white (37%) or Latina women (38%). Overall, 66% thought pills to be an effective or very effective method, though there was also variation by ethnic group on their view of the pill’s effectiveness (African-American 82%; Latina 46%; white 63%) (see Table 7). While overall, 11% thought the pill was not effective, 26% of the white participants held this view. Over one-half (54%) of Latinas were unsure regarding the pill’s effectiveness. A little over one-third of participants (37%) thought the pill was safe, though 27% of African-American participants thought it was mostly unsafe (Table 8). Approximately one-half of Latina (54%) and white (47%) respondents were unsure about its safety.

The most frequent and strongest comments regarding the pill in the focus groups were regarding the negative side effects (weight gain, moodiness, hair loss, getting sick). Sometimes these opinions were based on personal experience and for others, hearing about side effects from friends caused them to stop using the method. The experience of peers or even women who they did not know, but who they had heard about because they had had a negative experience with the method, was tremendously influential in whether or not an adolescent was going to try a method. A few of the older adolescents in the group could differentiate that the experiences of some other

women did not necessarily imply that they would have the exact same experience. However, for the clear majority across all ethnic groups, the power of other women's stories, particularly negative ones, was a barrier to their testing a method of contraception.

Having to remember take the pill and needing to hide them from parents were other problems shared with some of the adolescents. In fact, at the time of this study, only four of the non-pregnant teens (15%) were currently using the pill as a contraceptive method (Table 9).

### **Depo Provera (The Shot)**

Comments about the Shot among adult women were mostly negative but there were a few very satisfied users who particularly appreciated the convenience of this method (some also enjoyed not having a menstrual period). Less than one quarter of the women (22%) had ever used the Shot and only 5% were currently using it. The proportion who had ever used it was highest among Spanish-speaking Latinas (37%) and current use was restricted to this group and African American women.

Perhaps not surprisingly, a large proportion of respondents were unsure about the Shot's safety and effectiveness (Tables 4 and 5), and women tend to be somewhat suspicious of it (in every racial/ethnic group more people said it was harmful than said it was safe, though the differences are small). There were some reports of personal experiences with very negative side effects but many of the negative comments were based on the experiences of close friends and family members with problems. Women mentioned weight gain (as much as 60 or 70 pounds in some cases), decreased libido, depression, hair loss, aching bones, irregular cycles and bleeding. There were no stories of unintended pregnancy on the shot, however, (possibly in part because few people have been on it very long). Some women did overcome the fear generated by others to try the method for themselves and found it was fine; others were initially favorably disposed toward it and then extremely unhappy with results; a few ceased use because of fear or vague dissatisfactions. In contrast to the pattern with the Pill, very few of those who discontinued the Shot believed to be safe (only 7%); 36% said it was mostly harmful and 43% were unsure of its safety (Table 4).

### **Teen Experience with Depo Provera (The Shot)**

Thirty percent (30%) of teen participants had used the Shot (Table 6). African-American participants were more likely to have used the shot (41%) than Latina (23%) or white women (21%). Overall, 77% thought it to be a somewhat effective or very effective method (Table 7). White participants were the least likely to see it as effective (African-American 86%; Latina 84%; white 64%) and were more likely to be unsure of its effectiveness (26%). Few thought it was an ineffective method. Similar proportions of the group viewed the shot as mostly safe (25%) and mostly unsafe (21%), while a large proportion (40%) were not sure (Table 8). Almost two-thirds of the Latina group (62%) were unsure of its safety and none of this group rated the shot as safe. There were many comments regarding the negative side effects of the shot including bleeding all month and headaches. One group was particularly concerned about potentially dangerous long-term side effects. The main advantage cited was it lasted for three months. At the time of this study 10 teenagers, 36% of the non-pregnant participants, were using the shot.

### **Condoms**

In the focus groups, women were asked about condom *effectiveness* specifically, because other research has indicated that the method's effectiveness is often underestimated (Silverman and Torres, 1987), but most discussion centered on other aspects of condom use. On the question of effectiveness, women said the method was "OK" "if you use them right" or "if they don't break" or "if they stay on"--in other words, they're not seen as an absolutely reliable method of contraception. Questionnaire data (Table 5) were consistent with these responses: larger percentages of women in all groups saw condoms as "somewhat effective" rather than "very effective (though African Americans did rate them more favorably than did other groups). Among both English- and Spanish-speaking Latinas, however, there were sizable proportions who were uncertain. Current users are more likely to believe condoms to be effective than are nonusers. Somewhat surprisingly--given the lack of controversy about condoms--not everyone believes they are "mostly safe", at least among blacks and Latinas Table 4). Particularly notable is the high proportion of Spanish-speaking Latinas who are uncertain (53%) about condom safety

(note that this is consistent with their uncertainty about safety of all methods).

No one *likes* condoms, but some women do see them as their best option for birth control, and many women also see them as essential for protection against AIDS (to be used primarily in new or short-term relationships). In fact, condoms were the most common method of current contraception, with 27% of women using them (11% to 40% by racial/ethnic group). It is clear that messages about protection against AIDS are reaching most of these women; a number reported having been tested, requiring new partners to be tested, and insisting on condom use. Women occasionally use condoms as a method of disease prevention and something else as a method of birth control. It should be noted that explicit concern for STDs was less evident among our Spanish-speaking Latinas than in other groups, and in a southern California focus group study (Silberman and Hamilton, 1994), STD prevention was almost never raised by Latinas.

There appear to be cultural differences in condom use. Though men's dislike of condoms is common, the strength of their resistance or the ability of women to overcome it varies. Spanish-speaking Latina women simply say their men refuse to use condoms and report almost no use (consistent with the findings in Silberman and Hamilton, 1994). Among English-speaking Latinas and black women, some said their partners wouldn't use condoms but others said they would use them, despite their dislike of this method. A few Latina and black women reportedly insisted on condom use ("Anyone that doesn't agree with the condom is not a partner," said one black woman.) White women did not report strong male resistance, and many had used condoms, but these women tended not to have particularly high opinions of the method, though some recognized its importance in disease prevention. Questionnaire data (Table 3) are consistent with these comments: higher proportions of black and white women than of Latinas are current users of condoms. Most women have tried condoms in the past, including--somewhat surprisingly, given their negative comments--almost three-quarters of Spanish-speaking Latinas.

### **Teen Views on Condoms**

Eighty-three percent (83%) of participants had used condoms (Table 6). Those in the African-American groups were the most likely to have used condoms (91%) and those in the

Latina groups the least likely (69%), with the white participants somewhat in the middle (84%). When asked on the questionnaire about the perceived effectiveness of the condom, 77% felt that it was very or somewhat effective, 9% thought it was not effective, and 13% were not sure. The Latina participants were the most likely to be unsure of their effectiveness (31%). When asked about their safety, 68% of participants felt it was mostly safe, 4% felt it was mostly harmful, 19% felt it was neither safe nor harmful, and 9% were not sure. The Latina participants were much more likely to be unsure of their safety and were less likely to feel that condoms are mostly safe.

In the focus groups, participants complained that the condom was uncomfortable for them, that their partner did not like using it, that they are embarrassing to purchase and use, and that they are likely to break. The main advantage of the condom was that it was seen as useful in preventing sexually transmitted diseases. This perspective was most strongly felt by African-American adolescents. The overall opinion reflected a sense that while one could live with pregnancy, one could not live with disease.

### **Sterilization**

The focus group data on sterilization offer a very partial view of the attitudes of AFDC recipients to this method, because the focus groups were recruited from a sample of women who had not already chosen sterilization as of AFDC research interviews late in 1993. Of the full research sample of women receiving AFDC at that interview, 27% were sterilized: 33% of whites, 27% of English-speaking Latinas, 26% of African Americans and 23% of Spanish-speaking Latinas (overall, this is consistent with Zill, 1996, whose figures indicate that 33% of AFDC mothers have had tubal ligations). The somewhat lower sterilization rate of Spanish speakers persists when this sample is subdivided into younger and older respondents. Among women under 30, 18% of whites, 14% of English-speaking Latinas, 14% of African Americans, and 9% of Spanish-speaking Latinas had been sterilized. Among women aged 30 or older, 46% of whites, 44% of English-speaking Latinas, 38% of African Americans, and 30% of Spanish-speaking Latinas had been sterilized.

In short, sterilization rates are highest among whites and English-speaking Latinas and lowest among Spanish speakers, but substantial numbers of women in all groups rely on this

method to end their childbearing. Between one-third and one-half of AFDC recipients over age 30 in all racial/ethnic groups have been sterilized.

The attitudes toward sterilization expressed by women in our adult focus groups reflect these racial and ethnic variations in sterilization rates. White and English-speaking Latina women were most favorably disposed toward this method, with some women in most of these groups saying they were seriously considering it and some having already had the procedure (16% of whites and 19% of English-speaking Latinas had done so--see Table 3). Most powerful were the stories of the English-speaking Latina women who had had tubal ligations despite strong familial disapproval (from a husband in one case, a mother in another). Black women and Spanish-speaking Latinas were most vocal in their opposition to tubal ligation, although two black women had had the procedure (one after 7 children) and were satisfied with the choice, and a few other black and Spanish-speaking Latina women would consider tubal ligation. These Latinas expressed fear of physical and emotional side effects and believed there was a strong risk of regret if one had the operation as a young woman; none had been sterilized. Black women also saw the procedure as potentially physically damaging and were concerned about regret; one black woman also knew women who had become pregnant following tubal ligation.

Opinions on safety and effectiveness as expressed in questionnaire responses are generally consistent with discussion comments; for example, 79% of white women but only 29% of blacks thought female sterilization is "very effective." Somewhat surprisingly, though, rather sizable proportions of all groups were uncertain about sterilization's safety (26-63% of women said they were unsure--see Table 4); in addition, 27% of black women thought the method it was "mostly harmful." Relatively high proportions of all groups but white women were also uncertain about sterilization effectiveness (Table 5).

At least four women (one English-speaking Latina and three white women) had actively sought tubal ligations in their late teens or early 20s and been denied the procedure on the basis of age, despite having two or more children.<sup>4</sup> One of these women had asked her doctor to

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<sup>4</sup>A few other women had "considered" sterilization at an early age and been discouraged from it. Silberman and Hamilton (1994) also found in their focus groups a number of Latinas who reported having been denied sterilizations.

perform a tubal ligation when she was 20 years old and already had 3 children; he refused to do so. At the age of 24 with 5 children she “begged” her husband to get a vasectomy; when he resisted doing so, she finally obtained her tubal ligation. Another woman had asked for a tubal ligation at the age of 19 after delivering her third child; she is now glad she didn’t have it because she is pleased she had her later children. A third woman with two children has had very difficult pregnancies and serious problems with the Pill, Shot, and Norplant; her request for a tubal ligation at age 23 was denied, as was her husband’s request for vasectomy (at the age of 26). She is committed to obtaining a sterilization for herself or her husband.

Many women commented on the strength of male resistance to vasectomy--despite the relative simplicity and low cost of this procedure in comparison to tubal ligation. In some cases, women seemed resigned to male intransigence, but others expressed disgust, impatience or anger. The 24-year old mother-of-five mentioned just above explained that her husband had gone to see a provider about the possibility of vasectomy, but “couldn’t find a place to park” and as a result was late for his appointment and couldn’t be seen. That was the end of his efforts. “I figured I had all the kids, the least he can do is have a vasectomy.” An English-speaking Latina commenting on men’s resistance to vasectomy said simply that “they don’t have a conscience.”

It should be noted that female sterilization has been increasing in popularity (Mosher, 1990; Mosher and Pratt, 1990), and is particularly heavily used as a method by AFDC women (Zill, 1996). To some degree, this trend probably reflects deep dissatisfaction with reversible methods.

### **Sterilization Thoughts Among Teens**

There was some discussion of female sterilization in the teen groups. Several of the African-American participants mentioned that they had requested sterilization but been refused because of their young age. This angered the young women because they felt that they had had all the children they wanted and that they were able to make this decision even at their young age.

## **Other Methods**

**Norplant.** The only positive Norplant experiences were reported in one group of Spanish-speaking Latinas. A few white women had tried Norplant and been dissatisfied, in one case reporting a extremely difficult experience. Most other women had not tried the method and had heard very negative things about it; a few knew women who had had problems with it, and even those who didn't tended to be quite suspicious of it. Black women were particularly vehement in their objections to the method; a woman who said she'd tried everything commented, "The only one I really knew I wasn't gonna try was that Norplant," and her comment was met with a chorus of agreement. No black women had ever used the method (see Table 3).

This is an appropriate context in which to note the special concerns of the African American community with respect to the motives for family planning programs and the credibility of the medical establishment with respect to the safety of birth control methods. These concerns, grounded in the very real experiences of racism, undoubtedly influence some African American women's feelings about birth control providers and methods (IOM, 1995). It is particularly noteworthy that in the early 1990s, coercive intent was evident in the legislation introduced in a number of states that would have paid welfare mothers to use Norplant.

**The IUD.** IUD use was very uncommon (only 12 women had ever used it, 4 were current users), and many women expressed fears about the IUD (migrating through the body, causing infection, doing serious damage to a fetus, lodging in the uterine wall). In some cases, fears were grounded in personal experiences or the experiences of close associates but in many cases they were based on "grapevine" reports. There were satisfied current users, however, including three Spanish-speaking Latinas and one white woman; one English-speaking Latina had used the device successfully for some time but then had had to have it surgically removed.

**Rhythm/Natural Family Planning.** A few women reported having used rhythm with success for extended periods of time, and it seemed to be a fall-back method (along with condoms) for some women who dissatisfied with or suspicious of hormonal methods and the IUD. Twenty-eight percent (28%) of women (primarily whites and blacks) had used rhythm/NFP at some point, and 8% were current users (Table 3).

**Diaphragm.** There was virtually no discussion of the diaphragm; only one woman was

currently using it, and only 9 women (11%) had ever used it.

### **Other Methods Among Teens**

A frequently used other method among teenagers was withdrawal (74% having ever used) (Table 6). Fifteen percent (n=8) had used rhythm, one reported using the diaphragm, one had used the IUD, two had used film, and seven (13%) used other ways of making love to avoid pregnancy (oral or anal sex).

### **Abortion**

The questionnaire data reveal that almost a third of the women (30%) had had abortions, with the highest proportion among African Americans (46%) and the lowest among Spanish-speaking Latinas (11%). In almost all focus groups (Spanish-speaking Latinas were the exception) one or two women spoke of their experiences with abortion, sometimes with only passing reference, and sometimes in detailed stories about the circumstances and psychological difficulties associated with the experience. Disagreement and deep ambivalence were evident in these discussions, particularly among the African American and English-speaking Latina women. Some of these women expressed unequivocal disapproval of abortions while others said it was a matter of a woman's own choice--only the woman could know what was the right thing to do given her circumstances (including responsibilities to existing children). Among those who had had abortions were some who felt very uncomfortable about it, not necessarily regretting the specific decision (though one or two did) but vowing not to do it again.

Abortion seems to play an important but almost invisible role, in the sense that a significant number of women do obtain abortions, but are reluctant to acknowledge it as an important aspect of their family planning experience. An occasional woman does openly acknowledge her use of abortion as a method of family planning and an important way women have to control fertility when other things fail.

### **Overall Patterns of Use and Reasons for Nonuse**

Among adult women, almost one-third (31%, 27 women) were not currently using any method of contraception and 5% (4 women) had never used a method (Table 2). Table 10

summarizes the reasons (sometimes more than one) they gave for not currently using a method. The single most common response was that the woman was *not having sex with men at all these days* (44%), followed by *wanting to be pregnant or feeling that it would be OK to be pregnant* (20%), and then *currently pregnant* (16%). Two noteworthy observations can be made about the responses to this question. First, a very small number of women gave any other reasons, including problems obtaining birth control. Second, for women without steady partners, sexual activity may be very unpredictable, and the uncertain comments in focus group discussions about what methods would be used if a woman were to become sexually active strongly suggest that many women are not well prepared for this possibility. Most of those who did answer said they would use condoms, and indeed, condoms are the most popular current method among all respondents. However, this method requires a high level of motivation for effective use, and other research has found very small percentages of condom users consistently engage in appropriate usage (Oakley and Bogue, 1995; Peterson, et al., 1995); as a result, the failure rate of condoms in actual use is quite high--estimated to be 12-20% in the first year (IOM, 1995, citing Hatcher, et al.). These findings taken together suggest that a substantial proportion of the women in these groups are at risk of unintended pregnancy *despite* their awareness of birth control methods and services, and may be an argument for more widespread access to emergency contraception.

Among teens also, there was also very little mention of problems obtaining access to birth control. More frequently, adolescents shared that they were given supplies (pills or condoms) that they did not use. At the time of the focus groups, 82% of the 28 non-pregnant participants were using some method of pregnancy prevention as reported on the questionnaire. It should be noted, however, that 29% were relying on withdrawal as their method of birth control. Four of the five young women who were not currently using any form of birth control reported not having a sexual partner and the fifth gave reasons of not having sex often, cost of supplies, and time to obtain birth control. Again, these findings argue for a need for a back-up measure such as emergency contraception.

## **Partners, Family and Friends**

It was striking and disturbing how rarely the women in these groups spoke of partnership in the context of family planning. Occasionally a woman would report a supportive partner--a husband who volunteered to get a vasectomy, or one who would remind her to take her birth control pills--but the overwhelming pattern was of partners either uninvolved or actively opposing--this, primarily in the case of Latinas--a woman's efforts to control her fertility.

Among African Americans, male uninvolved fit with to some degree with the women's attitude that these matters *should be* up to the woman; representative comments included the following: "It's about me." "It don't matter what they think, I gotta do what's best for me." "I think it's my choice. I'm *very* particular about my body." "He has an opinion, but that's about it." But at the same time, black women regretted lack of support from their partners. They *should* make it easier for a woman to use birth control, but more often, "they make it harder, because they have this perception [that] . . . we've been dating for like a year, why do we have to use condoms? You forgot to take your birth control, well why does that matter? You know, I love, you love me." Lack of communication about birth control reflected the sad fact, said one woman, that "relationships now aren't based on discussion."

Among English-speaking Latinas, many were in long-term relationships in which birth control and family planning were discussed with the partner, and women sought male support, but these women also believed it was ultimately their decision. Spanish-speaking Latinas (also likely to be in long-term relationships) reported that their men knew and cared very little about birth control, and in some cases actively opposed its use; these women felt a strong need and responsibility to educate their men. White women who were in steady relationships with men felt it was important to discuss birth control and that the partner should be supportive--though this wasn't always their experience. Those not in relationships reported that partners were not significantly involved in family planning (this was true of the English-speaking Latinas in Alameda County as well). All agreed that it was helpful when a man was actively supportive of a woman's use of birth control, consistent with research showing that partner support is positively related to the effective use of contraception (IOM, 1995).

Women's feelings about male involvement are understandably complicated. On one hand, male responsibility and understanding are seen as very positive things and their absence is

resented. But women also have reason to be fearful of male involvement when it is a form of domination. As noted in an earlier section, an English-speaking Latina woman who decided to have a tubal ligation after three children and difficult pregnancies had to ignore her husband's oppositions. "He wasn't gonna wear a condom, that was for sure . . . he wasn't paying for my pills no more . . . [I told him,] 'I can't keep having babies just because you don't wanta get sterilized.'" Against significant obstacles, she obtained the tubal ligation and has no regrets about it, but her husband's attitude toward her changed as a result of this decision, and she's single now. An African American woman's story--also cited above--made a slightly different, but related point about male irresponsibility. She was reluctant to tell her baby's father that she had decided to have her tubes tied (this was her seventh child) because she knew he'd be "pissed off" but when she did make this announcement, just after the baby's birth, he informed her that he had another child on the way. Two of her children were by this man, and he took little responsibility. "And when my baby cried at night, and I was sick . . . he didn't move. My oldest daughter was the one went and got the baby. And the baby was layin' next to him . . ." As she described the man's anger at her having a tubal ligation, another woman responded, "To me, he shouldn't have no opinion on that," and she acknowledged this with a heartfelt "Thanks."

### **Parents, Partners, and Friends: Issues for Teens**

One of the barriers to using family planning, particularly for the Latina participants, was the possibility that parents would discover that they were sexually active. It was their impression that if parents or other adult relatives did not see evidence of birth control, that they believed their daughter was not having sexual relations. One participant was even asked by a friend to keep her birth control so that her family would not discover it. At the other extreme were mothers who without much discussion simply brought their daughters to a family planning clinic when they began menstruating or when they thought they were sexually active. Sometimes their daughters felt that the birth control was being pushed on them and rejected their parent's intrusiveness. Participants in the African-American groups were much less likely to feel the need to hide their use of birth control from their parents than were the Latina participants. It was more common for family members to be involved in the woman obtaining birth control in the

African-American groups. A few participants did feel that their mothers were more open and discussed family planning with them, which they appreciated. In spite of a strong message from their parents not to get pregnant while they were adolescents, many of these adolescents had turned to their peer groups to shape what they would do with their lives. It was only after they had been pregnant and given birth that they could begin to understand what their mothers were trying to prevent them from experiencing too prematurely. In many of the households, the adolescents' mothers had experienced an early pregnancy. While they were trying to prevent their daughters from having this experience, there appeared to be too few viable alternative options for these groups of adolescents.

In general, there was very little discussion of birth control with partners. In one group of Latinas, none of participants had even raised the topic with their partners, even though some had had a lengthy relationship. Some of the participants felt embarrassed discussing the topic with their partner or thought he would become irritated or think poorly of them if they brought it up. Some were pressured by partners to not use birth control, including Latinas whose partners expressed concern that birth control would harm them. Sometimes the partner would use a condom early in the relationship, until they felt more comfortable with each other, at which point they stopped using condoms. STD prevention may have been part of the original reasoning, although the continued potential risk as the relationship evolved was not considered. All of these decisions occurred in silence, including whether or not the relationship was a monogamous one. Later in the relationship, couples used either no method or the adolescent began using another method (e.g., the pill). This latter scenario was rare among this sample of young women. One exception to this finding was documented in one African-American group in which all participants had discussed the topic of birth control with their partners. For some of these young women, discussions contributed to their continued use of condoms, while for other participants, the discussion did not necessarily result in consistent contraceptive use. Experiencing side effects (e.g., weight gain or moodiness from the pill or shot) from a method was cited as another reason someone might stop using birth control. There was also some embarrassment at going to a store and purchasing over-the-counter supplies.

## **Learning about Birth Control and Life**

When asked specifically where they'd learned about birth control, adult women cited a variety of sources, including family, friends, and peers, school sex education programs, providers, and the trial-and-error of their own experience. But they also put birth control in the context of larger issues, such as understanding the realities of male-female relationships, childbearing, and family responsibilities. A significant common theme in these discussions was the ignorance and naivete many women recalled from their teenage years, and the importance of early education, particularly for girls. Some women whose mothers were uncomfortable with the subject ("My mother never even said the word 'pregnant'," said one white woman) hadn't learned about birth control until their first pregnancy. Others were grateful for having had mothers who were more open.

All groups of women expressed concern about the lack of knowledge as well as the thoughtless behavior of teenagers--in some cases, distancing themselves from this group but in other cases recognizing that they had behaved very much the same way. In their calls for more education, many of the women--especially white and English-speaking Latina women--emphasized a need to inform young people not only about birth control and reproduction, but about the realities of child rearing. Women sometimes suggested that if they'd known "then" what they know now, they would have postponed childbearing. As one white woman said, "I wish I had gotten an education [and that my family could have afforded a better school for me]. . . I feel real bad that my children don't get some of the things that they would like to have." An English-speaking Latina woman commented, "I don't think a woman should start young. I . . . got pregnant when I was 17. . . had [the baby at] 18. But that was too young. Because I knew nothing." And another said, "You should wait until you get out of school and have a good job and have some money saved, and things like that." Some of the white and Latina women mentioned using their own lives as object lessons to their daughters, wanting them to understand how difficult it could be.

An African American woman said she could understand with the motives of teenagers, based on her own experience, and this understanding strengthened her concern. When she got

pregnant at 15, her mother had taken her to a clinic to have an abortion, which she hadn't wanted. She went on the pill afterwards but then got pregnant again "'cause I think for me, my whole reasoning, which--that's why I can understand why a lotta teenagers sometimes just get pregnant--was I wanted a baby. Not for any particular reason, I just wanted a baby 'cause my mother made me get rid of my first child. So I just wanted a baby. And I (didn't know) the responsibility or any of that had to do with that, I just wanted a baby." Other African American women expressed concern about how early girls were having children; one said she'd been talking to her daughter since the girl was 12 because on TV talk shows she saw how "these kids are starting to have sex at 10 and 11 years old . . . [I] can't even imagine." Another woman interjected that in the housing project where she lives "there's some that's pregnant at 10 years old, and there's girls that look older than all of us in here, and they're nothin' but 10." A third participant then noted that she had a grandchild whose "momma just made 14 . . . And my son is 20 and she was 13 when he got her pregnant."

Whether their comments were judgmental or empathetic, the adult women were concerned about a lack of understanding among young women and men of all ages--of both the specifics of birth control and sexuality *and* the realities of child rearing. One white group was particularly strong on the need for better sexual and family-life education and information for all ages, and for programs to facilitate family communication. They seemed frustrated by the inattention to these extremely important topics in educational institutions and the media; as one woman said vehemently, "We don't need to know about the Ottoman Empire and crap that happened 500 years ago, we need to know how to save our kids."

### **Learning Among Teens**

Parental influences on teen behavior were noted above; it is noteworthy that teen participants supported the idea of more education for their parents around this area, especially parents who feel uncomfortable speaking about the subject. The amount of conversation about methods among friends varied by ethnic group, with it being a less common topic in the Latina groups. Side effects, usually negative ones, seemed to be the most common topic of discussion. Some participants also learned about birth control in school. Not all participants knew that they could get birth control at no cost without a parent's permission.

### **EXPERIENCE WITH SERVICE PROVIDERS**

In an effort to learn more about what aspects of service provision either facilitate or hinder use of family planning, focus group participants were asked about their experiences seeking and obtaining such services. It is noteworthy that almost no one reported encountering significant barriers to obtaining contraception when it was actively sought, with the principal exception of women denied tubal ligations because of young age. There were occasional problems for women seeking a particular method, though, and also problems arising from lack of awareness, particularly noted by adult women reflecting back on their teenage years when many said they knew little about sexuality, birth control, or family planning services. It is possible that had more of these women sought such services as teenagers, they might have encountered more serious barriers to service, but they were not in fact seeking birth control at that time. As adult women, once they knew what they wanted and needed, they were generally able to get it.

Because of the specific policy concerns in this study, women were asked about the context in which they preferred to receive family planning services, about communication with their providers, about sources of information and referral, about pressures they experienced from providers, and about their impressions of services. The most notable differences between adults and teens were in sources of service: smaller proportions of teens than adult women reported using private physicians or HMOs for reproductive medical care, and larger proportions of teens reported using clinics and hospitals for both method-related care and supplies. In their judgments about services, teens and adult women were generally quite similar.

## Context of Services

Consistent with national data (Mosher and Pratt, 1990), family planning clinics are not currently the predominant source of care for these women as a whole, though there was considerable use of multiple providers and heavy use of clinics for supplies. The majority of our respondents had obtained their most recent family planning advice or supplies in a setting where they received other health care: 43% from a private physician or HMO, 27% from a hospital or general care clinic, and 24% from a family planning clinic (Table 11). But almost half (44%) of the respondents had used a family planning clinic within the last 2 years for supplies (37% of those going to private doctors/HMOs for care did so), and a number of women had used such clinics at some point in the past (as teenagers, for a pregnancy test and/or abortion, for a sterilization). As noted, there was considerable overlap in use: of those who reported sources of birth control within the last two years, 27% used both a private doctor/HMO *and* some kind of clinic. Though the majority of these adult women are not receiving general reproductive health care from family planning clinics, they do turn to clinics with some frequency for particular needs.

There were some clear racial/ethnic in the patterns of care. Spanish-speaking Latinas were much less likely than other groups to use private doctors/HMOs (11% versus 42-59%) and the most likely to use family planning clinics (Table 11). African American women were by far the least likely to use family planning clinics (even for supplies), and indeed, several spoke disparagingly of such services in the focus groups. These patterns differ somewhat from national data, in which African American women are disproportionately represented among clinic users (Mosher and Pratt, 1990), but are consistent with at least one southern California study, which found Latinas to rely more than other groups on subsidized clinics (Radecki and Bernstein, 1989). At least one possible explanation for our findings is the language issue: it may be that Spanish-speaking women more readily find bilingual staff members in clinics than in private doctors offices.<sup>5</sup>

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<sup>5</sup>Radecki and Bernstein offered as their explanation the lower rates of insurance (public or private) among Latinas.

There was also an apparent geographic difference in the patterns of care reported in focus group discussions, but it is difficult to establish with the numerical data because the geographic difference is overwhelmed by the racial/ethnic difference (and there was a relationship between race/ethnicity and geography in the study). Specifically, focus group discussions suggested that women residing in the Central Valley (Stockton area), regardless of race/ethnicity were somewhat more likely than those residing elsewhere (other than Spanish-speakers in Los Angeles) to use family planning clinics. We would hypothesize that there is heavier use of clinics in the Central Valley because of the more limited choices available to these women, but the questionnaire data reported on Table 12 show that clinic use is equally heavy in Los Angeles—perhaps because of the predominance of Spanish-speaking Latinas in this location.

Though some women liked the services at family planning clinics and others thought it was absolutely critical that such clinics be available (especially for teenagers), many women expressed strong preferences for receiving family planning in the context of other medical services, with a single provider who knows their health history and their circumstances. As a black woman explained, “I prefer havin’ my own personal doctor I can call on the phone . . . they know me. . . . I feel more comfortable . . . I don’t have a problem in there talkin’ to them about *anything*.” Asked what clinic should be doing differently, one Latina woman responded, “I think that they should just have one doctor. . . . You don’t want to be seen by different doctors. That’s why I went to my private doctor.” These findings are quite consistent with other research, in which women across income categories and races have been found to prefer private physicians to family planning clinics as a source of family planning services (Silverman, Torres and Forrest, 1987; Sonenstein, et al., 1995; Radecki and Bernstein, 1989), though it should be noted that those using clinics often have a higher opinion of the service than nonusers (Silverman, Torres and Forrest, 1987). Women in general also seem to prefer receiving reproductive health care in a setting that also provides general health care (Sonenstein, et al., 1995). A related finding from other work is that countries in which family planning services are integrated into general health care tend to have lower rates of teen pregnancy (AGI, cited in IOM, 1995).

### **Sources of Care for Teens**

Based on data collected from the questionnaires, teenage participants had used a variety of sources for their birth control methods and supplies in the previous two years: 50% had relied on a clinic/hospital; 39% on their partners partner; 35% on family planning clinics; 24% on friends/family; 22% on drug stores or grocery stores; and 19% on private doctor/HMO (Table 13). Three of the 54 teenagers (6%) indicated that they had never used birth control.

There were substantial ethnic differences in the sites where this sample was most likely to seek contraceptive care. Responses also appeared to be affected by the site where the focus groups were held. For example, in one African American group held in Oakland, all participants obtained services from a local health center from which they also obtained other services. Overall, African Americans in the two Oakland groups were most likely to obtain supplies and services at a clinic or hospital (73%), friends or family (45%), or family planning clinic (41%) (Note that respondents could offer more than one site where they received care or where they had access to contraceptive supplies). The sources most utilized by the white participants were their partner (53%), clinic or hospital (42%), or private doctor/HMO (37%). Latina participants were most likely to get supplies from the store or a family planning clinic (31% each) or clinic/hospital or partner (23% each). None of the Latinas obtained birth control from a friend or family member.

### **Importance of Regular Gyn Care**

The respondents all felt that it was very important to obtain regular reproductive health care, including pelvic exams, pap smears, and breast exams, though they differed in their estimates of how frequent exams needed to be (1-2 years). With few exceptions, they disapproved of the idea of offering prescription methods of birth control without a full gynecological exam, though a few woman acknowledged that more teenagers might obtain birth control if the exam were not required. Asked if they would prefer to receive family planning methods without an exam, only 11% said yes; 69% said no (Table 11). Consistent with their beliefs, almost all of them also reported receiving regular gynecological care: 66% reported having had a check-up within the last 12 months, and 81% had done so within the last two years

(Table 11). These findings held across racial/ethnic groups with one exception: Spanish-speaking Latinas were more likely than other groups to report that their last check-up was more than two years ago.

### **Teen Feelings about Regular Gyn Care**

It is often thought that requiring a full medical and pelvic exam may serve as a barrier for teenagers obtaining birth control. Teen participants were asked if they felt teenagers in general would prefer to get the pill or shot without a full medical and pelvic exam. Few respondents (19%) thought that other teenagers would want the exam (Table 14). They were either unsure regarding what others would prefer (40%), thought that teens did not care (9%), or felt that most teenagers would like to get the pill or shot without the pelvic exam (32%). However, when asked what they would prefer for *themselves*, 65% did indicate that they wanted a full exam. This trend crossed ethnic groups. Thus, these women have been educated as to the health benefits of a full physical exam and pap smear. This belief was especially predominant in the African-American discussion groups. While everyone stated their dislike of the pelvic exam, they felt it was very important for their health and did return for their annual exams. In one group, participants were suggesting to one participant who does not receive an annual exam that she do so for her health. Thus, while a full medical exam may be a barrier initially for some adolescents, it should not be assumed that it would prevent teenagers from obtaining care. In fact, 87% of participants had had a gynecological check up (exam and Pap smear) within the last twelve months, most of those having been done within the last six months.

### **Communication Issues**

For the most part, women didn't report having difficulties talking to primary care providers about birth control or family planning; of those who reported the date of their last gynecological check-up, 80% said that the doctor or nurse at that visit had discussed family planning or provided them with birth control supplies. The percentages did not vary significantly by racial/ethnic group. Note that the question did not specify which party initiated the discussion of birth control, so many of these could have been patient-initiated conversations.

Occasionally women would report an unsatisfactory relationship with a provider who was perfunctory or uninterested. This lack of attention was usually a general attribute of the provider, but some women reported a sense that their providers didn't take their suspicions of birth control side effects seriously. In cases where a woman was unsatisfied, the general feeling was that the woman should seek another provider, not necessarily look for care from specialists such as family planning providers (in fact, family planning providers were sometimes seen also as dismissive of women's worries about birth control safety). Elsewhere (Silberman and Hamilton, 1994), Latinas have expressed reticence or difficulty in raising concerns with providers, but the women in our groups did not generally do so.

Most women did not describe their providers as taking a proactive role in birth control education, and they seemed to have mixed feelings about this. Some women thought it was good when providers raised the question of birth control, but others thought it was unnecessary, even intrusive, and should be up to the woman. When asked if providers raised the subject of birth control, one black woman said she had never run across a doctor that did so, but her comment suggested she didn't think it should be up to the physician: "I think that there are other issues that are raised by even answerin' that [focus group] question, because then you're puttin' the responsibility of your own birth control onto whether the doctor mentions it or not . . ."

There was also a sense that some providers were critical of low-income women having children (teens expressed this also), and women didn't necessarily want to have birth control discussions with a provider who wasn't interested in their own (the client's) well-being. An African American woman stated that her "biggest criticism of the birth control industry is the amount of down-talking that they do to a lot of the ladies . . . If I'm comin' to you to ask about somethin' that is goin' on in my life, that is openin' up a level of vulnerability that is not present in most situations. . . . They wanta know what you use, what you don't use, . . . how many partners . . . how many times you been pregnant . . . you got to lay your life down." This kind of complaint might be directed at a clinic, at a private doctor's staff, at the staff at Kaiser; it wasn't limited to a particular kind of provider, but it was indicative of women's feelings that they don't want to hear about birth control from someone they feel doesn't know them, respect them, or care about them as individuals.

### **Too Much Information, Not Enough Answers**

Some women complained that their providers did not give adequate time and attention to their concerns, and when they did get information--printed materials, for example--it was not necessarily relevant to them. Many women seemed to feel that they were not adequately informed, but they were not looking so much for generic birth control lectures, as for family planning information *in the context* of their specific health and social concerns. In other words, they wanted information or education contingent on their own needs.

Other work has found that information on birth control is more likely to be provided in clinics than in HMO and private physician offices (Radecki and Bernstein, 1989), and some women seemed to appreciate *the idea* that a lot of information was available at family planning clinics and that the staffs generally seemed concerned with giving clients plenty of information, but it wasn't clear that this informing was relevant to their own decision-making, and sometimes it may have felt intrusive. As one white woman said, "Yeah, when they see somebody in there having an abortion, they think, 'Ahh, I got another stupid guinea pig,' and they just overwhelmed you with stuff." Some women insisted information should be "optional . . . [not] pushed down anybody's throat," but others thought it was good that providers take a more proactive stance: "I think they should tell you, no matter what. What if you're too shy, to even ask?" (Both of these comments were from white women.)

A not uncommon sentiment was that proactive information-giving might be appropriate for some women and in particular, for teenagers, but it could be resented by older women. In response to a question about the Welfare office giving out family planning information, a Latina woman noted, "I think they should for the . . . little girls that are having babies. For the 12, 13, 14, 15 year old girls that are too embarrassed to actually go down to a clinic. I think it's good for them. But I think that if the older women don't want it, it shouldn't be pushed on 'em."

### **Communication Between Providers and Teenagers**

As noted above, 87% of the teen participants had had a gynecological exam within the last year. In two-thirds of those visits (67%), the provider discussed family planning or provided them with birth control supplies. However, whether the provider discussed family planning did

vary dramatically by ethnicity: among African-Americans, the figure was 90%; among whites, 56%; and among Latinas, 42% (African Americans did report more use of clinics--of all sorts--than did the other groups, though in some categories, the differences were small--see Table 13).

There was a great deal of variation in the quality of the counseling that took place. Some family planning counselors were described as being very comfortable to talk to, while others did not leave enough time to answer questions or determine what the participant wanted.

Participants in all groups reported that their prenatal care providers did ask them what method of contraception they plan to use after their baby is (was) born. In the three counties, it appeared that the bridge between prenatal care and post-natal contraceptive visits were well established. However, there appeared to be little focus on use of birth control before first conception.

### **Sources of Information about Family Planning and the Role of the AFDC Office**

Women learned of their medical providers (family planning and general health care) through friends and family members, referrals from other providers, the yellow pages, and sometimes written referral information obtained from the AFDC office. Some women recalled having checked the item on the application form to request family planning and other information, and most of these women remembered receiving materials in the mail, which a few women used. They felt that written referral lists could be of use, provided the information was up-to-date (many times it was not) and that it addressed the specific needs the woman had at that time. Most women complained of inadequate information about services and resources available, but they referred primarily not so much to family planning as to other programs, such as the Child Health and Disability Prevention program (CHDP), child care resources and Medi-Cal options.

Most women thought the AFDC office could usefully provide written information (through the mail with checks perhaps, in the waiting room, or perhaps handed out by workers *without* advice) or videos (in the waiting room) on family planning as well as other services of interest, but that the material shouldn't be shoved down women's throats. (However, some women specifically mentioned tossing out whatever they received from AFDC unless it was a check or pertained to the check.) A number of women thought that the time of application was

*not* a good time to give women any extraneous information.

Almost unanimously, though, the women had no interest in hearing about family planning in conversation with their eligibility workers. They felt workers had enough to do already, and shouldn't be concerning themselves with more of the clients' personal business. A black woman observed, "I'm down on them on that, because I don't necessarily feel that that's their job to do that, you know . . . that's not what they're there for." Many told stories of unpleasant encounters with the AFDC office and hostile feelings with workers. A white woman said, ". . . it's like the money's comin' out of her pocket . . ." A Latina woman said they did talk about family planning, "Especially on the renewals. If you get the real nasty workers, they'll get on your case about it. [About family planning?] Oh, yes, they think they know everything. . . . For the women that need it, need to be punched, sorta like, with it, fine. But these workers are pretty bad. . . . Because they're really rude about it." Another, Spanish-speaking Latina expressed similar sentiments: "The workers call you in a contemptuous manner . . . and treat you as if they were detectives. Their demeaning attitude, arrogance, and lack of respect makes you feel like a roach. They lower your self-esteem." ("Las trabajadoras lo llaman a uno despectivamente . . . y me trataban como que eran detectives y su actitud, arrogancia, y menosprecio lo hacen sentir a uno como una cucaracha. Le bajan a uno el estima.")

Some women expressed less negative or even positive sentiments about their workers, and a few thought it would be appropriate for eligibility workers to discuss family planning with their clients, though it should be at the client's request. But the overwhelming majority didn't want to see AFDC workers involved in this matter, other than perhaps in offering written information without comment.

### **Sources of Information Among Teens**

Teen awareness of services varied somewhat by group and location. For example, African American teens in urban areas were aware of and had access to family planning services. They reported finding out about providers from friends, school newspapers, and/or mothers. By contrast, white participants in a semi-rural area reported difficulty locating accessible services; (whites in an urban area did not have these problems). Latina teens were more reticent in their

discussions of their experiences in seeking family planning services. As will be noted again below, teens were also opposed to the provision of birth control information by AFDC caseworkers.

### **Obstacles, Pressures, Discouragement**

As noted, very few respondents expressed much in the way of serious obstacles to obtaining desired birth control. Most complaints had to do with occasional, apparently idiosyncratic difficulties with a particular provider, such as a woman who wanted to get on the pill but the doctor she was seeing--for a non-Gyn problem--wanted her to see a gynecologist and she didn't have one; he wouldn't write the prescription and told her to stop having sex. Sometimes women were refused a desired birth control method because a provider felt there were medical contraindications (e.g., smoking and being over age 35 in the case of one pill user), and as previously mentioned, several women had been denied tubal ligations when they requested them at an early age (regardless of the number of children they had).

Cost was not generally an issue because of Medi-Cal coverage, but there were circumstances in which it came up as a problem, primarily for women who were using condoms and had not been able to get them for free. In most cases these were women being seen by private physicians but one clinic user reported a serious difficulty in this regard:

I'm on a county program where they pay for you to go the clinic and pay for your prescriptions and stuff, and I told her I wanted another prescription for condoms and foam. They wouldn't give it to me. She says, "Oh well, you can just go buy that over the counter." I says, "Yeah, but it starts gettin expensive, to go and buy them over the counter," and she says, "Oh, well, then we'll have to go through all the paperwork and all that and it's just a long process," and she says, "You can just go buy those over the counter." That's what she told me. And this was just recently. . . . it made me mad, is what it did. You know, because I'm tryin to *prevent* another pregnancy, you know, and she's . . . Who is she to say that?

There were some reports of pressure to choose certain methods over others: one woman felt she'd been discouraged from using the diaphragm (told more about its disadvantages than advantages) and another said her doctor had "tried to push the pill off on me" despite her interest

in using rhythm in combination with foam and condoms. Even among women who hadn't felt pressured, there was a sense that the Pill was often the providers' preference, the first thing they told a woman about, and in a few cases "the only thing that was offered." Latina women in a southern California focus group study (Silberman and Hamilton, 1994) had very similar complaints, and other researchers have remarked that limited medical school training in contraceptive methods may decrease options actually available to women (IOM, 1995; Stewart, 1995).

### **Teen Reports of Pressures**

Some participants felt pressured by their family planning provider to use the birth control pill, even when that was not their preferred method of choice. Some said they had not used supplies they were given (e.g. pill, foam, film). Some were also talked out of selecting Norplant and were steered to using Depo-Provera. One participant had been very upset that her provider had not shared all the pros and cons of using the shot. She had learned more about it when reading some other materials and had found out about the potential side effects, including risk of breast cancer. She planned to stop using the method and was planning to rely on condoms. She was particularly frustrated that the provider had not been more up front about these potential risks. The only method that has been denied to participants has been sterilization (raised by African-American adolescents only).

### **Likes and Dislikes About Services**

Descriptions of what women did and did not like about services were consistent with what has been reported elsewhere (Silverman, Torres, Forrest, 1987; Sonenstein, et al., 1995) with comments often focusing on clinician characteristics and women tending to favor private practices. Personal attention, sensitivity, and competence on the part of the provider are all highly valued, and the importance of personalized care can hardly be overstated (this has been found elsewhere; see Silverman and Torres, 1987). Women appreciated providers who took time to listen and talk to them, who were familiar with them and their families, who provided what feel like personalized service. As noted, seeing the same provider consistently is quite desirable,

and some women who otherwise liked the services at clinics thought it was a serious drawback not to see the same clinician each time (a few women were not bothered by this). Once women found a provider they liked and trusted, they would stay with that provider for many years, sometimes even if other aspects of the service--such as location--were inconvenient. Other research has found a strong preference for private physicians based primarily on two factors: clinician continuity and a perception of higher quality of care (Sonenstein, et al., 1995; Silverman, Torres and Forrest, 1987; Radecki and Bernstein, 1989).

Many but not all women had a preference--in some cases, quite strong--for female clinicians, including nurse practitioners in private practices. Those who preferred women were not only more comfortable with female providers but thought they provided care that was more attuned to a woman patient's needs. "It's a lot better havin' a female than havin' a male because she does know what you're going through," said one white woman. "She's been there," agreed another. Nurse practitioners in particular were sometimes felt to be more accessible to patients, to be less rushed and more sensitive than are doctors.

Women sometimes felt that they were looked down upon or poorly treated because of their low-income status and Medi-Cal insurance. They appreciated doctors' offices and clinics where they didn't sense this kind of disapproval or distinction. Women also objected to being judged on the basis of their reproductive choices--whether it was to have a baby or use a particular kind of birth control or be sexually active as a teenager. One woman made a particular point of praising the local Planned Parenthood for its supportive, nonjudgmental environment.

One of the primary advantages of clinics in theory is their low cost, but this was not cited as an advantage by these women, presumably because most of them were Medi-Cal recipients (though a few had no coverage). Cost concerns--for either low-cost services or Medi-Cal acceptance--tended to be expressed as a constraint that had to be met rather than an "advantage" of particular providers; in other words, if women could afford it, many would not choose to go to clinics but would use private physicians. Occasionally women reported using private physicians for most of their medical needs, but going to a family planning clinic for inexpensive supplies.

Long waits are a problem, particularly with some clinics and public hospitals. A black woman who had gone to Planned Parenthood for many years found that when she switched to a

different clinic location (still PP) the wait was so intolerable she quit going. “I make a eleven o’clock appointment because that’s the middle of the day, I don’t have to worry about the kids and stuff, and I’m still there at 2?! For a Depo shot?! I don’t think so. And I’ve been a customer for like 20 years. So I stopped . . . [and found another provider].” Some women also acknowledged that this could be a problem in private doctors’ offices as well as in clinics.

In some other research, women have been found to believe that the quality of care is higher in private doctor’s offices than in clinics (Silverman, Torres, and Forrest, 1987; Sonenstein, et al., 1995), particularly in terms of provider competence. This viewpoint was not openly expressed in most focus groups (and preferences for private physicians were generally based on other factors), but there was one focus group in which a number of Latina women complained that their local family planning clinic made “a lot of mistakes.” These women seemed to like the staff well enough, but they told stories about inaccurate results on pregnancy tests, Pap smears, and STD screening. One woman who used the clinic for supplies said, “when I have problems, bleeding or something, then I go back up to him [my private doctor].”

Convenient locations and the ability to get an appointment readily are also important, though they rarely override other concerns (such as clinician characteristics). It should be noted that in a recent poll of Medi-Cal recipients (Harris, 1994), it was found that patients of HMOs were likely to have longer waits for “routine” appointments (as opposed to treatment of illness or injury) than those in either fee-for-service or primary care/case management plans; the two-week or longer wait for HMO appointments could be a significant barrier for women seeking family planning. Among other facility characteristics, cleanliness was a concern expressed by some clinic users--one community clinic was described as overcrowded and as a result, unsanitary; a woman who was pleased with the local Planned Parenthood described it as clean with a nice staff. Lack of child care and transportation difficulties were mentioned by a few women as problems with providers.

### **Teen Feelings and Experiences of Service**

The African-American groups (located in urban areas) did not encounter obstacles of cost, location, transportation, or knowing where to go. In one group, all participants received

their services from a convenient community health center where they had received comprehensive care throughout their lives. They were extremely positive about the care they received, except for long waits. However, several respondents shared that there was one provider who worked there that was not respectful and that they had quickly changed providers. In spite of the fact that the clinic was readily available and financially accessible, few indicated that they had used the clinic for family planning services before they experienced their first pregnancy. Other African-American adolescents were currently obtaining family planning services from a variety of providers, all of whom they felt had good reputations.

These adolescents tended to shop around until they found a provider they liked. They often reported that they had found out about the family planning providers from friends, the school newspaper, and/or their mothers. Several of the respondents expressed an interest in having family planning services as part of the general medical care they receive, although a smaller number indicated that they had also relied on Planned Parenthood at some point in their search for contraceptive services. The most frequent complaint across all groups was the long wait in getting services. Other participants knew where they or their boyfriends could obtain condoms for free and the wait was limited. Some participants shared that they did have a problem obtaining pregnancy tests due to their concerns of confidentiality, the amount the clinics charged to do the test, limited time periods in which the clinics offered pregnancy tests, and the relatively long wait to get the test done.

When Latina participants were asked about where they got family planning services, few mentioned the specific details that they had checked off in their written questionnaire. Several indicated that they did not seek contraceptive services because their partners were concerned that birth control would harm them. These questions appeared to be particularly sensitive to share verbally in the group. In the second Latina focus group, a number expressed that they wanted to have more information from their providers on pregnancy, labor and delivery, and use of family planning methods. They also wanted to know what to expect as part of their family planning visit, as well as their pre-natal care visit. They also wanted to have a greater sense of continuity in their provider of care as many were upset that they had to see a different provider each time they received care. Continuity as a means of creating a relationship with their provider appeared

to be an important service quality they would have preferred. This was especially apparent in the area of prenatal care where the participant was surprised to find out that the doctor who had provided prenatal care was not necessarily the physician to deliver the baby. It should be noted that adolescents across all groups consistently expressed a preference for the provision of family planning services integrated with other services.

White adolescents who participated in the focus group in a semi-rural area indicated that they had greater difficulty finding affordable birth control services. In fact, one participant reported that she might not have been pregnant if birth control had been more available. They also had problems with nurses treating them badly when they were pregnant. Two reported being pressured to have an abortion or to relinquish the baby for adoption. In contrast, adolescents living in an urban area indicated that they had not experienced any difficulty in receiving care. They appeared to be knowledgeable about where they could receive supplies and services. Other factors appeared to have interfered with their contraceptive compliance, including a concern about their own fertility and the lack of cooperation of their partners.

A common experience across all the groups was that of being treated with disrespect by providers or their staff, particularly when the patient was pregnant. One participant felt that she was treated differently at her HMO because she was a teenager. Another cited being put on hold on the telephone for an extended period of time. A few participants in one group had had bad experiences with one of the doctors at a particular clinic. There were mentions of staff being rude, judgmental, or seemingly trying to make the teen feel bad with comments such as "Are you sure you're not trying to get pregnant?" when their previous pregnancy tests had been negative. Several of the participants across ethnic groups shared that they felt that they were physically being treated roughly and with little consideration for their feelings especially when undergoing the physical exam. One African-American participant shared that a physician chiding her regarding her reluctance to having a pelvic exam had said that she had had "sexual relations with someone larger than the speculum" being used in the exam.

## **SUGGESTIONS FOR IMPROVING INFORMATION, EDUCATION, AND SERVICES**

Many ideas for enhancing services and improving information can be drawn from the reported experiences and attitudes of the focus group participants, as summarized above. In addition, participants were given an opportunity to offer their own suggestions as to how to services, information, and education might be improved. This discussion began with the question “What does ‘family planning’ mean to you?”--an attempt to elicit women’s reactions to the phrase and their sense of the scope of services that could be or should be included. They were then asked about what they thought should be done in the way of service improvements, better family planning education and social marketing.

Consistent with other research, those in both teen and adult groups highlighted the importance of continuity of care and a sense of personalized, high-quality service, and they preferred to receive family planning in the context of other services. Teens placed a higher emphasis than did adult women on transportation and cost issues, and also expressed a more unanimous preference for female clinicians. There were also interesting differences in the two groups’ understanding of the term “family planning”--with adult women associated it strongly (sometimes negatively so) with birth control/pregnancy prevention and teens being unclear as to its meaning.

### **The Meaning of “Family Planning”**

To many adult women, the phrase “family planning” is narrowly construed to mean “birth control,” and the services associated with family planning providers were usually limited to birth control, pregnancy testing, and perhaps abortion; a few respondents mentioned general gyn exams, pap smears, and STD testing/treatment, but almost no one cited prenatal care or obstetrics. Some women, Latinas in particular, thought of family planning clinics as places one could go for expert advice and assistance with contraceptive decision-making (though it wasn’t clear from their previous comments that they had necessarily used clinics in this way). A few women associated the term with services for teenagers, or prevention of teen pregnancy.

It was clear from the responses to this question that most women understood that the term “family planning” commonly refers to pregnancy prevention, and it was also clear that many of

these women saw this is a narrow, controlling, and/or nonsensical interpretation of the words themselves. It means “people telling me what to do,” said one white woman. Another claimed that it made no sense to refer to birth control services as “family planning” because taking the Pill was not at all the same thing as “planning a family.”

In many ways--their preference for reproductive health services in the context of other medical care, their interest in realistic family life education as well as birth control information, and their emphasis on the need to involve partners in decision-making--these women argued for a broader understanding of “family planning” accompanied by a broader, more integrated range of services. As one white woman explained, it should mean *starting* with birth control, but then helping a woman to get pregnant when she wants to.

### **Teen Responses to the Term “Family Planning Services”**

Teen participants were asked what the term “family planning services” meant to them. The majority of adolescents did not have a clear understanding of what it referred to when they first heard the term. Many thought it was how to plan a family. Thus some perceived that these services did not apply to them because they were not ready to plan to have a baby. One group did understand the spacing component: “planning on how to have and space children.” This group in particular had a very comprehensive view of the term including AIDS education, STD prevention and treatment services, overall sexual health, pregnancy services, and abortions. They felt that disease prevention was actually the most important component of family planning. None of the groups used words such as pregnancy prevention or birth control in their definition of family planning. Some participants identified the term with Planned Parenthood and others were not able to describe what family planning services were.

### **Service Improvements**

Focus group participants were asked how family planning services should be improved, what would make them more appealing and accessible. They were also asked for their opinions on certain possible alternatives. In some cases, “improvements” simply translated to important qualities of service--that is, qualities already found in some providers, but of sufficient

importance that all providers should strive for them.

Consistent with previous comments, there was an emphasis on the need for sensitive, considerate, respectful staff members--mentioned most often by African American women, but also by other groups. Some women in all groups wanted female practitioners, and African American women also mentioned a desire for more explanation of procedures by the clinician and in a few cases, a provider of the same race. White women noted the need for cleaner, more attractive locations, and all groups wanted shorter waiting times. In terms of convenience, there was some call for acceptance of drop-in appointments, longer hours, more locations and more convenient locations (i.e., located near transportation and other services such as WIC), and the ability to call in for prescription refills (as at a pharmacy). Assistance with transportation was important to some women, as was child care (mentioned primarily by African American and Spanish-speaking Latina women). Spanish-speaking women noted the need for bilingual staff members and for information in other than written form.

### **Teen Thoughts About Service Improvements**

Teen groups came up with a number of possible service improvements, in some cases independently and in some cases in response to facilitator prompts.

There was almost universally expressed sentiment that they would prefer that family planning services be integrated with other health services, rather than being provided by a separate, stand-alone practitioner. Like the adult women, they suggested that staff be more positive, provide good advice, and not be judgmental. Some African American participants were especially bonded with one health educator (a white woman) who had a special accepting attitude towards them and who appeared to truly care about the young women. Some liked the idea of some positions being staff by people their own age, though others were concerned about the level of confidentiality that might not occur if adolescents who worked in clinics were too young or immature. In the monolingual Latina group, some preferred that the provider be able to speak Spanish as well. They felt that the language capability provided an additional level of communication not available to them when they had to communicate in English. However, for the other Latina group the language of the provider was of no consequence.

In terms of clinician characteristics, nearly all preferred that the examining physician or nurse be female because they know what it is like to have a physical exam. In one group, several Latina respondents felt it was important that the provider be married. This reflected the opinion of their partners who were concerned about their partners being examined by a male doctor or a female who might be lesbian. With respect to qualifications, some participants very specifically expressed a preference for a doctor over a nurse, although issues of gender were far more important.

Cost, transportation, and child care were also highlighted. Several of the teen groups said that the one thing that would make getting family planning easier would be if services were offered free of charge (not all of these young women were on Medi-Cal consistently). All of the groups felt that assistance with transportation, particularly taxi vouchers, would be helpful. And most would like to see child care provided at the clinic site. The exception here was one Latina group and several white adolescents who expressed that they would not feel comfortable leaving their child with a stranger - they would rather arrange for a relative to care for their child.

Opinions were mixed on the issue of drop-in clinics versus having appointment times. Some felt that if visits were on a drop-in basis, they would wait longer than if they had a specific appointment time. However, some enjoyed the ease and flexibility of drop-in situations. Finally, a few participants mentioned that their boyfriend usually accompanies them to visits. For them, it is important that the partner be encouraged and involved in the discussion and in the medical appointment. For the Latina group, the presence of their partner appeared to also serve as a chaperone.

### **Better Education and Wider Availability of Information**

Adult women felt a need for better education--of themselves, of younger women, and of men--not just on birth control and reproduction, but on sexually transmitted diseases, substance abuse, child and sexual abuse, family life and child rearing, and life opportunities for study and work. Teenagers should be told not only about birth control, but about what happens in family planning clinics. They would like to see schools do more sex education and family life education, but would also like to have more opportunities for adult and family classes. They feel

a need for better sources of information to answer specific questions and concerns; some women suggested the possibility of an 800 number that could be called with specific questions about such things as birth control methods and sexually transmitted diseases.

Many women argued strongly that family planning information should be *everywhere*--as prominent as beer ads, said one Latina woman. Information on services should be available in markets, malls, libraries, AFDC and WIC offices, high schools (some said junior highs), video game centers, colleges, gyms, pharmacies, dental offices, hospitals, bus and train stations, and churches (mentioned by African American women). (Note, however, as explained above, that respondents were largely opposed to the involvement of AFDC *workers* in the discussion of family planning with clients.) Written hand-outs should be widely disseminated (and some said, mailed to AFDC recipients), but material should also be available on video--for example, educational videos for parents and teenagers, available at no cost in video stores. Referral information should provide maps and detailed information on transportation options (e.g., bus routes).

Information as well as social marketing (see below) should be located on TV and radio (including Spanish language media) as well as in major magazines and on popular products (e.g., romance novels and feminine hygiene products if women are the audience).

### **Reaching Teens with Family Planning Information**

Teen groups had a number of comments and suggestions about possible ways to reach adolescents with family planning information.

As noted above, almost none of the participants felt that birth control information should be provided by AFDC caseworkers. They did not like spending time in these offices and their relationships with caseworkers tended to be extremely negative. Information made available through the AFDC office, such as posters and brochures, were often not read. There were strong feelings that family planning services be kept quite separate from this site. In terms of the use of pamphlets in general, a few groups mentioned that used alone, these are not a good way to convey data because people generally throw them away. However, some expressed the opinion that some information--for example, on sexually transmitted diseases--might be usefully

presented in this way. It was clear that if this channel of communication was going to be used, pamphlets needed to be especially attractive or distinct.

In terms of where to reach teens, schools were thought to be a good source for providing information and services. A few participants had had very positive experiences with school-based clinics and cited that the clinic offered care in a convenient and non-judgmental or threatening manner. One participant felt that placing condom vending machines in schools would prevent the embarrassment of purchasing them in stores. The groups were somewhat divided on the idea of providing information over the radio. Some said that because they listen to radio for the music, they didn't think that would be a good source of information. However, one of the Latino groups suggested that Spanish language stations may be a good way to provide information to a broad audience.

Some acknowledged receiving information from television, though one group mentioned that most of these advertisements were about safe sex and condom use. Participants in one group were critical of "funny" messages, much preferring information to be conveyed in a serious or straightforward manner. In apparent contrast to the adult women, they felt that commercials that implied that young women should not have sex if their partners refused to use condoms were highly unrealistic. Participants in one group suggested that the State Department of Health should have a television show that answered people's questions about birth control, as well as showing different methods of birth control and how to use them. Interestingly, these groups were highly critical of television and movies showing people having sex yet without concern about preventing sexually transmitted diseases or pregnancy.

Teens also felt that parents would benefit from information on talking with their teenagers about family planning issues. However, there appeared to be some ambivalence in this regard in some of the African-American respondents. They felt that their parents, especially their mothers, had placed a great deal of pressure on using birth control to prevent the first pregnancy, but that they were not ready to listen to their parents. For many of the Latina participants, creating lines of communication with their parents in this area appeared to be particularly challenging, as the topic was seen as particularly taboo.

*The Message.* Teens suggested that messages that should be conveyed in a state-

sponsored information campaign include the following: 1) Teenagers can obtain services for free; 2) services are confidential, 3) services do not require parents' permission; 4) additional information on the risk of getting pregnant; and 5) information on methods and their side effects.

### **Social Marketing: A Message of Responsibility and Conscious Choice**

Adult women felt that even more important than increasing awareness of birth control, however, is a need to change attitudes and expectations, particularly among young people and among men. Some African American women felt that more birth control information will accomplish very little if we fail to challenge the increasing sense among teens that it's a *good* thing for them to have babies. These women would like to see social messages to young people that say, "You don't have to have sex. It's cool not to." And "you do not have to get pregnant."

In all discussion of family planning and childbearing, there needs to be more emphasis on couples or relationships and on male involvement. Visual images should include men as well as women, and a message of male responsibility (including the requirement of child support) should be conveyed. But the social marketing campaign should be a positive one, with an emphasis on good role models, positive incentives, and responsible adult images, rather than threats or preaching.

Among teens, though, as noted above, there was more emphasis on family planning information than on social messages. Teens also expressed some skepticism about the effectiveness of social marketing campaigns to change behavior and attitudes. In particular, it was suggested by one of the Latina groups that despite public information efforts, the state cannot change peoples' minds regarding use of family planning. One message that could be conveyed, though, is that if you have children, you need to be prepared to raise them and to consider both the economic costs and time that they require.

## **SECTION IV: IMPLICATIONS FOR POLICY**

This section opens with a discussion of the possible role of an informational campaign or a social marketing campaign that deals with family planning. It then turns to service delivery, including the transition to Medi-Cal managed care, and to the role of AFDC policy and staff.

### **SOCIAL MARKETING AND INFORMATIONAL CAMPAIGNS**

One goal of this research project was to explain why relatively few Medi-Cal recipients use family planning services--that is, why only 22% of the Medi-Cal respondents to the 1994 Harris survey referenced above had gone for family planning services in the preceding 12 months. It was hoped that an explanation of this apparently low utilization rate would suggest a way to identify underserved groups and meet their needs for reproductive health care.

#### **Reasons for the Low Utilization of Formal Family Planning Care**

While the focus group data offer rich and subtle insights into women's views about family planning services, the questionnaire data combined with the AFDC research data on sterilization permit the following thumbnail sketch. The AFDC survey indicates that just over one-quarter of women on AFDC (27%) have been contraceptively sterilized. Applying the frequencies of current methods reported in the questionnaires to the remaining 73% of non-sterilized women generates the estimates shown in Table 15. The following paragraph presents the overall distributions; readers should look at the Table to see how women in each of the four racial/ethnic groups are distributed across the four use categories of sterilization, non-prescription methods, prescription methods and non-use. (Because our questionnaire data are from a non-random sample of 86 adult focus group participants, these estimates should be considered merely suggestive of the behavior of all AFDC women.)

We would estimate, then, that about one-quarter of adult AFDC mothers (24%) are using only non-prescription methods of birth control--chiefly condoms, but also withdrawal, rhythm, or foam. About one-quarter (26%) are using a prescription method (often in conjunction with

condoms)--chiefly the Pill, but also Norplant, the IUD, the Shot or the diaphragm. These users of prescription methods are probably the respondents who in the Harris survey reported going for family planning services in the past year. In all, 50% of women reported current use of some form of birth control other than sterilization. However, there was no measure in our questionnaire of consistency of use of these methods, nor of correct use. Some of these methods demand considerable discipline on the part of the user, which may not always be present. Finally, just under one-quarter--23 women in a hundred--are not using any method.<sup>6</sup> Among this non-using group of 23 women in a hundred, 4 women are currently pregnant, 5 would be content to be pregnant, 11 women are "not having sex with men at all these days", 2 are having sex only rarely, and 1 woman thinks she cannot get pregnant. In sum, there is no single reason why women do not utilize formal family planning services. Women are roughly evenly divided into the four use categories of sterilization, prescription methods, non-prescription methods (only) and non-use.

These estimates are based on questionnaires from the adult focus groups. The picture is somewhat different for adolescents. None of the young women in our focus groups, and virtually none in the State, are protected by sterilization. The questionnaire data indicate that of the 28 non-pregnant teens in the focus groups, 18% were not using any method, half (50%) were using a prescription method (the Pill or the Shot), and 32% were using a non-prescription method, chiefly withdrawal or condoms. (Again, we had no measures of consistency of use.) Better data on birth control utilization by adolescents on AFDC will be available in September when the analyses of interviews with Cal-Learn teen parents are available.

### **Most Women Do Not See Themselves at High Risk for Pregnancy**

Any strategies to increase access or utilization must recognize that most women do not see themselves at high risk for unintended pregnancy, even though their family planning strategies are far from 100% reliable. Their strategies will in the long run lead to many unwanted pregnancies, but they are not inherently unreasonable or irresponsible strategies. A woman may

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<sup>6</sup>These numbers differ from those shown in Tables 2 and 3 because here the denominator is all women on AFDC, not solely non-sterile women as in those Tables.

use a prescription method (but, for example, not always remember to take the Pill at the same time every day); or she may rely on an over-the-counter method such as condoms (but these sometimes break and sometimes are not used); or she may use withdrawal or rhythm (but sometimes lose track of the days); or she may be sexually abstinent (most of the time). In this context, note that 42% of our adult respondents said they were not now "in a steady relationship with a man" and may have sex only rarely or unpredictably.

It is in these ways that women "take chances" (Luker, 1975) with imperfect use of birth control, but few women are--or see themselves as--heedless about the risk of pregnancy. And very few of the adult women in our focus groups indicated they were not contracepting because they wanted (or would feel okay about) another pregnancy. Any social marketing or informational campaign must take account of most women's perception that they are doing their best, and their hope that their current strategy to prevent unwanted births (whatever it is) will probably work for them.

A campaign must also speak to the diversity in contraceptive choices between racial and ethnic groups and older or younger women. The reasons for these differences between groups have to do with (among other factors) varying levels of knowledge about different birth control methods and varying perceptions of their safety and effectiveness; with partners' attitudes to birth control in general and condoms in particular; with women's tolerance for the side effects of prescription birth control; and with a shared level of trust in prescription birth control specifically and the health care system generally. Interested readers should turn to the Findings section to learn how focus group participants discussed these matters.

### **Misinformation, Uncertainty and Fear about Birth Control**

There is a great deal of misinformation and uncertainty about birth control methods among women. Substantial numbers of women of all ages and in all ethnic groups hold unwarrantedly negative ideas about birth control, if not in general, then about specific methods. However, the reasons for their inadequate or false information may differ between groups. Any campaigns intended to remedy these problems must be developed with extensive input from members of a target audience. In particular, teenagers should be involved in every aspect of

shaping a message directed at them. Several in our groups expressed irritation with "cutesy" advertising that adults seemed to think young women would like.

Many women are uncertain about the safety or effectiveness even of methods that have been around for a long time and are non-controversial. For example, between one-third and one-half of respondents in all racial/ethnic groups were unsure about the safety of female sterilization or rated it as "mostly harmful". Tables 4, 5, 7 and 8 suggest the need for a credible, appealing information campaign about birth control methods, with some broad-based releases and some targeted ones. For example, a particularly large fraction of younger and older Latinas, especially the Spanish speakers, were unsure about the safety or effectiveness of all methods.

The younger women were more forceful than older women about the need to market birth control methods, suggesting that detailed information about birth control methods and family planning clinics should be available to adolescents in a variety of formats (in school, in television shows) and that there should be condom vending machines in schools. Several focus groups suggested an advertisement directed at teenagers explaining what happens to you when you go to a family planning clinic. Indeed, the younger women had more anxiety than older women about many aspects of birth control. Sometimes their fears stemmed from first-hand experiences, but at other times were based only on third-hand reports and rumors.

However, the focus group conversations suggest that there might be little scope for persuasion or information around use of the Pill, at least where older women are concerned. Adult women's views about the Pill tended to be grounded in first-hand or close-to-hand experiences. Even the common (but theoretically inaccurate) perception that the Pill is only "somewhat effective" or "not effective" was reflected in women's frequent references to their own or friends' experiences of becoming pregnant while on the Pill. A method that requires a woman to take it every day at the same time is, apparently, not very effective in the real world, whatever its laboratory effectiveness.

## **Messages About Choice and Access in Reproductive Health Care**

Broad dissemination of accurate information about birth control methods would surely serve a valuable social purpose, and not only for low-income women. However, it is not a panacea, for people absorb very little of the information they encounter every day (unless it is useful in the moment, or repeated very often). A social marketing campaign might, in addition to providing specific information about methods, also convey the message that women can and should make choices about their birth control method and about the clinician who provides it. The public has become increasingly sophisticated and demanding in its expectations for health care; the Office of Family Planning could usefully encourage a consumers' rights movement in family planning. The message might be, "It's your body, and your choice to have children: there are many safe and effective birth control choices available to you, perhaps more than you know; you have the right to accurate information and sensitive care, and here is where to get it."

Along the same lines, women of all ages highly value preventive care such as cancer screening and routinely seek it out. A campaign pointing out that family planning clinics provide general reproductive health care as well as contraception might bring more clients to those locales, with the side benefit of increasing their awareness and perhaps use of birth control methods.

Finally, the marketing campaign for family planning services must be sensitive to the stigma that most women on AFDC have felt from the larger society around their own childbearing. Family planning must not be seen as anti-children or anti-family. Clinics could offer women help in choosing when to have children, in preparing for pregnancy and even in actually getting pregnant. They could market services for couples rather than for women alone; they might offer mother-daughter nights for parents of teenagers. A pro-family message can be developed that would not also seem to encourage teenagers to start families at a young age.

## **Concerns About Teenage Sex**

Adolescents and adults need different types of information and have different concerns. There was a perception among our informants that many teens (but not group participants themselves) did not know they could get, nor how to get, confidential, free birth control without

parental consent. They recommended an informational campaign for teenagers describing where to go for free confidential service and explaining what happens at a gynecological visit. This would be particularly important for Latina teens, many of whom tried hard to keep their sexual activity hidden from their parents.

Many of the older women said that they had not learned anything about sex and contraception from their mothers, and they wished they had. Thus, a campaign encouraging and assisting parents in talking to their children about sex, and, when appropriate, helping them to get birth control, might be useful for families where intergenerational communication about sex is still difficult.

However, a number of the young women reported that their mothers had not only talked to them about sex but taken them for family planning, yet they had become pregnant anyway. For them, sexual pressure from boys and men, peer norms that support childbearing, and an absence of appealing alternatives to early motherhood propelled them into pregnancy. A substantial investment in social, educational (for men and women) and employment programs to address these concerns is surely needed. Additionally, a campaign designed to help parents talk effectively with their children from an early age about decision-making, values and life options (as well as about sex) could be useful.

The older women (who were very worried about teenagers' sexual activity) suggested social messages directed at teens of "You don't have to have sex. It's cool not to", and "You do not have to get pregnant." Even more, they wanted messages about childrearing itself, emphasizing for teenagers how difficult and costly it is to raise a family. They realized that the consequences of early childbearing lasted throughout their young adulthood, sometimes undercutting their own opportunities for personal growth. These women had been taken by surprise on this score when they became mothers and wished younger women could somehow learn it before they became pregnant.

### **Messages to Women who Have Sex Infrequently and Unpredictably**

The majority of women on AFDC are single (42% of our respondents reported not being in an intimate relationship) and have intercourse infrequently and unpredictably. In these

circumstances few women are motivated to remain protected against pregnancy day in and day out. Rather, many women say they do not have a "current method" of birth control while others rely on non-prescription and relatively ineffective methods. This large group of intermittent users could be a particular target for a social marketing campaign. Many women have already responded to condom advertisements ("No glove, no love") but they could usefully hear other pregnancy-prevention strategies. In particular, they should be informed about post-coital options for emergency contraception (hormonal pills, emergency IUD insertion.)

### **Including Men in the Picture**

Men are conspicuously absent from most discussions about providing family planning services or stimulating demand for them. Clinicians, whether clinic staff or private doctors, tend not to think of men as family planning clients. Yet women resent and regret the lack of support they feel from men. They also resent the exclusive emphasis in the public debate on the woman's role in preventing unwanted pregnancy. A few mentioned that they thought Medi-Cal should provide family planning services to men as well as to women. (Presumably, the unmarried male partners of women on Medi-Cal are not themselves eligible for family planning services subsidized by Medi-Cal.)

A social marketing campaign directed at low-income men could offer positive images of men taking responsibility and "protecting" their partners, or of making choices to create the family they want. It might also emphasize obligations to pay child support (though this might have more credibility if California's rate of child support collection were higher). However, it would be wise to hold some focus groups with men of different races and ethnicities before developing this campaign.

### **Vehicles for Education**

The Findings section lists the range of creative suggestions that groups offered for disseminating information and persuasion about family planning. An effective campaign will require that messages be repeated often, in a variety of contexts and over a significant period of time. An additional intervention apart from outreach in various media is suggested by our

research itself. Almost all participants said that they enjoyed being in a focus group very much. Most had never had candid conversations with other women about family planning, and they said they had been informed or felt upheld in their decision-making by the group discussion. Similar peer groups discussions, facilitated by a well-liked birth control counselor, could clarify misconceptions and encourage young women in particular to find reasons and ways among themselves to increase their use of family planning.

### **General and Targeted Messages**

Some themes recurred in all racial/ethnic groups and for older and younger women. For example, no groups wanted AFDC workers asking intrusive personal questions. All adult groups acknowledged the costs of children, and most women wanted to take good care of the children they already had before having more. All groups agreed that it is important to try to plan when to have children, but that plans go awry. There was a uniformly high value placed on health care per se--perhaps a higher value than on contraception per se. As the questionnaire data indicate, uncertainty and misinformation about various birth control methods was widespread.

There were also some marked differences between groups, generally larger between older and younger women than between the different ethnic groups. We discussed above the particular needs of teenagers and will not repeat them here. Racial and ethnic differences showed up somewhat in women's choices of birth control methods, and also in the family contexts in which they made reproductive decisions. Social marketing and informational campaigns should utilize images that reflect the different models of family and social life, of male-female relationships, of health care utilization and of acculturation which characterize different communities. The Findings section of this report includes detail on these matters.

## **DELIVERING FAMILY PLANNING SERVICES**

### **Access to Services**

Virtually none of the adult women or urban teenagers had had serious difficulty getting prescription birth control when they wanted it, with the exception of sterilization for relatively young women (under 24). Nor did women complain about problems that are traditionally classed

as "access issues": cost,<sup>7</sup> limited clinic hours, inability to get an appointment, transportation, or cultural barriers. One group did suggest publicizing not only the location and hours of clinics but the bus routes that went close to them. Long waits were sometimes a problem, but could occur in private doctors' offices or clinics and for problems other than getting birth control.

Some features of teenagers' access to services are worrying, however. First, there was some indication of access problems for teenagers in San Joaquin. Second, as discussed above, younger women thought that often teenagers did not know that by enrolling in Medi-Cal they were entitled to confidential, free family planning. Thus, ignorance of their route into services may be a problem for adolescents, perhaps especially for Latina teens who are most likely to worry about their parents learning they are sexually active. Third, some teenagers had been treated disrespectfully, rudely or incompetently in family planning clinics (as had a few adults also). Respectful and caring service is especially important for teenagers, who are easily discouraged from seeking care. Occasional brief satisfaction surveys among users could identify problems and assist clinic staff in maintaining high standards of patient care.

### **Important Characteristics of Service**

Women are attentive to the health implications of prescription birth control, and want clinicians to be informed (and to inform them) about possible risks or problems. Their concerns about possible risks of methods are consistent with the high value they attach to preventive reproductive health care. They want providers whose first interest is in protecting and promoting their health, and they do not want to be condescended to or see their concerns brushed aside. Providers need to understand that "pushing the pill", something that young women in particular perceived happening, will not assure its use. On the contrary, it may result in discarded supplies and a lack of confidence in the clinician.

Women, especially older women, want to make choices about birth control-- prescription or not--in the context of their general health needs and their familial circumstances. Hence the

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<sup>7</sup>Note that most of the adult women and many of the teens were covered by Medi-Cal. Cost is more of a concern for those not covered by public insurance, even if they have private insurance (Kirkman-Liff and Kronenfeld, 1994).

widespread preference for integrating their birth control care into primary health care more generally, and the even stronger preference for continuity of care (being able to see same clinician at each visit). The value that our informants placed on high-quality care (well-informed and experienced clinicians working in a clean and professional locale), continuity of care, and access to a range of health care services, has been documented by other researchers.

The only specific feature of care that was repeatedly mentioned was the gender of the examining clinician. Young women especially had very strong preferences for a woman provider. Spanish speakers naturally preferred Spanish-speaking clinicians, and the high level of ignorance about methods among this group does suggest inadequate services available in Spanish.

### **Location of Care**

The suggestion that prescription birth control should be available without a pelvic exam in a non-clinic setting received very little support. While women were divided about what they thought *others* would want, most of them thought a full exam was necessary for themselves. The preventive care represented by a pelvic exam is a valued adjunct to receipt of birth control, not a barrier. Only 11% of adult women and 15% of adolescents said they would prefer to not get an exam when they go for birth control.

Most adult women seemed to associate their preferred features of care with private physicians rather than clinics. However, clinics could in principle offer the kind of care women want and some women utilized clinics that they loved. Our data suggest that many adult women use private physicians for their reproductive health care but turn to clinics in certain circumstances and for particular needs. More than one-third (37%) of adult women who had gone to a doctor or HMO for their most recent gynecological examination had also gone to a clinic for birth control supplies in the past two years, while one-fourth (24%) of adult women who had most recently gone to a family planning clinic for their gynecological care, had acquired birth control supplies from a doctor or HMO in the past two years.

The role that clinics play as primary sources of care for almost all teenagers, and as important (sometimes back-up) sources of supplies and care for adults, was strongly suggested by

the questionnaire data. Among our respondents, 85% of teenagers and 59% of adult women had acquired birth control supplies from a clinic in the past two years, while 49% of adult women but only 19% of teenagers had gone to a doctor or HMO. Family planning clinics are especially important sources of care in San Joaquin County (more so than in the Bay Area or Los Angeles), and among adults, they are most often used by Latina women, especially Spanish-speaking women. The apparent absence of serious access problems among our adult and teenage informants may be a direct result of the ready availability of services through clinics.

The adolescents in our study wanted to be able to see the same clinician (preferably a woman, who Latinas said should be married), and to get all their care in the same place. These wishes were met at the clinics the adolescents utilized. Most of the adult women had also gone to a family planning clinic for their first birth control supplies, and may not have enrolled with a private physician until they had a child.

These points suggest the need for vigilance as the State implements the "State-Only Plan" for family planning services, which would reduce or end direct State grants to clinics and (it is hoped) stimulate the delivery of family planning services by private physicians. As the State moves to expand the role of private physicians in service provision it should make sure that popular and efficient clinics are not forced out of business. Clinic staffs have expertise in family planning matters and knowledge and flexibility in helping women choose the most appropriate birth control. Clinics are visible institutions in many communities and they are--and will surely continue to be--a vital point of family planning access for certain groups of women (especially teenagers).

Physicians, on the other hand, often do not have much training or experience in working with a range of family planning methods (IOM, 1995; Stewart, 1995); they may favor a single method (for example, the Pill) and prescribe it exclusively. (A few women in focus groups mentioned misinformation or discouragement from doctors when they asked about methods other than the Pill.) And most teenagers do not feel they have an ongoing confidential relationship with a private physician and probably do not know how to establish one. For them, clinics are a far more comfortable location. In short, clinics currently are an important part of the service delivery infrastructure, and policies that undermine their role are likely to reduce overall access

for low-income women.

### **The Transition to Medi-Cal Managed Care**

As Medi-Cal shifts from fee-for-service to a capitated managed care system, it will be important to protect women's access to choices in family planning services. An important impetus behind managed care is to control costs and utilization, largely through concentrating primary care and gatekeeping functions in a single person or organization which faces structural incentives to keep costs low. The imperative to control costs runs directly counter to the effort to expand access to routine reproductive health care. It is likely that managed care organizations will have built into them various barriers and disincentives to full utilization of family planning services (Stewart, 1995).

Moreover, as organizations gear up rapidly to serve a new and different client base of Medi-Cal recipients, complex responsibilities such as allowing women free access to the family planning provider of their choice may be neglected. In the 1994 Harris survey referenced above, one-third of managed-care enrollees were unaware of their right to freely see family planning providers other than their primary provider (Harris, 1994). They had internalized the message that their primary provider was for most health needs their only provider, and was always the gatekeeper to other providers.

Family planning clinics, "hospital or general" clinics, and private doctors or HMOs are all now important sources of family planning and reproductive health care. It is likely that the ability women now have to select among these systems and to combine them largely explains the absence of complaints about "access" in our focus groups. However, under managed care, family planning clinics--which are particularly important for Latinas, for teenagers, and in rural areas--may lose their client base and become nonviable unless the State of California takes steps to protect them. We highlight two specific areas that should receive attention from policy makers as the transition proceeds (see Rosenbaum, et al., 1995).

First, managed care plans must be pushed to include family planning clinics as providers of gynecological services. Without a forceful State requirement and accompanying technical assistance, managed care plans will have little inherent incentive to do so. Technical assistance

could be useful in helping plans negotiate confidentiality and reimbursement issues (see Orbovich, 1995; Stewart, 1995).

Second, Medi-Cal recipients need to be clearly informed of their rights to obtain reproductive health care from any Medi-Cal provider. They do not have to choose a single provider and only go there; they can continue to mix and match services. A social marketing campaign to promote family planning should include this information.

## **THE ROLE OF AFDC**

### **The Maximum Family Grant ("Family Cap") Policy**

Almost all adult women had heard of the proposal to not increase aid for more children in the family, but fewer teens had (perhaps because not all of them were on AFDC). Women agreed that it would not change most recipients' childbearing behavior. "Responsible" AFDC recipients like themselves did not have children in order to get more money and would not be deterred by the loss of a few dollars. "Irresponsible" women did not plan their families anyway, and unlucky women whose birth control failed would similarly get pregnant anyway. In most groups, women referred to a few (sometimes many) AFDC recipients they knew or had observed who "abused the system" and had more children heedlessly or in order to get a higher grant. With these recipients in mind women could acknowledge the fairness or legitimacy of the policy, although they still questioned its overall usefulness.

Overwhelmingly, they were concerned that every reduction in AFDC, including this one, penalizes children and the responsible AFDC recipients such as themselves who are struggling to make ends meet and to get off welfare. There were long discussions about how difficult it is to get off welfare, how little additional money came to them from their earnings if they had jobs, and how carefully they had to calibrate their earnings so as to retain their eligibility for Medi-Cal, Food Stamps and subsidized child care.

### **Providing Information in the AFDC Office**

Almost without exception, women strongly objected to the idea that eligibility workers would have conversations with them about their use of family planning. Many had felt

disrespected and condescended to by their eligibility workers. All recognized that eligibility workers are extremely busy and should focus on doing their primary job--providing financial assistance--accurately and courteously.

At the same time, the focus group participants were eager to imagine ways that a woman's contact with the AFDC program could be more useful to her. A few thought eligibility workers could play a very limited informational role (handing out a brochure, without comment). Some suggested sending information out with the AFDC checks. Most popular were suggestions for a variety of materials in the waiting rooms, ranging from brochures to posters to videos. All emphasized that the information provided should be accurate and up-to-date.

## **CONCLUSION**

Although many low-income women are knowledgeable about birth control, are motivated to use contraception and have good access to birth control services, our research has uncovered several opportunities to expand access and knowledge for specific groups. The AFDC program can play a limited role in this effort, utilizing waiting-room time to maximum advantage but not encouraging eligibility workers to discuss family planning with clients. High priority should be put on the following: 1) reaching adolescents with information about how to get free, confidential services and about what happens in a family planning clinic; 2) providing accurate information about birth control methods (in addition to the Pill) to all women, especially Spanish-speaking women; 3) developing an image of family planning services that does not imply a general hostility to child-bearing; and 4) in the transition to the State-only plan and Medi-Cal managed care, protecting women's access to a range of providers of family planning services.

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APPENDIX A

QUESTIONNAIRE DATA TABLE

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- Table 15. Estimated Use of Birth Control by All Adult Women on AFDC

**TABLE 1**

<b>ADULT FOCUS GROUP PARTICIPANTS COMPARED TO ALL AFDC RECIPIENTS</b>		
	<b>Adult Focus Group Participants<sup>a</sup></b>	<b>All AFDC recipients<sup>b</sup></b>
Primary language English	78%	71%
Primary language Spanish	22	19
Primary language other	0	10
Married	21%	22%
Formerly married	28	26
Never married	51	45
Unknown	0	7
Unmarried but in relationship	37%	--
Unmarried, no relationship	42	--
Age 16-19	0%	6%
Age 20-24	15	23
Age 25-29	27	21
Age 30-34	32	19
Age 35-39	25	17
Age 40-44	2	8
Age 45 or above	na	5
Average age	30.6	30.4
1 child in family	26%	43% <sup>c</sup>
2 children in family	31	28
3 children in family	26	17
4 or more children in family	18	11
Not HS Grad	46%	49%
HS Graduate	32	37
Any college	22	14
Family Group (FG) case	74%	82%
Unemployed Parent (UP) case	26	18
On AFDC	95%	100%
Has earnings	15	9
<i>Number of respondents</i>	86	1,317

<sup>a</sup> Data on the ages and current relationship status of focus group participants are from focus group questionnaires. All data from the focus groups are from the 1995 AFDC research survey.

<sup>b</sup> Data from the AFDC Characteristics Survey for April 1994, California Department of Social Services, Statistical Services Bureau.

<sup>c</sup> Number of children in family is the number in the Assistance Unit.

TABLE 2

<b>ADULTS' CURRENT AND LIFETIME USE OF BIRTH CONTROL</b>	
	<b>All Respondents<sup>a</sup></b>
<b>Currently using:</b>	
Condoms	27%
Pill	18
Female sterilization <sup>b</sup>	11
Rhythm/NFP	8
Withdrawal	7
Foam (perhaps with condom or other method)	5
Shot (Depo-Provera)	5
IUD	4
Norplant	2
Diaphragm	1
Male sterilization	0
Other method	11
<b>No method</b>	<b>31</b>
<b>Ever used:</b>	
Pill	83%
Condoms	78
Withdrawal	41
Abortion	30
Foam (perhaps with condom or other method)	30
Rhythm/NFP	28
IUD	14
Female sterilization	11
Diaphragm	11
Norplant	8
Shot (Depo-Provera)	22
Male sterilization	4
Has <b>never used</b> a method	5
<i>Number of respondents</i>	<b>86</b>

<sup>a</sup>Totals may exceed 100% because respondents were allowed multiple responses.

<sup>b</sup> None of these women had been sterilized as of the 1993-94 interview. Of the AFDC recipients interviewed at that time, 26% were sterilized. They were not eligible to participate in the focus groups.

**TABLE 3**

<b>ADULTS' CURRENT AND LIFETIME USE OF BIRTH CONTROL, BY RACE AND ETHNICITY</b>					
	<b>All Respondents</b>	<b>White</b>	<b>African-American</b>	<b>Latina, English-speaking</b>	<b>Latina, Spanish-speaking</b>
<b>Currently using:</b>					
Condoms	27%	37%	40%	14%	11%
Pill	18	16	10	24	26
Female sterilization <sup>a</sup>	11	16	10	19	0
Rhythm/NFP	8	11	5	5	5
Shot (Depo-Provera)	5	0	10	0	11
IUD	4	5	0	0	11
No method	31	32	20	38	26
<b>Ever used:</b>					
Pill	83%	95%	86%	76%	79%
Condoms	78	90	82	62	74
Shot (Depo-Provera)	22	21	18	19	37
IUD	14	26	5	10	21
Abortion	30	37	46	33	11
Rhythm/NFP	28	42	41	24	5
Norplant	8	16	0	5	16
<i>Number of respondents</i>	86 <sup>b</sup>	19	22	21	19

<sup>a</sup>None of these women had been sterilized as of the 1993-94 interview. Of the AFDC recipients interviewed at that time, 26% were sterilized.

They were not eligible to participate in the focus groups.

<sup>b</sup>Race/ethnicity was not determined for 5 participants.

TABLE 4

ADULTS' OPINIONS ABOUT SAFETY OF DIFFERENT METHODS FOR A WOMAN'S HEALTH BY RACE, ETHNICITY AND PRIOR OR CURRENT USE OF METHOD									
	White	African- American	Latina, English- speaking	Latina, Spanish- speaking	Ever Used Method in Question	Now Uses Method in Question	Does not now use Method in question	Discontinued Method in question	Never Used Method in Question
<b>The Pill is:</b>									
Mostly safe	58%	38%	40%	11%	41%	29%	37%	44%	13%
Mostly harmful	26	38	25	16	28	14	32	31	33
Neither	5	10	15	11	10	14	9	9	7
I'm not sure	11	14	20	63	22	42	22	16	47
<b>Condoms are:</b>									
Mostly safe	95%	67%	86%	26%	76%	82%	65%	74%	47%
Mostly harmful	5	0	5	0	0	0	3	0	11
Neither	0	19	5	21	12	5	12	14	5
I'm not sure	0	14	5	53	12	14	20	12	37
<b>Shot is:</b>									
Mostly safe	11%	24%	14%	6%	16%	-- <sup>a</sup>	12%	7%	12%
Mostly harmful	16	29	19	28	26	--	27	36	26
Neither	11	5	5	17	16	--	8	14	6
I'm not sure	63	43	62	50	42	--	54	43	55
<b>Female sterilization is:</b>									
Mostly safe	58%	46%	48%	21%	78%	78%	35%	na	35%
Mostly harmful	11	27	19	5	0	0	20	na	20
Neither	5	0	0	11	0	0	4	na	4
I'm not sure	26	27	33	63	22	22	41	na	41
<i>Number of respondents</i>	19	22	21	19	-- <sup>b</sup>	--	--	--	--

<sup>a</sup>Only 4 respondents were currently using the Shot.

<sup>b</sup>Column totals are not given in this section because each cell refers to a different number of respondents.

TABLE 5

ADULTS' OPINIONS ABOUT EFFECTIVENESS OF DIFFERENT METHODS IN PREVENTING PREGNANCY BY RACE, ETHNICITY AND PRIOR OR CURRENT USE OF METHODS									
	White	African- American	Latina, English- speaking	Latina, Spanish- speaking	Ever Used Method in Question	Now Uses Method in Question	Does not now use Method in question	Discontinued Method in question	Never Used Method in Question
<b>The Pill is:</b>									
Very effective	53%	14%	33%	53%	42%	67%	32%	36%	20%
Somewhat effective	32	73	33	32	45	33	44	48	27
Not effective	11	9	14	0	7	0	10	9	13
I'm not sure	5	5	19	16	6	0	15	7	40
<b>Condoms are:</b>									
Very effective	5%	32%	19%	16%	22%	41%	15%	14%	16%
Somewhat effective	84	56	43	37	63	59	49	63	21
Not effective	11	9	10	11	9	0	13	14	11
I'm not sure	0	5	29	37	6	0	23	9	53
<b>The Shot is:</b>									
Very effective	26%	18%	24%	26%	53%	-- <sup>a</sup>	20%	43%	15%
Somewhat effective	21	18	10	5	21	--	13	21	10
Not effective	0	0	5	5	5	--	3	7	2
I'm not sure	53	64	62	63	21	--	65	29	73
<b>Female sterilization is:</b>									
Very effective	79%	29%	55%	37%	88%	88%	46%	na	46%
Somewhat effective	5	33	0	11	0	0	14	na	14
Not effective	0	5	5	0	0	0	3	na	3
I'm not sure	16	33	40	53	12	12	38	na	38
<i>Number of respondents</i>	19	22	21	19	-- <sup>b</sup>	--	--	--	--

<sup>a</sup> Only 4 respondents were currently using the Shot.

<sup>b</sup> Column totals are not given in this section because each cell refers to a different number of respondents.

**TABLE 6**

<b>ADOLESCENTS' BIRTH CONTROL METHODS EVER USED BY ETHNICITY N=54</b>								
<b><i>Ever used:</i></b>	<b>All Respondents</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Withdrawal	40	74%	19	86%	8	62%	13	68%
Rhythm	8	15%	2	9%	0	0%	6	32%
Pill	24	44%	12	55%	5	38%	7	37%
Condom	45	83%	20	91%	9	69%	16	84%
Foam	9	17%	3	14%	2	15%	4	21%
Shot	16	30%	9	41%	3	23%	4	21%
Diaphragm	1	2%	1	5%	0	0%	0	0%
Abortion	4	7%	3	14%	0	0%	1	5%
IUD	1	2%	0	0%	1	8%	0	0%
Film	2	4%	0	0%	0	0%	2	11%
Other ways of having sex	7	13%	6	27%	0	0%	1	5%
Never used birth control	3	6%	0	0%	2	15%	1	5%

\* No respondents indicated that they had ever used Norplant or male or female sterilization

TABLE 7

<b>ADOLESCENTS' PERCEIVED EFFECTIVENESS OF METHODS BY ETHNICITY N=54</b>								
	<b>All respondents</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<i>Pill</i>								
very effective	4	7%	3	14%	1	8%	0	0%
somewhat effective	32	59%	15	68%	5	38%	12	63%
not effective	6	11%	1	5%	0	0%	5	26%
I'm not sure	12	22%	3	14%	7	54%	2	11%
<i>Condom</i>								
very effective	10	19%	7	33%	0	0%	3	16%
somewhat effective	31	58%	11	52%	7	54%	13	68%
not effective	5	9%	1	5%	2	15%	2	11%
I'm not sure	7	13%	2	10%	4	31%	1	5%
<i>Shot</i>								
very effective	29	56%	14	67%	5	42%	10	53%
somewhat effective	11	21%	4	19%	5	42%	2	11%
not effective	3	6%	1	5%	0	0%	2	11%
I'm not sure	9	17%	2	10%	2	17%	5	26%
<i>Sterilization</i>								
very effective	25	48%	10	48%	4	33%	11	58%
somewhat effective	9	17%	5	24%	3	25%	1	5%
I'm not sure	18	35%	6	29%	5	42%	7	37%

**TABLE 8**

<b>ADOLESCENTS' PERCEIVED SAFETY OF METHODS BY ETHNICITY N=54</b>								
	<b>Total</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<i>Pill</i>								
mostly safe	20	37%	11	50%	2	15%	7	37%
mostly harmful	9	17%	6	27%	2	15%	1	5%
neither one	5	9%	1	5%	2	15%	2	11%
I'm not sure	20	37%	4	18%	7	54%	9	47%
<i>Condom</i>								
mostly safe	36	68%	16	76%	4	31%	16	84%
mostly harmful	2	4%	1	5%	0	0%	1	5%
neither	10	19%	3	14%	5	38%	2	11%
I'm not sure	5	9%	1	5%	4	31%	0	0%
<i>Shot</i>								
mostly safe	13	25%	7	33%	0	0%	6	32%
mostly harmful	11	21%	7	33%	2	15%	2	11%
neither	8	15%	2	10%	3	23%	3	16%
I'm not sure	21	40%	5	24%	8	62%	8	42%
<i>Sterilization</i>								
mostly safe	10	19%	4	19%	0	0%	6	32%
mostly harmful	4	8%	3	14%	1	8%	0	0%
neither	10	19%	7	33%	2	15%	1	5%
I'm not sure	29	55%	7	33%	10	77%	12	63%

**TABLE 9**

<b>ADOLESCENTS' CURRENT USE OF BIRTH CONTROL: NON-PREGNANT WOMEN BY ETHNICITY N=28</b>								
	<b>Total</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Withdrawal	8	29%	4	33%	1	14%	3	33%
Pill	4	14%	1	8%	0	0%	3	33%
Condom	9	33%	6	50%	2	29%	1	13%
Foam	1	4%		8%	0	0%	0	0%
Shot	10	36%	5	42%	3	43%	2	22%
Other Ways of having sex	3	11%	1	8%	0	0%	2	22%
No method	5	18%	1	8%	2	29%	2	22%

\*No respondents indicated that they were currently using Norplant, film, IUD, rhythm method, or male or female sterilization.

**TABLE 10**

<b>ADULTS' REASONS FOR NOT CURRENTLY USING BIRTH CONTROL</b>	
	<b>Non-using respondents agreeing<sup>a</sup></b>
Not having sex with men at all these days	44%
Not having sex with men often	8
Currently pregnant	16
I want to be pregnant	12
It would be okay to be pregnant	8
I don't think I can get pregnant	8
No methods work for me	0
Birth control costs too much	0
Don't know where to get birth control	0
Hard to get to the clinic/drug store for b.c.	4
Hard to get an appointment	4
No time or No transportation	0
No childcare	4
I don't like the clinic	0
Partner does not want me to use birth control	4
Partner will not use condom	4
Other reason	16
<i>Number of respondents</i>	<i>27</i>

<sup>a</sup> Totals may exceed 100% because respondents were allowed multiple responses.

TABLE 11

<b>ADULTS' MOST RECENT OB-GYN CHECK-UP AND RECEIPT OF FAMILY PLANNING ADVICE OR SUPPLIES, BY RACE AND ETHNICITY</b>					
	<b>All Respondents</b>	<b>White</b>	<b>African-American</b>	<b>Latina, English-speaking</b>	<b>Latina, Spanish-speaking</b>
<b><i>How long ago was their last Ob-Gyn check-up?</i></b>					
Within the last 6 months	47%	37%	59%	43%	47%
6-12 months ago	19	21	18	19	16
1-2 years ago	15	26	5	24	5
More than 2 years ago	12	5	9	10	26
Can't remember	2	0	0	5	5
Has never had such a check-up	5	10	9	0	0
<b><i>Where in the medical system did respondents have their most recent conversation about family planning, or get supplies?</i></b>					
Doctor or HMO	43%	42%	59%	57%	11%
Hospital or clinic for general care	27	21	27	10	53
Family planning clinic	24	26	5	29	37
Other	1	0	5	0	0
Unknown	5	11	5	5	0
<b><i>Where have they acquired family planning supplies in the last 2 years?</i></b>					
From a clinic (any type)	59%	58%	41%	62%	74%
From a family planning clinic	44	46	29	48	50
From a hospital clinic	30	15	36	29	39
From a doctor or HMO	49	42	73	67	11
From a drug store	25	47	18	19	6
From partner	8	16	5	5	6
From family or friends	5	5	0	0	6
<b><i>Would they want to get family planning without a pelvic exam?</i></b>					
Do not want the exam	11%	26%	15%	5%	0%
Do want the exam	69	68	60	76	63
Don't care	12	5	25	19	0
Did not answer the question	8	1	0	0	37
<i>Number of respondents</i>	86	19	22	21	19

TABLE 12

<b>ADULTS' MOST RECENT OB-GYN CHECK-UP AND RECEIPT OF FAMILY PLANNING ADVICE OR SUPPLIES, BY COUNTY<sup>a</sup></b>				
	<b>All Respondents</b>	<b>Alameda</b>	<b>Los Angeles</b>	<b>San Joaquin</b>
<b><i>Where in the medical system did respondents have their most recent conversation about family planning, or get supplies?</i></b>				
Doctor or HMO	43%	47%	36%	38%
Hospital or clinic for general care	27	19	28	31
Family planning clinic	24	13	28	28
Other	1	0	4	0
Unknown	5	22	4	3
<b><i>Where have they acquired family planning supplies in the last 2 years:</i></b>				
From a clinic (any type)	59%	59%	52%	66%
From a family planning clinic	44	38	36	54
From a hospital clinic	30	46	28	25
From a doctor or HMO	49	59	48	39
From a drug store	25	28	16	29
From partner	8	3	8	14
From family or friends	5	9	0	0
<i>Number of respondents</i>	86	19	22	21

a Totals may exceed 100% because respondents were allowed multiple responses.

**TABLE 13**

<b>ADOLESCENTS' SOURCES OF BIRTH CONTROL IN LAST TWO YEARS BY ETHNICITY N=54</b>								
	<b>Total</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Private Doctor/HMO	10	19%	1	5%	2	15%	7	37%
Clinic/Hospital	27	50%	16	73%	3	23%	8	42%
Family Planning Clinic	19	35%	9	41%	4	31%	6	32%
Store	12	22%	5	23%	4	31%	3	16%
Friends/Family	13	24%	10	45%	0	0	3	16%
Partner	21	39%	8	36%	3	23%	10	53%
Never used Birth Control	3	6%	0	0%	2	15%	1	5%

\*Because respondents may obtain birth control supplies from multiple sources, percentages will total more than 100%.

TABLE 14

<b>ADOLESCENTS' ATTITUDES TOWARD A REQUIRED MEDICAL EXAM WHEN OBTAINING                      BIRTH CONTROL, BY ETHNICITY                      N=54</b>								
	<b>Total</b>		<b>African-American</b>		<b>Latina</b>		<b>White</b>	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<i>When the teens I know go to get the pill or shot, they ...</i>								
do not want a medical or pelvic exam	17	32%	5	24%	1	8%	11	58%
want a medical or pelvic exam	10	19%	4	19%	3	23%	3	16%
don't care if they get an exam	5	9%	3	14%	1	8%	1	5%
I don't know how they feel	21	40%	9	43%	8	62%	4	21%
<i>When I go to get the pill or shot, I...</i>								
do not want a medical or pelvic exam	8	15%	4	18%	3	23%	1	5%
want a medical or pelvic exam	35	65%	13	59%	9	69%	13	68%
I don't care if I get an exam	11	20%	5	23%	1	8%	5	26%

**TABLE 15**

<b>ESTIMATED USE OF BIRTH CONTROL BY ALL ADULT WOMEN ON AFDC<sup>a</sup></b>					
	<b>All Respondents</b>	<b>White</b>	<b>African-American</b>	<b>Latina, English-speaking</b>	<b>Latina, Spanish-speaking</b>
Sterile	27%	33%	26%	27%	23%
Prescription method	26	20	23	33	28
Non-prescription method	24	25	36	13	28
No method	23	21	15	28	20

<sup>a</sup> Unlike the previous tables, this table includes sterilized women in the denominator.

APPENDIX B

ANNOTATED BIBLIOGRAPHY

## Annotated Bibliography

Brindis, Claire and Korenbrot Carol. "A Study of the Cost Effectiveness of the California Office of Family Planning Expenditures for Reversible Contraceptive Services." Unpublished manuscript draft. Center for Reproductive Health Policy Research, UCSF. 1994.

Analyzes the cost-benefit ratio for OFP-funded contraceptive (not sterilization) services. Reviews previous cost-benefit studies of OFP services (1977, 1981, 1983, 1989), also a 1990 report by AGI on cost-benefits of state and federal contraceptive expenditures across the US and in California. The AGI model, unlike previous California studies, included four different scenarios with alternative assumptions about what the behavior of women would be if they were unable to receive state-funded contraceptive services (the most extreme scenario is no use of contraception; other scenarios include varying degrees of contraceptive use and substitution of methods). These different scenarios produce different probabilities of pregnancy, the basis for the calculation of state costs. Including costs for Medi-Cal funded abortion, deliveries, newborn care, continuing health care, AFDC grants, foster care, infant day care, disability services, and special education, the report estimates that for every dollar spent on OFP services, the state saves from \$3.66 to \$8.03 (an average of \$5.57) for the three likelier scenarios, with \$14.59 saved if women used no contraception in the absence of OFP services.

"Characteristics of Women Receiving Family Planning Services at Title X Clinics--United States, 1991." *Morbidity and Mortality Weekly Report*. 43 (2): 31-34. January 12, 1994.

Reports data from the 1991 Family Planning Services Surveillance project, in which all 75 Title X grantees in the U.S. reported summary statistics on the patients. "The findings in this report indicate that patients at these clinics are predominantly young, nulliparous, and poor and use oral contraceptives more than any other method of contraception." (33) Details include: Age: 34.5% were aged 20-24 years and 27.3% were 15-19; 1.5% were under 15. Race: 71.8% were white, 23.0% black (blacks were overrepresented relative to their percentage of women of reproductive age, 13.4%); 14.9% were Hispanic (overlapping w/race breakdown). More than half (58.5%) had had no live births. Most common method was the pill (69.4%), followed by condoms (6.2%) and foam and condoms (5.1%); note that all other methods (including sterilization) constituted only 7.6%; 11.3% had no method (some were pregnant, some seeking infertility services, some abstinent, some receiving counseling only). Income: 64.6% were at or below Federal poverty level; another 18.9% were 101%-150% of poverty.

Forrest, Jacqueline Daroch and Singh Susheela. "The Sexual and Reproductive Behavior of American Women, 1982-1988." *Family Planning Perspectives*. 22 (5): 206-214. September-October 1990.

Compares data from the 1982 and 1988 National Survey of Family Growth (NSFG). In

general, changes are not dramatic. Older age of women as a group resulted in some shifts (including part of the small increase in the percentage of women either contraceptively or otherwise sterile and half of the slight increase in the total proportion of women who had ever had sexual intercourse). Some changes were evident within subgroups, however, including a slight increase in sexual activity among teens. Furthermore, increases in sexual activity among teens occurred primarily in white and nonpoor teens, so that the gap in sexual activity between white and black/Hispanic teens and poor and nonpoor teens narrowed during this period.

The 1988 NSFG for the first time obtained information on numbers of partners. Among women who have ever had intercourse, 67% report having two or more partners in a lifetime, with the highest proportion among women aged 20-34 (71-72%). Among teens, even though they have been sexually active a relatively short time, the figure is 58% reporting two or more partners. Estimates from the General Social Survey 1988-89 indicate that 49% of women 18-19 and 78% of men of this age had had two or more partners within one year. The authors point out the need for counseling for both disease and pregnancy prevention and focusing on appropriate method selection.

An increasing number of teens are using birth control at first intercourse (65% of those sexually active in the 1988 survey), with the increase (from 48%) due to a large increase in condom use, particularly among Hispanics.

Of women at risk of an unintended pregnancy, about 12% in 1982 and 10% in 1988 were not using contraception (or sterilization)--representing about four million women in 1988. By age, teens are the group most likely not to use birth control even though at risk, but the proportion doing (at risk, not using birth control) so did decline from 29% in 1982 to 21% in 1988. Poor women are also more likely to be in this situation: the percentage of poor women at risk reporting nonuse is about twice that of nonpoor women.

Forty percent of recent (3-4 years prior to survey) births to women in 1988 were unintended (up slightly); 28% were mistimed and 12% unwanted (to women who wanted no more children). Poorer women are much more likely than nonpoor women to report that recent births were mistimed. Overall, the rate of unintended *pregnancies* (as opposed to births) was unchanged during this period, but it did vary by group. Among sexually active teens the rate actually declined but because sexual activity among teens increased, the proportion of teen pregnancies that were unintended actually rose.

Forrest, Jacqueline Darroch and Fordyce, Richard R. "Women's Contraceptive Attitudes and Use in 1992." *Family Planning Perspectives*. 25 (4): 175-179. July-August 1993.

Analyzes data from the 1992 and 1987 Ortho Birth Control Study (mail survey of participating households; overall response rate 63%). Nonwhite women, especially blacks, are underrepresented, as are higher income women; in other respects the sample is similar to American women generally. From the 1992 survey, the most favorably rated methods were the pill, condom, vasectomy, and female sterilization (all viewed favorably by more than half the respondents; 77% favorability rate for the pill). Among those who gave an opinion, the favorability rates were even higher; also, of those giving an opinion, 64% gave implants a

favorable rating. Ratings are more favorable among users of a specific method (they've selected it); among users, the hormonal implant and the IUD had the highest ratings (98% and 96%) (note that these groups are limited). Levels of sexual activity rose between 1987 and 1992. 94% of women aged 15-44 who were at risk of unintended pregnancy (sexually active, fertile, not wanting a child) reported current use of a contraceptive method. Level of use was higher among married than unmarried women (97 vs 92%). Most common methods were the pill, condom, tubal ligation, and vasectomy; only one other method--withdrawal (8%)--was used by more than 4% of at risk women. Unsurprising differences in method use by marital status were found. Proportions of unmarried, at risk women *not* using a method decreased from 14% in 1987 to 8% in 1992. Current users were using 1.3 methods, on average (possibly for STD prevention).

Grady, William R.; Klepinger, Daniel H., and Billy, John O. G. "The Influence of Community Characteristics on the Practice of Effective Contraception." *Family Planning Perspectives*. 25 (1): 4-11. January-February 1993.

Reviews other research on community correlates of contraceptive use. Analyzes community influences on contraceptive use (use and effectiveness of method) for nonblack, married women, from the 1982 National Survey of Family Growth. Uses cost/benefit model of decision-making: hypothesizes that community characteristics shape opportunity structures/cost-benefit calculations. Included in possible community influences: abortion and family planning providers; SES (measured by housing values); community religiosity; community liberality (voting patterns); social disorganization (including divorce, pop. growth, UE); women's labor-force participation; racial/ethnic composition and fertility patterns. Individual factors are age, marital duration, parity, ethnicity, family background, SES, religion. Dependent variable is "average effectiveness variable" of methods used during a 3.5-year period preceding the NSFG. Individual factors related to effectiveness of contraceptive practice were: age (-; supposedly because older women are less likely to get pregnant); parity (+); Hispanic origin (+ (pill or no method)); living in "broken" home at age 14 (-); SES (+); Christian religious affiliation (all +; hypothetically because it increases the psychic cost of abortion). Contextual influences were: the number of family planning clinics (+); local SES (+); concentration of religious adherents (+; again, assumed because of prohibitions on abortion); liberality, when religiosity is controlled (-; supposedly because of support for both abortion and welfare); pop growth and UE rate (both -; both reflective of "anomie" and high potential cost of pregnancy). Surprisingly, women's labor-force participation and opportunities did not have significant effects, though they have been found to be influential in other studies. One countervailing effect was noted: women's opportunities were positively related to use of pill and no method (having to do with the fact that the husband's opportunity may also go up as women's opportunity goes up). Community race/ethnicity and marital fertility were not influential in their model. Policy-relevant findings included the following: the number of family planning clinics was positively related to effective contraceptive practice; availability of abortion in the community was unrelated (the acceptability of abortion was more important than cost/access)--though access to family planning was high during the study period, and effects may be stronger now.

Harris and Associates, Inc. *Medi-Cal Managed Care Study*. New York: Louis Harris and Associates. 1994.

Reports on results of a telephone survey of 1600 adults receiving MediCal benefits in three California counties and compares experiences and attitudes of enrollees in fee-for-service, HMO, and PCCM plans. With respect to family planning services, the following findings are relevant. Twenty-two percent of MediCal beneficiaries have obtained family planning services within the past twelve months; HMO members (26%) are slightly more likely than fee-for-service (22%) and PCCM enrollees (18%) to report having received such services. Nearly all of those who received family planning services were very or somewhat satisfied with them, but PCCM enrollees were less satisfied than those in fee-for-service or HMO plans. Perhaps most noteworthy is the fact that almost a third (31%) of those enrolled in managed care plans are *not* aware that they have a right to seek family planning services from a MediCal provider outside their plan. The overwhelming majority of managed care clients stay within their own health plan for these services. One other finding not reported in connection to family planning services but relevant to it is that significantly more HMO clients (42%) than fee-for-service (22%) or PCCM enrollees (17%) must wait two weeks or more for a routine medical visit (as opposed to treatment of illness, for which they can be seen quickly). Two weeks or longer can be a very long wait for a woman seeking family planning services, in the even those services are defined as routine care.

Henshaw, Stanley K. and Torres Aida. "Family Planning Agencies: Services, Policies, and Funding." *Family Planning Perspectives*. 26 (2): 52-59, 82. March-April 1994.

Summarizes findings from a survey of family planning providers. Also cites relevant findings from other work, including the finding that a majority of contraceptive users obtain methods from private physicians or managed care organizations, but one out of three go to a family planning clinic. Clinics are particularly important sources of care for teens, women of color, and low-income women (cites are to Mosher on both of these points).

The authors compiled a list of all family planning agencies, based on an AGI listing, updated and reviewed by a variety of sources. In late 1992, a sample of 934 agencies was surveyed, with 589 usable responses. Different categories included: 52% operated by county health departments, 15% by PP affiliates, 6% by hospitals and 27% by other agencies.

All agencies offer birth control pills. More than 90% of each type also offer condoms, diaphragm, and spermicides, and 78% offer NFP training; 69% provide the sponge. Only 41% provide the IUD, 21% postcoital hormonal contraception, and 20% the cervical cap. Some variation by type of agency was found: Planned Parenthoods more likely to offer a greater variety of methods, but hospitals more likely to offer injectable contraceptives. A large proportion of agencies (26-31%) neither provided nor referred clients for injectable contraceptives, postcoital contraception or the cervical cap.

Birth control clients almost always receive a pelvic exam, blood pressure test, breast

exam, and Pap smear annually. Planned Parenthood affiliates are the most specialized, tending to focus on contraceptive services and offering on average a smaller proportion of noncontraceptive services than do other agencies. Hospitals offer the widest array of services, not surprisingly. Health departments fall between these. PP's clients are overwhelmingly there for contraceptive services, as compared to half of those coming to "other" agencies, and one quarter of those coming to health department and hospital clinics.

83% of the agencies received some income from Medicaid but for most it was a small percentage of total income. The most important single source of funds was the federal Title X program; additional funding was provided through MCH and social services block grants, but these tended not to account for a large proportion of agency revenues. State and local government were the second most important source of funds after Title X. Client fees were also important. Health departments relied more than the other agencies on both Title X and state and local government funding. Planned Parenthood affiliates relied relatively more on client fees. Hospital funding tended to be Medicaid. In clinics funded by Title X, 92% provide first-visit services and a 3-month pill supply free to a client who has an income less than or equal to 75% of poverty. At 125% of poverty, though, 89% charge something for the visit and 60% charge for pills. Among clinics without Title X funding, about half charge the poorest clients for these visits.

"While 18% of all women who made a family planning visit in 1987 went to a Title X clinic, 35% of women under the poverty level, 34% of black women and 39% of teenagers utilized Title X clinics." (FN omitted, p. 59) Family planning clinics are an important source not only of specialized services unlikely to be available from primary care providers, but also offer a location for other health screening (such as for reproductive cancers). "Results of the 1988 NSFG indicate that more than 90% of women who made a family planning visit in the previous 12 months had had each of these tests, [pap, pelvic, blood pressure, and breast exam] while 52-75% of those who had not made such a visit had had each of these tests." (FN omitted, p. 59) The authors note that countries with national health insurance often maintain family planning clinics (see ref#17, Jones, et al., *Pregnancy, Contraception and Family Planning in Industrialized Countries*, Yale University Press, 1989).

Institute of Medicine. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Washington, D.C.: National Academy Press. 1995.

An extensive and thorough discussion of unintended pregnancy from many different perspectives, including the following: demographics, consequences, patterns of contraceptive use, knowledge and access, personal and interpersonal factors, socioeconomic and cultural influences, and preventive programs. Only the portions most relevant to increasing use of family planning services will be noted here.

Though the authors don't state this conclusion directly, the chapter on contraceptive use demonstrates that it can be complicated and difficult. Unintended pregnancies occur even among couples using contraception because many methods have less than perfect effectiveness even with perfect use and some have the additional problem of difficult use. Coitus-dependent

methods, because they require much more dedicated and careful use, make couples relying on them much more susceptible than other contracepting couples to unintended pregnancy. Variability in patient ability and commitment to use of more difficult methods may not be fully appreciated by researchers and practitioners in this field. In addition, the process of contraceptive selection is increasingly complicated by the presence of HIV.

In their chapter on knowledge, the authors note that the focus of this chapter "is not meant to obscure another possible explanation for unintended pregnancy, which is the relatively limited and often unsatisfactory array of contraceptive methods available to men and women in the United States." (126) Misinformation and lack of knowledge about contraception are common in the US, particularly about the risks and benefits of particular methods (risks tend to be exaggerated and benefits underestimated, especially in the case of the pill). This misinformation may be the result of media emphasis on negative stories as well as lack of media and advertising attention to pregnancy prevention. (Lack of awareness is also evident in the low rates of awareness of emergency contraception among both providers and clients.) Adolescents have particularly poor understandings of human fertility and may be at especially high risk because of lack of information as well as misinformation: a study of sexual active teens found that "one of the most commonly cited reasons for delay in attending a family planning clinic was that contraception is 'dangerous.'" (130)

In line with the UC Data findings that many women prefer family planning services in the context of other health care, the findings of an AGI cross-national study of teen pregnancy are particularly noteworthy: "The investigators concluded that contraceptive use--and, in particular, the use of the more effective methods--was favorably affected by such factors as the presence of a national health plan or health care system that includes family planning . . . ; the full integration of family planning services into general health care services, rather than such services being separate or specialist-based; the fact that family planning clinics are seen as serving all women, not just those who are poor or adolescent . . ." (136)

Some data indicate that cut-backs in family planning funding may be limiting access in some ways (for example, increasing waiting times for appointments or travel times to clinics) and the authors point out that because pregnancy prevention requires diligent commitment and action, even small changes in access to services may have dire effects. Specific issues with respect to cost and lack of insurance coverage for birth control are also discussed. Another concern with respect to access is the rather limited training in pregnancy prevention received by many primary care providers (including ob-gyns), which may result in their over-reliance on only one or two methods.

Also important are the discussions of personal and interpersonal determinants as well as social and cultural influences on contraceptive use. With respect to personal and interpersonal factors, the authors return to the question of motivation, noting that "the human organism is designed to reproduce under even adverse biological circumstances," and therefore, motivation "must be powerful if pregnancy is to be prevented." (162) But strong motivation isn't always present. Zabin and colleagues studied inner-city girls and found that those ambivalent about pregnancy were just as likely to become pregnant in the following two years as the few who definitely wanted pregnancy; these findings are consistent with ethnographic reports of other writers. Teenage girls may be ambivalent or even desire pregnancy because of its rewards,

particularly if rewards are lacking elsewhere in their lives (e.g., the emptiness of male-female relationships may promote a young woman's desire for pregnancy/motherhood). Personal factors that may affect contraceptive use include self-efficacy (+), negative emotions such as fear or guilt about sex (-), and the capacity to plan (+).

Attitudes toward specific contraceptive methods are also predictive of contraceptive behavior. "Overall, it appears that both nonuse and the use of less effective methods derive at least in part from method-related fears and dislikes and from a general negative feeling about contraception." (171) Among young women, parent involvement may have some effect, but peer influences are likely. Partner support has been found to be positively related to contraceptive use.

Relevant to any social marketing campaign also are the cultural and social factors that may influence contraceptive behavior. One view is that the conflicting views of sexuality in American culture are in part responsible for patterns of use and nonuse of contraception: sex is glamorized everywhere but nonmarital sexual contacts are disapproved of by many people, and there is little or no media coverage of contraception/pregnancy prevention ("the major national networks have adopted the position that contraceptive advertising will not be accepted" (191)). With respect to economic influences, the authors note that evidence suggests that although early childbearing among poor teens can contribute to later poverty, its independent effect is probably less than that of her family's economic status. Empirical research also suggests that AFDC and other income transfer programs do not have much if any effect on childbearing, though they may affect marital status.

Another important sociocultural factor is racism. The authors note the continuing evidence of racially motivations behind governmental action with respect to welfare and contraception, as well as historical episodes (such as forced sterilizations) that fuel African American suspicions of family planning programs and methods. Particularly relevant is the contemporary evidence of coercive intent: the proposal of legislation in various states in the early 1990s to pay welfare mothers to use Norplant, for example. The emphasis on birth control to the near-exclusion of other anti-poverty measures has also prompted African Americans to see birth control programs as genocidal (the goal is to prevent black babies not poverty).

In discussing programs to reduce unintended pregnancy, the authors focus on a carefully selected set of programs that have been evaluated and found to be effective in this area. Looking across these programs, they draw out some general observations, including the following: (1) our understanding of how to reduce unintended pregnancy at the local level is limited; (2) most programs target adolescents, so little is known about reaching adults (women and men); (3) there is insufficient evidence to determine the effectiveness of abstinence-only programs; (4) sex education programs that provide messages about both abstinence and birth control do not encourage sexual activity and do seem to be effective in delaying onset of intercourse and encouraging contraceptive use once activity has begun; (5) there is a "notable reluctance" in these programs to provide contraceptives directly to participants, probably because of divided feelings about adolescent sexual activity and use of birth control; (6) about half of the evaluated programs targeted at preventing repeat pregnancies were successful and most of these took a health-oriented approach; (7) little is known about how to influence behavior by changing the socioeconomic or cultural environment.

Finally, the committee's recommendations include not only increasing knowledge and access, but also directly addressing "the major roles that feelings, attitudes, and motivation play in using contraception and avoiding unintended pregnancy" (254) and researching both new methods and forms of service delivery.

Keith, Judith B., McCreary, Cynthia, Collins, Kay, Smith, Charlotte, and Bernstein, Ira. "Sexual Activity and Contraceptive Use Among Low-Income Urban Black Adolescent Females." *Adolescence*. 26 (104): 769-783. Winter 1991.

Reports on a study of black teenage girls attending a school-based comprehensive health clinic in Dallas. Because family planning services are readily accessible at a trusted, low-cost, conveniently located facility, the study investigated the question of what factors other than knowledge of and access to services influenced contraceptive and sexual behavior in this group. 142 teens were surveyed (by interview) and given paper-and-pencil cognitive tests. The analysis assumed a psychosocial model in which "modifying and enabling factors" influenced the perceived threat of pregnancy, the probability of contraceptive use and contraception. Modifying/enabling factors included three types: psychological factors including cognitive reasoning, locus of control and present v. future time orientation; attitudes about premarital sex and religion; and interpersonal factors. Subjects were defined in three groups: not sexually active (NA), sexually active but not contracepting (A/NC), and sexually active and contracepting (A/C). The differences between the first group and the other two were greater than differences between the two sexually active groups. "The church and the family, including the presence of a father, were associated with not being sexually active during early and middle adolescence. In addition, subjects who were not yet sexually active were also younger, more career motivated, somewhat more academically motivated, and tended to be less approval of premarital sex in general." (781)

Notably, differences between sexual active contraceptors and noncontraceptors centered on feelings/beliefs about birth control. "The noncontraceptors' apparent aversion to contraception was expressed quite broadly. It is best seen as an active rather than a passive decision." (781) The authors caution, however, that these two groups were more similar than different and the contraceptors may be inconsistent in their practices.

Kirkman-Liff, Bradford and Kronenfeld, Jennie Jacobs. "Access to Family Planning Services and Health Insurance among Low-Income Women in Arizona." *American Journal of Public Health*. 84 (6): 1010-1012. June 1994.

Looks at access to family planning services for low-income women in Arizona at two points in time: 1984 and 1989. Arizona had no Medicaid program until it instituted a managed care/HMO system for Medicaid eligibles in 1982 (the AHCCCS). At the time, and until 1986, waivers excluding family planning services were granted to providers; then in 1986, contractors were required to cover family planning services. Data were taken from two Harris telephone surveys of adults, in 1984 and 1989, and the comparison included low-income women.

Findings include the following: a significant increase in use of family planning services by low-income women, in all insurance status groups, but with the greatest increase coming among those with employment-based insurance (who went from 12.6% receiving family planning services to 37.4%). Very little difference was found in rates of use between those insured and those uninsured. "Only when insurance status was separated into those with Medicaid and those with employment-based insurance was there improved access to family planning services, but only for the Medicaid-covered population." (1012) In other words, there was little difference between insured/uninsureds in terms of access to family planning services (and counseling) but there was a significant difference within the insured population between those w/employer-based versus public insurance and the latter had higher rates of access. Possible explanation: because most private insurance doesn't cover family planning services. Note that even in 1984, before family planning services were mandated by the AHCCCS program, women in the program had higher rates of use than did other women (insured or not). Note that the article says nothing about varying levels of need in different groups.

McCarthy, Miriam, Jacquart, Katherine, and Quam, Lois. "Family Planning, Managed Care, and Rural America." *Western Journal of Medicine*. 163 (3): 45-49. September 1995 Supplement.

Points out that family planning providers have traditionally played a major role in health care services in rural areas, for some people being the closest health care provider and often the only means of obtaining confidential services. Though recent managed care plan expansion has primarily occurred in more heavily populated areas, some states are seeing an expansion of rural HMO services. (The growth of managed care in rural areas has been inhibited because of lower rates of insurance and less likelihood of some managed care strategies being effective in these areas.)

This article focuses on rural Minnesota as a case study of possible collaboration between managed care plans (which are growing in the state) and existing family planning providers (established in rural areas). Looking at three areas of the state, the authors "found well-developed rural family planning services with little link to managed care." (47).

Milligan, Sharon E. "Accessibility and Organizational Settings for Public Supported Family Planning Services." *Women & Health*. 115 (1): 71-80. Spring 1989.

Notes that affordability is not the only important criterion of access, but that temporal measures--travel time, waiting for appointments, and office waiting time--are significant as well and can influence use. The article reports on a survey of clients of three different types of family planning clinics in Western Pennsylvania, in which clients were asked to report travel and waiting times and their overall satisfaction with the services. Clinics were distinguished by organizational setting: hospitals, freestanding clinics, and community clinics. The clients' reports were compared across setting and overall to federal access standards for primary care set in PL 93-641. Overall, 32% of the 44 clinic sites exceeded these norms and 43% met them; 25% failed

to meet these access norms. A comparison across organizational settings found that freestanding clinic sites were the most accessible and hospital settings the least. In addition, hospital clients expressed lower satisfaction with quality of care, staff courtesy, and physical environment.

Mosher, William D. "Contraceptive Practice in the United States, 1982-1988." *Family Planning Perspectives*. 22 (5):198-205. September-October 1990.

Reports on patterns of contraceptive use and changes between 1982 and 1988. Most data are taken from 1988 (4th cycle) NSFG.

The percentage of teens using contraception rose significantly, from 24% to 32%, reflecting primarily increased use of condoms. Contraceptive use also increased among 35-39-year olds; among older women, increased use of female sterilization is key, but note that there are significantly different patterns by race/ethnicity, income, and education. Contraceptive use increased among non-Hispanic whites and non-Hispanic blacks but not among Hispanics. The percentage of women who were at-risk of unintended pregnancy *and* not contracepting was roughly the same in 1982 and 1988 (7.4% and 6.7% respectively) overall; among Hispanics the proportion went from 8.5 to 9.6, among non-Hispanic whites from 6.2 to 5.5, and among non-Hispanic blacks, from 13.6 to 10.3 (blacks having the highest proportion of noncontracepting at-risk women, non-Hispanic whites the lowest).

Overall, IUD use dropped (two major manufacturers withdrew from the market), female sterilization use rose, diaphragm use dropped slightly and condom use rose. Over a longer time period, 1973-1988, female sterilization surpassed the pill as the most popular method among married couples (in 1988 tubal ligation was first, then the pill, then vasectomy).

Female sterilization rose in part because of the aging of the female population, but this wasn't the whole story. Note also that there are significant differences by race/ethnicity, income, education. Female sterilization use increased sharply among Hispanic women, who were previously relatively heavy IUD users. In general, increases in female sterilization were greatest among the formerly married, the less educated, low-income, Hispanic, and black women. Among whites, female sterilization is most popular among those with the least education. Female sterilization is more common and male sterilization less common among black contraceptive users than among whites at all educational categories. Among those with more education, black women are more likely than white women to use the pill and less likely to use diaphragm or condom (though note trends were somewhat different, with educated blacks moving to tubal ligation and educated whites moving to the pill over the 1982-88 period).

Between 1982 and 1988, the least educated black and white women shifted toward female sterilization. Among the best educated, blacks increased their use of female sterilization and the condom, but whites increased their use of the pill. "Among white women with high levels of education and among high-income women, declines in IUD use were associated with increases in pill use. Among college-educated black women, on the other hand, there was no similar increase in pill use; instead, use of female sterilization increased." Why the difference?

Among never-married women, blacks are much more likely than whites to use female sterilization, probably because they are also much more likely to have had all the children they

want. "However, even among never-married women who do not intend to have any more children, blacks are much more likely than whites to use female sterilization . . ." (203) White married couples using contraception are more likely than their black counterparts to use male sterilization, the diaphragm and condom, and less likely to use female sterilization and the pill. But formerly married black users are less likely than formerly married white users to use the pill, probably because of their higher use of female sterilization.

There were slight increases in pill use, primarily among better educated, higher-income, and white women.

Diaphragm use declined slightly. Condom use increased slightly, but the proportion of teens using condoms increased more dramatically. Condom use also rose in all three racial/ethnic groups but most among Hispanic women. Decline in diaphragm use and increase in condom use among younger women, never-married, and those intending to have more children probably reflects rising concerns about STDs.

Mosher, William D., and McNally, James W. "Contraceptive Use at First Premarital Intercourse: United States, 1965-1988." *Family Planning Perspectives*. 23 (3): 108-116. May-June 1991.

Analyses data from the 1988 cycle of the National Survey of Family Growth (note the potential recall problem, given that first intercourse may have been many years before). Includes variables found in other studies to be associated with use of contraception at first intercourse. Trends over time include the following: the proportion using a method at first intercourse was about the same between 1965 and 1979 (44-47%) but climbed to 53% in 1980-82 and to 65% in 1983-88. Most of the increase reflects an increase in condom use beginning in the early 1980s; there were small increases in pill use between 65-69 and 70-74 but otherwise no significant changes. Trends among different racial/ethnic groups: non-Hispanic whites similar to overall trends (large increase in condom use); blacks: method use rose between 65-69 and 83-88 but most of it reflected increased use of the pill, w/half the increase occurring before 1980. Condom use increase among blacks was smaller.

Overall, about half of women had used a method at first intercourse, with the proportion higher for Jewish women, about half for other whites, 45% for black women and 32% for Hispanic women. Much of this variation reflects differences in the rates of condom use (highest among Jews, lowest among Hispanics). Withdrawal use varied by race: whites more likely than blacks to use withdrawal or condoms, but blacks more likely than whites to use the pill. Younger women (<15) were less likely than older women (19/older) to have used a method at first intercourse. Women living w/both parents at age 14 were a bit more likely than others to use a method at first intercourse (consistent w/other research). Mother's education was important, particularly the difference between those who had 11 or fewer years versus those with 12 or more (those with better-educated mothers were more likely to use a method at first intercourse, reflecting greater use of both condoms and pills. Among whites, fundamentalist Protestants were less likely than other groups to use either condoms or pills at first intercourse; among blacks, condom use was the same but fundamentalists were less likely to use the pill.

Several important variables are correlated, and multivariate analyses conducted for

different racial groups indicated some factors having different levels of effect for different racial groups (e.g., effect of mother's education was smaller among blacks than whites, having lived in a one-parent household at age 14 had a stronger negative effect on blacks' method use than on whites').

When community-level factors were introduced into the models, some effects were altered (e.g., having lived in a one-parent household at age 14 was not significant for whites--it turns out to be mostly a proxy for SES effects). Significant community factors (controlling for individual factors as given above) included male UE and proportion Hispanic residents (both negatively associated with method use), for whites and Hispanics. For blacks, proportion on public assistance was negative related to method use, but male UE and proportion Hispanic were not significant. Probabilities of use for black and white women with the same baseline characteristics were significantly lower for blacks than whites. Bottom line: some community factors had large and significant, independent effects, but they varied by racial group. "These findings are generally consistent with theories that living in an economically depressed area discourages the planning and deferral of gratification that use of contraceptives at first intercourse requires." (115, FN omitted) But, as the authors note, the mechanism is unknown and there could be selection bias.

Mosher, William D. and Pratt, William F. "Use of Contraception and Family Planning Services in the United States, 1988." *American Journal of Public Health*. 80 (9): 1132-1133. September 1990.

Reports contraceptive use findings from the National Survey of Family Growth. In both 1982 and 1988 the most popular method of birth control was the pill, but by 1988 female sterilization was approaching the popularity of the pill. If both male and female sterilization are combined, sterilization becomes the most commonly used form of contraception among couples. (In 1988, the percentages of contracepting women using the pill and tubal ligation were 31 and 28 respectively.) Among never married women using contraception, the proportion relying on condoms for birth control jumped from 12 to 20 percent between 1982 and 1988; if women using other, more effective methods are included, the total number of women using condoms is about 10 percent of all women of reproductive age. Because the IUD was withdrawn by two major manufacturers in 1985 and 1986, its use dropped by two-thirds during the 1982-88 period, and groups that had had high rates of IUD use turned increasingly to female sterilization.

Of the 20 million women making family planning visits during the 12 months prior to the 1988 survey, about 65 percent used private physicians/practices or HMOs; the remainder used clinics (about half of them using Title X clinics). Black, teen, and low-income women were much more likely to use clinics than were other women, as were those making their first visit.

O'Campo, Patricia, Faden, Ruth E., Gielen, Andrea C., Kass, Nancy, and Anderson, Jean. "Contraceptive and Sexual Practices Among Single Women with an Unplanned Pregnancy: Partner Influences." *Family Planning Perspectives*. 25, (5): 215-219. September-October 1993.

291 unmarried, pregnant, inner-city women coming to the Johns Hopkins OB clinic were asked about contraceptive and sexual practices in the preceding 12 months. 90% of the sample was black, 42% had less than 12 years of schooling, 28% were aged 18-19 and 42% were 20-24. Among women with only one sexual partner, the pill was the most common method (32%) followed by the condom (16%). As number of partners increased, pill use decreased dramatically (to 9% of those with three or more partners and condom use increased (to 33% among those w/three or more partners). Substantial proportions of women reported not using contraceptives (roughly 44-45% of women with one or two partners, 54% of women w/three or more).

Women with only one partner were somewhat more likely to be solely responsible for contraceptive decision making than women with multiple partners.

"When women reported using no method with particular partners, the three reasons most frequently cited for not doing so were that they 'didn't think about it' (25%), 'didn't think you needed to' (24%) and 'didn't want to' (24%). Twelve percent cited health concerns, only 3% mentioned partner resistance and less than 1% cited cost or lack of availability." (218) ". . . merely ensuring access to family planning services may not be enough to effectively prevent unplanned pregnancy. Interventions designed to promote the importance and value of contraceptive use in fulfilling one's goal of not becoming pregnant would seem essential." (219)

The authors also recommend that ALL providers discuss family planning and STD prevention with their clients, because many women may not see family planning providers.

Oakley, Deborah, and Bogue, Erna-Lynne. "Quality of Condom Use as Reported by Female Clients of a Family Planning Clinic." *American Journal of Public Health*. 85 (11): 1526-1530. November 1995.

National surveys and other large studies have found that only 5-17% of condom users report use at each intercourse and factors associated with consistent use vary from study to study.

This report was drawn from a larger study of contraceptive care within a family planning clinic; data came from telephone interviews. Five behaviors were identified for the Condom Use Behavior Scale: use at each intercourse, putting on the condom before entry, withdrawal while there is still an erection, holding onto the rim during withdrawal, use of spermicide. From the larger study, three groups of condom users were studied: condom/pill users, condom choosers (those choosing the condom at clinic visits and subsequently using them for at least 1 month), and "other condom users" (those using condoms after some other method or no method).

Only 1% of women always engaged in all five behaviors necessary for condom effectiveness; 12% consistently engaged in four of the behaviors, 24% in three, 28% in two, and 21% in only one. Nearly 13% did not consistently engage in any of the 5 behaviors. 37% of all condom users reported use at every intercourse. "A main effects model indicated that higher Condom Use Behavior Scale scores were independently associated with having had no prior induced abortions, not being in the condom/pill user group, having more than average knowledge about birth control, having received the intervention [individualized assessment and counseling] and having more frequent partner communication about sex, birth control, and use of birth control." (1529)

Orbovich, Cynthia. "Case Studies of Collaboration Between Family Planning Agencies and Managed Care Organizations." *Western Journal of Medicine*. 163 (6): 39-44. September 1995 Supplement.

Reports on interviews with family planning providers in various states on their efforts to collaborate with local managed care plans. Focuses on five areas: Northern New England, Northeastern New York, Minnesota, and two localities each in Pennsylvania and California. Collaborations in each area are shaped by local market factors, client profiles, state laws and providers' previous relationships. In general, family planning agencies are moving to expand into primary care, to make themselves more viable partners of managed care organizations and to maintain their client base--but there are exceptions, such as Planned Parenthood Minnesota, which is focusing on the role of specialist. Most family planning agencies found that collaboration with them was very low on the list of priorities of managed care organizations, and in many cases such plans had difficulty understanding how to deal with clinics (they were used to contracting with individual private physicians). Some history of contracting, previous efforts to build relationships by family planning providers, access of family planning providers to large client bases or underserved areas, and laws requiring freedom of choice and involvement of community providers enhanced the likelihood of collaboration. Confidentiality and specific business/reimbursement arrangements were complex, difficult problems in the negotiating and implementation of collaborative plans.

Peterson, Linda S., London, Kathryn A., and Abma, Joyce C. "Determinants of Inconsistent Use of Coitus-Dependent Contraceptives Among U.S. Women: 1990." Paper Presented at the Annual Meeting of the Population Association of America. Miami, Florida. May 5-7, 1994.

A large proportion of unplanned pregnancies occur to women who are using a contraceptive method (53% of reported unplanned pregnancies in 1988) (see their refs). This study analyzed consistency of use of coitus-dependent methods (except withdrawal and periodic abstinence) and factors associated with consistency of use. Data were from the 1990 National Survey of Family Growth; sample was analyzed for use of any coitus-dependent method, including condoms (247 cases) and for use specifically of condoms/condom combination (181 cases). Among condom users, 44% reported inconsistent use in the previous month (only slightly higher than those using any kind of coitus-dependent method). Bivariate analysis found several factors associated with inconsistent use, but logistic regressions found no statistically significant (at .10 level) factors, perhaps because of small numbers. With this qualification, they did find age to be most strongly associated with consistency: women 20-34 were 5 to 6 times more likely to use condoms and/or other coitus-dependent methods consistently than were women 15-19; women 35-44 were also more consistent users than women 15-19. Low income and low levels of education were also associated with less consistent use. Surprisingly, unmarried or non-cohabiting women tended to use coitus-dependent methods slightly more consistently than married/cohabiting women. Women who had received instruction in birth control (from parent,

school, etc.) were more likely to report consistent use and women with one as opposed to two or more partners reported more consistent use (as in prior research). Women who were certain they intended to have a child in the future were less consistent users than ambivalent women; women who were certain they did *not* intend a future birth were 1.7 times more likely to use the condom consistently than were ambivalent women.

Radecki, Stephen, and Bernstein, Gerald S. "Use of Clinic Versus Private Family Planning Care by Low-Income Women: Access, Cost and Patient Satisfaction." *American Journal of Public Health*. 79 (6): 692-697. June 1989.

Reports on 1984-85 survey of poverty-level and near-poverty-level women residing in LA County. Sample was screened; final interview respondents had all visited a doctor or clinic for family planning with three years prior to the interview. Providers were categorized into four types: subsidized clinics; private, unsubsidized clinics that accept Medicaid; HMOs, and MDs in private practice. 25.8% of the respondents were currently using subsidized family planning clinics, 15.6% private clinics, 18.5% HMOs, 35.5% private MDs, and 4.6% other sources, including providers in other states or in Mexico. Utilization pattern did not vary by poverty level but did by race (and by poverty level within ethnicity): much higher proportions of Hispanics than whites or blacks used subsidized clinics, and among Hispanics, those below poverty were twice as likely to use subsidized clinics. Note that these findings differ from the NSFG cycle III, which found more use of subsidized clinics by blacks (and women below poverty). Also, women using subsidized family planning clinics were much less likely to have either private or public insurance than were women using other sources. (And Hispanics are much less likely to have insurance than are whites or blacks). Various other characteristics were found not to be strongly associated with source of care (including age, education, marital and employment statuses, etc.).

In terms of satisfaction with the provider, patients were generally most satisfied with private MDs and least with subsidized clinics, particularly as to convenience of time/date, length of wait in the office, waiting room crowding; different levels of satisfaction (same direction) were also found with respect to comfort around the other patients, a sense that the employees were understanding, a belief that care was the best available, etc. Patients in private practice were four times more likely than those in subsidized clinics to report seeing the same examiner at each visit. No differences between providers were noted with respect to completeness of the exam and considerateness of the examiner. Asked if they would prefer a different provider, 33.3% of those in subsidized clinics said yes, compared to 26.2% of those in HMOs and 15.5% of those seen in private clinics or by private MDs.

In terms of method education, subsidized clinics (followed by private clinics) are more likely to have provided information on each of the various methods than are HMOs and private MDs. Those seen by HMOs and private MDs are also much more likely to report having no methods explained. Patients of HMOs, followed by those of private MDs, were most likely to report that they could have any of a list of general medical problems attended to by their provider.

Rank, Mark R. "Fertility Among Women on Welfare: Incidence and Determinants." *American Sociological Review*. 54: 296-304. April 1989.

Quantitative analysis of Wisconsin welfare data with comparison to state and national data indicated that fertility rates (rates of childbearing) were significantly lower for women on welfare than for the overall female population, even when age, number of children, marital status, race, and education are controlled. Variables that affect the probability of childbearing among women on welfare are: education (lower=greater p.), race (nonwhite=greater p.), age (p increases until early 30s then decreases), marital status (married=greater p.), length of welfare use (longer use=lower p.). Effects of education, race, age, marital status are similar to what they are in general population. Qualitative study (50 interviews) looked at why rates are lower for women on welfare than women in general. Findings: most women were not seeking pregnancy, and their reasons for not wanting another child at this time had to do with their lack of resources and desire not to further limit their own opportunities. Women reported having gotten pregnant accidentally rather than intentionally.

Rosenbaum, Sara, Shin, Peter, Mauskopf, Alice, Fund, Karen, Stern, Gillian and Zuvekas, Ann. "Beyond the Freedom to Choose: Medicaid, Managed Care, and Family Planning." *Western Journal of Medicine*. 163 (3): 33-38. September 1995 Supplement.

Analyzes the implementation of the federal "freedom of choice" requirement enacted in the 1980s exempting family planning services from restrictions on Medicaid managed care participants' provider choices. The authors argue that for a number of reasons, the carve-out approach is not as effective as an effort to integrate family planning providers might have been, and that it should have been used as a last resort. Particular problems included ambiguity in the HCFA definition of family planning services, such that it could be interpreted narrowly to exclude some important services (especially treatment for STDs), limited application of the exemption (it does not apply to research and demonstration projects (S. 1115 programs), and there are no real implementation standards. State implementations vary, with some states making double payments to ensure access, others requiring prior authorization for family planning services, etc., increasing cost to the state and sometimes causing difficulty for providers and patients. Only one of the reviewed programs, that of Pennsylvania, used the requirement to integrate family planning providers into a managed care system. More effort should be put into such arrangements, with the carve-out approach relied on as a last resort in areas where managed care systems are nonresponsive.

Severy, Lawrence J. and McKillop, Kevin. "Low-Income Women's Perceptions of Family Planning Service Alternatives." *Family Planning Perspectives*. 22 (4): 150-157, 168. July-August 1990.

Analyzes data from a survey of 665 low-income women from predominantly rural

Florida. Respondents were asked to rate the importance of 25 possible features (developed from focus groups and other work) of family planning providers and separately to say how characteristic these features were of particular kinds of providers (private doctors; public health clinics, etc funded by government agencies; and "voluntary" organizations like Planned Parenthood). Note that the sample was drawn from women seeking services from different types of providers, but only 7 of the respondents were users of private doctor services.

Most desirable features of service delivery were well-trained staff, trustworthy staff, friendly staff, MD presence when needed, and gentleness of examiner. These are characterized as reflecting two general areas of concern: staff competence and quality of interpersonal interaction.

Perceptions of different providers were as follows. Public health clinics were seen as taking Medicaid, teaching clients how not to become pregnant and how to care for themselves/stay healthy, and treating people from varying backgrounds; also having well-trained staffs. Private doctor providers were perceived to have well-trained staffs, an MD present when needed, trustworthy staff, privacy, and information on how to care for oneself/stay healthy. Voluntary organizations were perceived as treating people from varying backgrounds, providing referrals, providing information on how to stay health and avoid pregnancy, and being friendly. There was some uncertainty about attaching specific characteristics to specific provider types.

These factors were analyzed for groupings and four were identified: clinic competence, friendly staff, "stereotypic social agency" (Medicaid acceptance, social workers present, etc.), and "minimalistic" (low-rent/low-quality). Rated according to these four factors, provider types looked very different: "Private physicians were perceived as offering extremely competent services but having the least friendly staff; voluntary organizations, conversely, were perceived as having a very friendly staff but offering the least competent services. Public health clinics were viewed as located between these two extremes . . ." (154-155)

There was some variation in perceptions by educational level, but more interesting distinctions were by race. Blacks saw private doctors more positively than did whites, but also expressed more support for public health clinics than did whites. Whites were more likely than blacks to favor voluntary organizations.

Finally, program perceptions were rated by the importance/value assigned to those by the respondents. the strongest reason for choosing public health clinics was belief that the staff is well trained. But women also dislike long waits and perceive this as characteristically found in public health clinics. Women also objected to programs that couldn't care for all of their health problems, also a perception of public health clinics. Out of the 25 features, private doctors were found to be most attractive on 13. In particular, privacy represented a significant advantage. Friendliness ratings disfavored physicians but the difference and disadvantage were slight. The most attractive feature of voluntary organizations were their perceived teaching and referral capacity.

There was some interaction between the site where respondents were recruited and their attitudes. In addition, though, and quite significantly, the authors note that respondent perceptions of private doctors may have represented idealization more than experience. And on the flip side, lack of experience with some providers--e.g. voluntary organizations--may have resulted in unrealistically low opinions.

Other notes of relevance, from other research: Approximately one-third of the more than 40 million family planning visits made annually in the US are to publicly funded family planning clinics, with the remainder made to ob-gyns, GPs, and family practitioners. Income and payment source significantly affect provider use. For teens, that two important reasons given for visiting a clinic as opposed to a private doctor are expense and worries about the physician notifying the family; teens also do not know of private physicians (cite to M. Chamie et al., 1982). Teen reasons for choosing a particular clinic were confidentiality, staff caring about teens, privacy and convenience of location, use by friends, and limited knowledge of alternatives (city to Zabin and Clar, 1981, 1981).

Silberman, Terry A., and Hamilton Ellen. "Facilitating WIC Participants' Access to Family Planning Services: Focus Group Results." Report of WIC Program, Harbor-UCLA Research and Education Institute, Inglewood, California. June 1994.

Reports on the findings of a series of 9 focus groups conducted among WIC program participants on the subject of family planning. Three groups were with African Americans and six were with Latinas (5 of these were conducted in Spanish). A total of 90 women participated, aged 18-40, with 5-9 women per group. Many findings were strikingly similar to those of the UC Data focus group study, but a few were different.

The term "family planning" was interpreted by Latinas to emphasize planning, responsibility, and control over family size. As benefits of family planning, Latinas emphasized the ability to support one's children better and to provide a better education. In describing motivations for using family planning, they cited a variety of factors (economic issues, health concerns, mother's occupational goals, need to establish a couple first, etc.) but economic concerns permeated the discussions. African American women thought the term referred to decision making about when to have children and how many to have; some also emphasized a healthy child rearing environment; younger participants saw it as "birth control." They were not asked directly about benefits, but offered as reasons for spacing children both attention available and health benefits to the mother. As motivations for family planning use, they cited personal and occupational goals, the difficult of caring for numbers of small children, and economic concerns. Health care providers were not seen by either group as tremendously influential in the decision to contracept, but did have an influence on method choice. Consistent with UC Data findings, a number of Latina women complained that doctors had not offered them a range of options but focused on the pill.

Latinas reported the advice of friends and relatives as being significant, but for African Americans they played less of a role in decision-making, though friends and family were an important source of information. Several African American women reported that their mothers had taken them to get birth control; others said parents had preached abstinence. Husbands or partners were not usually influential in the contraceptive decision making of African American women (though sometimes men persuaded women to bear children) but were important in the decisions and behaviors of Latinas. Consistent with our findings, many Latinas reported resistance by men to the use of contraception and suspicions of women for using it, though some

men were supportive, and there were reports of friends unable to use contraception whose husbands had volunteered to be sterilized or use something. Some African American women noted that men resist condom use and they suggested that men should take more responsibility.

Health concerns were cited infrequently as a motive for using birth control by the Latinas and they almost never raised the issue of STD concerns, somewhat in contrast to UC Data findings. African American women cited disease prevention as a reason for using condoms but only referred once to AIDS/HIV specifically.

Most noteworthy were reasons for nonuse of family planning, which echo many of the findings of the UC Data study. Among Latinas, reasons suggested included ignorance, not taking the time, directives from the husband, fear of side effects, concern about method failure and a perceived lack of good choices. (Note that "Some attributed nonuse (among other women) to ignorance, carelessness, laziness, or not taking the time to obtain information or methods." (8)) African American women suggested that many women simply leave things up to chance, an attitude by some as being due to indifference or thoughtlessness about becoming pregnant. "Women were more likely to attribute nonuse among themselves to the fact that they 'hadn't gotten around to it yet' or were not very [sexually] active at the time." (24) These women also reported concerns about method failure and uncomfortable side effects, resulting in a sense of limited choice. Consistent with UC Data findings, perceived lack of options, fear of side effects, and stories of method failure were significant reasons for nonuse reported by both African Americans and Latinas.

Many women in both groups were dissatisfied with relationships with health care providers. Some Latinas felt doctors offered only one birth control choice (the Pill), and a few cited instances in which their first choice was turned down. A number had been denied sterilizations. Latinas were hesitant to communicate their needs assertively, due at least in part to language barriers, as well as embarrassment in seeing male clinicians. African Americans reported some embarrassment over physicians' questions but apparently didn't specifically indicate a reluctance to ask questions themselves.

Both groups of women expressed strong in obtaining more information.

Silverman, Jane, and Torres, Aida. *Barriers to Contraceptive Services*. New York: The Alan Guttmacher Institute; 1987.

Purpose of the study was "to explore the barriers to utilization of family planning services and use of contraceptive methods among low income and minority women." Methodology was a telephone survey of women (black, white, Hispanic) in four geographic areas around the country. The survey instrument development was based in part on six focus groups conducted with women from the same population, though in different areas. Survey included questions about knowledge of, attitudes toward, and experience with medical Family planning providers as well as contraceptive methods. A provider survey was conducted in the same areas, partly to try to determine accuracy of women's perceptions and differences between women's and

providers' assessments. Women were 18-35, not pregnant, not trying to become pregnant, not sterile or with a sterile partner (for whatever reasons), have had sexual intercourse, and if 20 or above, have family income below 200% of poverty. 760 women were interviewed.

The study had an overall conclusion that is particularly relevant to the UC Data work. Specifically, in this study, the focus group topic guide primarily emphasized "structural" or provider-related barriers to contraception. But comments from focus group participants indicated that "nonstructural factors, such as fear of side effects, or fear, shame, and embarrassment about visiting a provider, or incorrect understanding of the probability of getting pregnant" were also very important. As a result, these concerns played a more prominent part in the survey instrument than was originally planned.

The survey itself found that nonuse and use of less effective methods related to fears and dislike of specific methods and of contraception in general, and that structural barriers such as cost were rarely reported. It's worth quoting from the authors: "The results of this study suggest that negative attitudes toward contraceptives, not negative attitudes toward medical family planning providers, are important determinants both of contraceptive nonuse and of reliance on nonprescription methods. . . . Negative attitudes and misinformation about contraception (especially about the most effective methods) must be resolved before a woman feels that she can approach a medical family planning provider." (quote in article by same authors+Forrest, p. 101) The study identified as important misperceptions both exaggerated fears about the pill and underestimates of condom effectiveness. "Structural" factors seemed to have more of an influence on the type of provider chosen than on the decision to seek out a medical provider.

The study found a sizeable minority of women at risk who do not contracept, though the number seems to be lower in AGI's 1995 data, which are not yet publicly released. In the earlier survey, 23% of women *who were "in a sexual relationship"* were not contracepting. [When broken down by age, the proportion was highest among the oldest women (30-35 years old); the figure for this group was 30% compared to 19-22% for the other age groups. By race/ethnicity, the proportion was highest among Latino/Hispanic women (33%, compared to 18% for whites and 22% for blacks).] In addition, the study reported that of the total number of women who were not using birth control, 15% were not doing so because they were not currently involved in a sexual relationship; note, however, that these women might well be sexually active and at risk.

The study also found that of those in sexual relationships who were not using birth control, half gave either side effects (experienced or feared) or

dislike of birth control as a reason. In particular, the Pill and IUD are seen by most women not using them as basically unsafe. Barrier methods are often rejected because of perceived ineffectiveness and intrusiveness. Two specific issues that need to be addressed are fear of side effects from the Pill and the underrating of condom effectiveness. Less than 5% gave cost as a reason for nonuse; another 5% said they had run out of supplies (as distinct from having difficulty obtaining supplies). 11% cited a partner's opposition, 13% had recently given birth, 4% "would not mind having a child," and 13% didn't know or gave other reasons. Negative attitudes toward specific methods (as found in the earlier study) included the following:

- pill and IUD: concerns about side effects and health risks
- condoms: concerns about effectiveness; intrusiveness; and partners' objections
- diaphragm: intrusiveness, messiness; secondary concerns re: effectiveness (which was overestimated).

The concerns were expressed as attitudes affecting choice and as reasons for abandoning a method. In addition, women tended to hold these views regardless of whether or not they were users of the method. Among women receiving contraception, a substantial proportion may end up not using it or using the method erratically (the later, as yet unreleased study will address this question).

As noted, the study concluded that structural or provider-oriented factors were more important in the choice of a particular provider rather than in the decision to find a provider. In choice of provider, the most important factors women cited were personalized care and affordability--though these were somewhat at odds, given that women felt that private physicians (the provider of preference in both studies) were more likely than clinics to give quality, personalized care but were less affordable. Women were more somewhat more favorably impressed with clinics if they had actually used them. The authors concluded that provision of more personalized care--and marketing of this fact--was probably the single most important change that providers could make. Some services and policies were not well known, but it is not clear that this lack of information constituted a major barrier to access.

Finally, the AGI studies excluded women over the age of 35 because of the popularity of sterilization *and* the lower likelihood of unplanned pregnancy among these women (They separately screened out those who could not become pregnant, for whatever reason.)

Silverman, Jane, Torres, Aida, and Forrest, Jacqueline Darroch. "Barriers to Contraceptive Services." *Family Planning Perspectives*. 19 (3): 94-102.

May-June 1987.

Reports on the study of barriers to contraceptive services and service preferences experienced by low-income women (same study as reported in the AGI report "Barriers to Contraceptive Services"). Data drawn from a telephone survey of 760 low-income women (ages 18-35) in four geographic locations who were at risk of unintended pregnancy. The study also included a mail survey of family planning clinics and ob-gyns and providers mentioned by the women, in the same communities.

94% of the women had used contraception at some point, but currently among women sexually active at the time of the survey, 23% were not using birth control. When asked why, about half alluded to negative attitudes toward methods, including concern with side effects. Another 11% said contraception was unacceptable to a partner or unsuitable for a relationship. "Only nine percent of the nonusers mentioned a reason that could be considered related to the provision of services (cost, for example, or no more contraceptive supplies on hand)." (95)

Women expressed concerns about side effects and health risks of the Pill and IUD, and were skeptical of the effectiveness of condoms (as well as objecting to its intrusiveness, an objection they had of the diaphragm as well). ". . . women were generally knowledgeable about the effectiveness of the pill, IUD and condom, but overestimated the effectiveness of the diaphragm and foam." (95)

"In summary . . . both nonuse of contraceptives and the use of less-effective methods appear to be related to method-related fears, a dislike of available methods and general negative feelings about contraception. . . . The respondents seldom reported structural or provider-related concerns, such as cost, to be barriers to contraceptive use." (95-96)

91% of the women had visited a clinic or physician for family planning services at some time. Those who had never done so were asked to name a clinic and private doctor in the area where birth control could be obtained; 62% could name a clinic and 28% could name a physician, but 27% (of those who had never seen a provider for birth control) were unable to name either. Among those who had not visited a provider (at all or within the last 3 years in the current area of residence), 3 out of 5 gave method-related reasons (including nonuse of prescription methods). 9% mentioned cost and lack of knowledge of where to go for service. "These results indicate that attitudes toward contraceptive methods (specifically toward prescription methods) are a hurdle that many women must clear before approaching a medical family planning provider." (96)

"Structural" factors are a relatively minor influence on the decision to seek a provider, but they do play an important role in the choice of provider

once the decision to seek care has been made. Very important factors to women are personalized care and financial accessibility. "Although more women had gone to clinics than to private doctors, three out of five of the respondents stated that they would prefer to go to a private physician for birth control services if they had the choice." (96) MDs were seen as providing a higher quality of care than clinics, and quality of care was cited as a reason by 78% of those who said they would prefer to see a physician. The main reason for preferring clinics was cost (cited by 41% who expressed this preference). Clients who have been to a clinic have a more favorable impression of the quality of care at clinics than do those who have not.

"The results of this study suggest that negative attitudes toward contraceptives, not negative attitudes toward medical family planning providers, are important determinants both of contraceptive nonuse and of reliance on nonprescription methods. Women's fears about the pill and their objections to barrier methods leave many with few contraceptive options besides sterilization. Furthermore, our findings indicate that even women who are using effective methods believe that there is a sizable chance of their becoming pregnant." (101) Where provider factors become important is in the choice of provider once the decision to find one has been made; here, "If clinics were to make a single structural change designed to better satisfy consumer preferences, that change would focus on the provision of more personalized care." (102)

Note that "few differences were found in the overall responses of women in different racial and ethnic groups, at least on key issues." (95).

Sonenstein, Freya L. "Accessibility and Affordability of Contraceptive Services: What Should the Role of the Public Sector Be?" Remarks delivered at the Fourteenth Annual Research Conference of the Association for Public Policy and Management. Denver, Colorado. October 30, 1992.

Summarizes history of recent federal funding for family planning and raises questions about recent/current policy, including decreases in real funding during the 1980s. Of note: preliminary tabulations of 1988 NSFG data indicate that, of poor women, 12% obtained family planning services within the last year from a Title X clinic, 11% from another type of clinic, and 13% from a private physician. More affluent women are considerably more likely to use a private MD (24% of those with incomes over 150% of poverty do so) but are not more likely to have had an family planning visit in the previous year--so clinic availability appears to result in at least apparently equal access to family planning services. Between 1982 and 1988 poor women's use of family planning services did not decrease but their reliance

on clinics rose significantly.

Another important point Sonenstein raises is that clinics are faced with increasingly complicated problems/needs, including the need for STD and HIV testing, treatment, and education/counseling. "With rising rates of heterosexual transmission of HIV, it is a matter of time before condoms will be routinely recommended for major portions of the sexually active population and condom education and distribution will need to be more fully integrated into the family planning visit protocol." (12) She also notes the problem that patients using the most reliable methods of birth control (pills and Norplant) are also less likely to use condoms, though they may be needed for protection against STDs.

Sonenstein, Freya, Leighton, Ku, and Schulte, Margaret. "Reproductive Health Care Delivery: Patterns in a Changing Market." *Western Journal of Medicine*. 163 (3): 7-14. September 1995 Supplement.

Analyzes patterns of reproductive care among women surveyed in the 1993 Follow-up of the National Survey of Women (1991); response rate was 65%, with 1093 women between the ages of 21 and 40 participating in the follow-up (note that for reasons having to do with their selection for a 1983 study, the sample may have reflected some bias in marital status compared to the US population as a whole).

80% reported have had at least one reproductive health service in the previous year, most commonly a gyn exam (72%), and a third of the women (34%) reported receiving birth control. These numbers are similar to the 1988 National Survey of Family Growth. The great majority of women-- 76%--received reproductive health care for private physicians, with 15% using clinics, 7% HMOs, and 2% other health providers. Poor women were much more likely than higher-income women to use clinics (and less likely to use private MDs, but even among those with incomes up to 100% of poverty, 56% used private physicians (and 33% clinics)). These figures are also similar to the 1988 NSFG. More detailed information on type of clinic is not available because respondents are usually unable to differentiate; clinic types could therefore include hospital clinics, community health centers, health departments, family planning and Planned Parenthood agencies, etc. Data from the National Ambulatory Medical Surveys of 1989 and 1990 show that 74% of visits primarily for a gyn exam are made to ob-gyns, with 14% to GPs/family practitioners and 12% to other specialists; visits including Paps were done by general/family practitioners (50%), ob-gyns (41%), and other specialists (9%). Multivariate analyses revealed that "In general, the most important factor affecting where a woman receives her reproductive health

services is where she receives her regular primary care . . . Clinics are . . . important sources of care for women who are on Medicaid or who are uninsured, but women who have regular private insurance are more likely to use a private physician." (12)

63% of those surveyed here reported that their most recent reproductive care visit was paid partially or fully by private health insurance; 7% reported Medicaid coverage and 7% free services; almost 25% paid for the visit themselves (though this may have included subsidized services). Somewhat unexpectedly, lower-income women more frequently reported self-pay- only visits than did upper income women, and not surprisingly, reported more incomplete insurance coverage. Average out-of-pocket dollar amounts were roughly the same for lower and higher income women, so they represented a higher proportion of poor women's income.

"Women overwhelmingly said that they would prefer to receive birth control and other reproductive health services from private physicians. Only 4% reported that they would prefer HMOs, and 8% said they would prefer clinics." (11) Those preferring HMOs were HMO users and those preferring clinics were clinic users, but more than half the users of these facilities would rather go to a private physician. Private MDs were preferred primarily because of the continuity of clinicians from one visit to another or because of a belief that the quality of care was higher. When clinics were preferred it was primarily for low cost and accessibility. Low cost also was the primary reason for preferring HMOs, but they were also believed by some to give high quality care.

Women also expressed a strong preference for receiving reproductive health care in a setting that also provided general health care (70%) although 28% preferred a place that provides reproductive health care in addition to birth control. (Choices were birth control only, reproductive care+birth control, and general health care.)

It is very important to recall that the sample did not include teenagers, whose preferences might be very different.

Stewart, Felicia. "Integrating Essential Public Health Services and Managed Care: Family Planning and Reproductive Health as a Case Study." *Western Journal of Medicine*. 163 (3): 75-77. September 1995 Supplement.

Discusses issues arising in the integration of public health services, particularly reproductive health services, and managed care plans. Notes that managed care plans grew out of indemnity models in which a goal is limiting utilization to contain costs; however, the preventive services that are the focus of public health efforts should result in decreased costs over time,

so the constrained utilization approach is inappropriate for these kinds of services. A related issue is the need to be able to identify/internalize long-term benefits arising from preventive care, so that there is an incentive for individual plans to provide it. Other issues are the need to provide sufficient intervention time for family planning education and counseling and the need to provide for confidentiality in service delivery.

With respect to the time problem, Stewart notes that gatekeeper/primary care providers almost inevitably have extremely busy schedules--sometimes expected to see as many as 40 patients a day--that do not allow for any significant informing and counseling opportunities. Other means must be found, then, to educate and counsel patients; in some plans, the well-person visit may be an opportunity for such discussion. In addition, primary care clinicians are not necessarily well trained in family planning and may be unable to provide a full range of contraceptives, particularly those known to be most effective. Because these services are underemphasized in medical training, plans may have to provide additional education for their clinicians.

Confidentiality is a particular problem in managed care plans where management information systems to track utilization play such a significant role.

Tanfer, Koray, Cubbins, Lisa A., and Brewster, Karin L. "Determinants of Contraceptive Choice Among Single Women in the United States." *Family Planning Perspectives*. 24 ( 4): 155-161. July-August 1992.

Analyzed data from the 1993 National Survey of Unmarried Women, conducted with 1314 never-married, 20-29 year-old women; analysis excluded women not currently sexually active (note that the choice not to be sexually active may itself reflect thinking about contraception) and those who were infertile or had infertile partners. Though some 80% of the white women and 90% of the black women had ever had sex, only 51% of the whites and 62% of the blacks had been sexually active in the 4 weeks prior to the survey (defined as currently sexually active). Dependent variable was contraceptive choice, divided into 3 categories: pill or IUD use, use of other methods, nonuse.

Independent variables included: childhood family structure, education, work status, religion, region, years of sexual experience, past contraceptive failures, abortions, relative fertility, living arrangement, duration of relationship, and race. Higher education was associated with higher probability of using a method (though not necessarily the most effective methods, as defined here). Family structure had minimal effects. Labor

force participation was salient only for women employed in career-oriented work (increasing the likelihood of use). Conservative religious affiliation is associated with less use, particularly of the pill and IUD. Women living in the South, surprisingly, were more likely to use a method than those in the Northeast or North Central regions; residence in the West had no effect on contraceptive use. The younger a woman was at first intercourse, the less likely she is to be a current contraceptive (this also meant that longer sexual experience was associated with nonuse). Prior abortion is negatively associated with contraceptive use, with no effect on method choice. Women who had experienced a contraceptive failure were more likely to use coitus-dependent methods. Relative fertility (defined as a woman's actual fertility compared to desired fertility) was important in the following ways: women with high relative fertility were much more likely to be contraceptors, but relative fertility was unrelated to choice of method. Both cohabitation status and length of relationship had minimal effects on contraceptive use or choice. With the other controls mentioned, white women were more likely to contracept than were black women, but there were no race differences in method choice.

A number of other variables were tested and found insignificant, including: mother's education, community size, religiousness, self-esteem, number of lifetime partners, and approval of abortion. Difficult to know if they had no real effect or it simply couldn't be captured.

Westoff, Charles F. "Contraceptive Paths Toward the Reduction of Unintended Pregnancy and Abortion." *Family Planning Perspectives*. 20 (1): 4-13. January-February 1988.

From data in the 1982 NSFG, along with adjustments for underreporting of abortion based on other studies, the author estimates the reduction in unintended pregnancy and abortion that would result from three scenarios: I, a significant increase in pill and condom use, a slight increase in the use of other methods and a 50% decline in nonuse; II, the use of new methods (implants and RU486) by 15% of at-risk teens, substantial increases in pill and condom use, little change in other method use, and an additional halving of nonuse; III, the elimination of nonuse with proportionate increases in all methods currently used. Model I results in a 20% reduction in unintended pregnancy rate among teens, Model II a 43% reduction among teens, and Model III a 41% reduction (less than Model II because of different method effectiveness). A problem with the models is the assumption of pregnancy rates for different methods (or for nonuse) that are independent of possible differences in the kinds of people using the

methods (e.g., that pill failure rate will remain the same following a substantial increase in use by women not now using the pill, etc.).

Zill, Nicholas. "The Need for Family Planning Services Among Welfare Recipients." Paper Presented at the Seminar on Family Planning Services for Special Populations, American Enterprise Institute, Washington, D.C.. April 23, 1996.

Discusses relationship between unplanned childbearing and welfare in the US and summarizes data from relevant surveys. Women are 5 times more likely to be on welfare if they had their first child outside marriage; likely to stay on welfare if they have more children while on welfare. Women on welfare are having fewer children than their predecessors did, but the drop has hit a plateau, not decreasing much since the early 1980s and possibly will be rising with the increasing proportion of Latino/as (who tend to have larger families) in the US population and welfare caseload. It is also still true that women on welfare have more children, as well as more unplanned and more unwanted pregnancies than do those not on welfare. In addition, the intergenerational interval is shorter for those on welfare than for middle class women (of any race) who postpone childbearing. Fifty-five percent of mothers on welfare began childbearing in their teens. Also, the ideal number of children is higher among mothers on welfare (3.0) than nonwelfare mothers in general (2.7) and nonpoor mothers in particular (2.5).

1988 NSFG shows that almost 17% of women on welfare were at risk of pregnancy and not using birth control, but only 3% said they wanted to get pregnant. "Compared to mothers who were not receiving welfare and were not in poverty, welfare mothers were less likely to be using some form of contraception . . . and more than twice as likely to be clearly at risk of pregnancy.

On the other hand, a high proportion of women on welfare who have had as many children as they want have had tubal ligations. Overall prevalence of sterilization is only slightly higher among welfare recipients than nonwelfare women but the former group is also younger and more often unmarried, which would tend to decrease the rate of tubal ligation. Mauldon & Miller found that 52% of AFDC mothers with three or more children had been sterilized and one percent were with partners who had been sterilized. By contrast, nonpoor, nonwelfare mothers with 3 or more children were less likely to have had tubal ligations (36%) and much more likely (26%) to have a vasectomized partner. There is evidence of limited responsibility by the partners of women on welfare also in the limited use of

condoms: "Welfare couples are only one-third as likely as nonpoor couples to use condoms..." (6)

The author hypothesizes that tubal ligation may be popular because so many women on welfare have had at least one mistimed conception (2/3 compared to 44% of nonpoor mothers--though note that the latter figure still is awfully high). 29% of women on welfare had had at least one birth that was unwanted at conception (i.e., no more children were wanted), compared to 13% of nonpoor women. "Welfare mothers in the NSFG reported that about 20 percent of the children that they had borne were unwanted at the time of conception." (7)

Although the general picture of women on welfare contradicts the popular negative stereotype, there is also a "high-risk minority" that is more similar to that stereotype, including those with drug or alcohol problems or chronic personality disorders. These women are overrepresented among the group of women with larger than average families and are also most likely to have at-risk pregnancies and infants. Reaching this group with effective family planning is likely to be extremely difficult and could possibly require intensive, even intrusive interventions.

The author suggests that interventions to assist women with family planning at the point when women have already had two children are likely to be successful, but efforts to persuade women to stop childbearing after one child are less likely to succeed. Note that many of these women do not see childbearing outside marriage as detrimental to the children.

## APPENDIX C

### DATA COLLECTION INSTRUMENTS

UC DATA REPRODUCTIVE HEALTH POLICY STUDY  
FOCUS GROUP DISCUSSION GUIDE

DRAFT January 19, 1996

**INTRODUCTIONS**

Thank you for coming and helping us out with this research.

I am \_\_\_\_\_, and I work with the Survey Research Center at the University of California at Berkeley. We are interested in learning more about women's actual experiences and ideas about childbearing and family planning, so tonight we'll be asking you to share some of your feelings and experiences in these areas. The State Department of Health and the Department of Social Services are concerned about what can be done to improve services, and your participation in this study will be especially helpful to them in deciding what changes to make.

Before we get into our discussion, I'd like us to briefly introduce ourselves. I'll begin. [Facilitator: give first name, city of residence, briefly describe family circumstances.] Can we go around the table now and have each of you tell us your first name, the city you live in, and anything else you'd like to say--maybe something about your family.

**I. ATTITUDES TOWARD CHILDBEARING AND PREGNANCY PREVENTION**

We'd like to begin our discussion by asking you what you think about the general idea of family planning--that is, planning when to have children and how many to have.

- (1) **Some people say that if it's your time to get pregnant, you will--regardless of what you do. What do you think about this? Does it make sense to really plan when you're going to have kids? How much control do people really have? What are the advantages and difficulties?**
- (2) **What if you get pregnant at a time when you're not ready for it? Is timing very important, or is it not so much when you have your children, but how many you have?**
- (3) **Some people in government are interested in changing welfare payments, so that women with more children will not get more cash aid. Have you heard about such**

plans? If such a plan went into effect, would this make a difference in how you think about family planning? Would it make a difference in your use of birth control?

## **II. PERCEPTIONS OF BIRTH CONTROL AND HOW THEY'RE FORMED; EXPERIENCES WITH BIRTH CONTROL**

A. Now we'd like to talk more specifically about methods of birth control, and about your own experiences either using or thinking about using birth control. When you came in today/tonight, we asked you to fill out a questionnaire about birth control, and one of the questions we were particularly interested in was what people think about some of the more popular methods. We'd like to talk about some of that now.

- (1) **We asked you about the Pill and its safety (that is, whether or not it is harmful to your health). Many people have strong ideas about the safety of the Pill. What do you think? Is it safe to use, or are there problems with it?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Is this something you talk about with your friends? Your family? Your partner?**

**Do these people all feel the same way about the Pill's safety or do some of them have different opinions?**

- (2) **Let's move on now to talk about the Shot (Depo Provera) and its safety. What do you think, or what have you heard about the Shot? Is it safe to use, or are there problems with it?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Do the people you talk to about this--your partner, family and friends--all feel the same way about the safety of the Shot or do some of them have different opinions?**

- (3) **Now let's move on to condoms, and switch to the question of effectiveness--that is, how good the method is at actually preventing pregnancy. What do you think about condoms and their effectiveness at preventing pregnancy?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Do the people you talk to about this--your partner, family and friends--all feel the same way about condom effectiveness or do some of them have different opinions?**

- (4) **We've talked a little about people's ideas about the Pill, the Shot, and condoms. Now we'd like to ask if you always held the same opinions about these methods or if you can remember things happening that changed your mind about any of them? [Rephrase as a specific question if needed: Like with the Pill--did you always feel the same way about it, or did something change your mind? ]**
- (5) **We happened to pick just a few birth control methods to ask you about, but there are many others. Are there some that we haven't mentioned that you have considered using and have some ideas about? [Probe for withdrawal; female sterilization.]**
- B. We've been discussing your ideas about different methods, their safety and effectiveness, and some of you have mentioned personal experiences with birth control. We'd like to focus now on your own experiences, and particularly, current or recent experiences with birth control.
- (1) **What's the most recent birth control method you've used? Can you tell us how you decided you needed/wanted birth control at all? And then, how you decided on that method?**
- (2) **Was it a good choice? Were you satisfied with it, or did you have problems with it? (If so, how did you resolve them?)**
- (3) **Was a partner involved in your choice and use of this birth control method? Do partners make it either easier or harder for you to use birth control? What about family and friends? Do they help or hinder you in any way in your decision about birth control? Or in your use of birth control? Are there any community, cultural, or religious influences on your use of birth control?**

### **III. EXPERIENCE WITH FAMILY PLANNING AND OTHER SERVICE PROVIDERS**

Let's talk more specifically now about where people go to get birth control services and information, and other medical services and information. We're interested both in where you get services (that is, what kinds of providers you use) and what you think of those services.

- (1) **Where have you obtained birth control services or methods (MD, clinic, drug store, friends, etc.)? If you've used condoms and/or foam, do you buy them or get them free**

from a clinic? Is it convenient? Is cost a problem?

(If people have obtained services from other than family planning providers, probe for whether the birth-control-related service was initiated by the patient or the provider.) [*In Latina groups, ask if providers were in the U.S. or another country.*]

- (2) **How did you find out about those places?** (Probe for possible sources of referral: friends, family, other service providers, ads.) **Did anyone find out about family planning services from their AFDC eligibility workers? Can you recall what you were told? Were you told services were free? Were you given any written information (e.g., brochures)?**
- (3) **In visiting service providers have you ever felt pressured to use birth control or to use a particular method? (If so, do you have any sense of why this provider pressured you?) Have you ever been given a method--say, by a doctor or clinic--that you then didn't use?**
- (4) **Have you ever been discouraged from using birth control, or from using a particular method? By whom, or in what setting? For what reasons?**
- (5) **Have you ever wanted or needed birth control and not gotten it? Looking back, would anything have made it easier for you to get and use birth control at that time?**
- (6) **Do you get regular GYN care--pelvic exams, Pap smears, breast exams? Is this important to you? Are you satisfied with the care you get?**

**When you've gone for general health care or GYN care, has your doctor brought up family planning? (If so *or* if not:) How do you feel about this?**

**Have you ever felt that you couldn't get birth control from your regular doctor for any reason? (Examples: maybe because you were uncomfortable discussing it with him/her or you were worried about confidentiality.)**

- (7) **When you've had questions or problems pertaining to birth control, where have you gone for answers or help? (return to provider, go to friend. . .)? Were you satisfied? (With provider:) were you comfortable asking for help? *For Spanish-speaking Latinas: probe for language issues.***
- (8) **Thinking about your most recent visit or visits to get family planning services, what did you like best about that service experience? (Probes: convenient hours, location; ease of getting appointment;**

sensitivity; take time with patients; low cost; confidentiality; get choice of MD/NP; short wait; etc.)

**Was there anything you didn't like, or thought was a real problem with these services?** (Probes: generally, opposites of good things.)

**Have you recommended any of these providers to a friend?** (Probe for what types of providers/why.)

#### **IV. SPECIFIC SUGGESTIONS ABOUT IMPROVING INFORMATION AND SERVICES**

Finally, we'd like to see if you have any additional comments or suggestions to make about how information and services could be improved.

- (1) **When you hear or read the term family planning services --like in a radio ad or a billboard--what does this mean to you? (Do people use any other names for this kind of service? Example, if needed: Planned Parenthood. ) What kinds of services do you think are included in family planning? Which of these are the most important to you?**
- (2) **Would you prefer to get family planning services in the context of regular medical care or would you rather go to a specialist (a family planning clinic), or does it not matter?**
- (3) **Are there ways in which family planning services could be changed that would make it easier or more pleasant to get services?** (Probes: use of same vs different provider as used for other care; transportation; child care; fees/cost; hours; location; different medical provider (sex/race/age/sensitivity); better non-medical staff; drop-in vs appointment; waiting time issues; eliminating pelvic/PAP; bilingual/bicultural staff.) [NOTE: This question should be a brainstorm in which suggestions are written down on an easel and participants get to look over the list and indicate which are the most critical.]
- (4) **Birth control is currently available in clinics, doctors' offices, county health departments, and so forth. Are there other locations that you think would be more convenient than any of these?** (Probes: mobile clinics, school-based, WIC office, mail-order pharmacies.)
- (5) **We've talked about some of the places where you get information about family**

**planning methods and services. Are there other places where people you know get this kind of information? Are there other good ways to reach people?** (Probes: TV commercials/shows, magazine ads/articles, social service program offices. Probe also for specifics throughout and for how likely they would be as individuals to pick up messages in these contexts--e.g., do they get other information from this source?)

- (6) **Would the AFDC office be a good place to get information about family planning? How should the information be made available: should there be brochures, should eligibility workers or other AFDC workers talk to their clients about services? Are there any other welfare or social service programs where it would be good to get information (e.g., GAIN, Cal-Learn)?**
  
- (7) **The State Health Department is interested in running a public information campaign on family planning. They're thinking of using radio, TV, and printed materials to try to answer people's questions about birth control. If they do this, what kind of information do you think they should try to provide?**

Questionnaire for Discussion Group Participants  
April 19, 1996

We're interested in learning more about women's actual experiences and ideas about child bearing and family planning (planning when and how many children to have).

We'd like to start by getting your opinions about four different types of birth control methods -- the Pill, condoms, the shot (Depo Provera), and female sterilization (having your tubes tied). Your answers to all these questions will be anonymous and confidential.

(1) How good do you think each of these methods is at keeping a woman from getting pregnant? Please circle your answer for each method.

The Pill is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
Condoms are:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
The Shot is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
Sterilization is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1

(2) How safe do you think each of these methods is, for a woman's health in general? Please circle your answer for each method.

The Pill is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
Condoms are:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
The Shot is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
Sterilization is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1

(3) Please check if you have ever used any of the following birth control methods. Check all that you

have used.

- withdrawal (man pulls out before he comes)
- rhythm or natural family planning (don't have sex when you're fertile/ovulating)
- the Pill
- condoms
- foam (or similar products)
- the Shot (Depo Provera)
- Norplant
- diaphragm
- abortion
- female sterilization (tubes tied)
- male sterilization (partner had vasectomy)
- IUD
- film (vaginal contraceptive film)
- preventing pregnancy by making love in other ways (oral sex, anal sex)
- other: \_\_\_\_\_
- never used a birth control method

(4) Where have you gone for birth control methods or supplies in the past two years? Check all that apply.

- private doctor, group practice, or HMO
- clinic or hospital that provides general medical care
- family planning clinic
- drug store, grocery store, etc.
- friends or family gave me supplies
- partner got supplies
- other: \_\_\_\_\_
- never used a birth control method

(5) Do you have the kind of Medi-Cal that lets you go to *any* doctor (who accepts Medi-Cal), or did you sign up for a managed care/HMO plan where you have to choose one doctor to stay with?

- I have the kind of Medi-Cal that lets me go to *any* doctor (who accepts Medi-Cal)
- I signed up for a managed care/HMO plan where I stay with one doctor

(6) When was your last GYN check-up (pelvic and Pap smear)?

- within the last six months
- six to twelve months ago
- 1 - 2 years ago
- more than 2 years ago

- I don't remember at all
- I have never had a GYN check-up

(7) Where was that visit?

- with a private doctor or HMO
- at a clinic or hospital where you can get general health care
- at a family planning clinic
- at some other place: \_\_\_\_\_

(8) Did that doctor or nurse discuss family planning with you or provide you with birth control supplies?

- Yes (GO TO QUESTION 11)
- No (continue with the next question)

(9) IF THAT DOCTOR OR NURSE DID NOT GIVE YOU FAMILY PLANNING ADVICE OR SUPPLIES, when did you last have a visit with a health provider to discuss or get birth control?

- within the last six months
- six to twelve months ago
- 1 -2 years ago
- more than 2 years ago
- I don't remember at all
- I have never visited a health provider for family planning

(10) Where was that family planning visit?

- with a private doctor or HMO
- at a clinic or hospital where you can get general health care
- at a family planning clinic
- at some other place: \_\_\_\_\_

(11) When women go to a doctor or clinic to get the Pill or the Shot, they usually are given a full medical or pelvic exam. Thinking about the women you know, which of the following best describes how they feel about getting this exam? [Please check one.]

- Most women would like to get the Pill or Shot without the exam
- Most women do want the exam
- Most women don't care

\_\_\_ I don't know what most women would prefer

Thinking about yourself, what do you prefer?

\_\_\_ I would like to get the Pill or Shot without the exam

\_\_\_ I do want the exam

\_\_\_ I don't care

(12) Please check any birth control method(s) you are using now.

\_\_\_ withdrawal (man pulls out before he comes)

\_\_\_ rhythm or natural family planning (don't have sex when you're fertile/ovulating)

\_\_\_ the Pill

\_\_\_ condoms

\_\_\_ foam (or similar products)

\_\_\_ the Shot (Depo Provera)

\_\_\_ Norplant

\_\_\_ diaphragm

\_\_\_ female sterilization (tubes tied)

\_\_\_ male sterilization (partner had vasectomy)

\_\_\_ IUD

\_\_\_ film (vaginal contraceptive film)

\_\_\_ other ways of making love (oral sex, anal sex)

\_\_\_ other: \_\_\_\_\_

\_\_\_ I am not using any birth control method now

IF YOU ARE USING A METHOD, please skip question (13) and go to question (14).

IF YOU ARE *NOT* NOW USING A METHOD, please answer question (13).

(13) **Only answer this question if you are not now doing anything to keep from getting pregnant.**

If you are not doing anything to keep from getting pregnant, please tell us your reasons. Check all that apply. Put two checks next to the reasons that are very important.

\_\_\_ I really want to get pregnant

\_\_\_ It would be okay to get pregnant -- I wouldn't mind

\_\_\_ I'm not having sex with men at all these days

\_\_\_ I'm not having sex with men often

\_\_\_ I don't think I can get pregnant (but I have not been sterilized/had my tubes tied)

\_\_\_ I have had a hysterectomy or ovariectomy

\_\_\_ I haven't found a method that works for me

\_\_\_ My husband or partner doesn't want me to use birth control

\_\_\_ My husband or partner won't use a condom

\_\_\_ I don't know where to get birth control

\_\_\_ It costs too much money to get birth control

- \_\_\_\_\_ I don't like going to a clinic or doctor for birth control because  
\_\_\_\_\_ I don't get good care  
\_\_\_\_\_ The staff does not treat me with respect  
\_\_\_\_\_ The staff does not speak my language  
\_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ It's hard to get to the clinic or drug store for birth control because  
\_\_\_\_\_ It's hard to get an appointment  
\_\_\_\_\_ I don't have transportation  
\_\_\_\_\_ I don't have anyone to take care of my children  
\_\_\_\_\_ I don't have time  
\_\_\_\_\_ Other: \_\_\_\_\_

(14) Please give us your age: \_\_\_\_\_ years old

(15) Are you:

- \_\_\_\_\_ married  
\_\_\_\_\_ in a steady relationship with a man but not married  
\_\_\_\_\_ unmarried and not in a steady relationship with a man

(16) How many children do you have? \_\_\_\_\_ children

What are the ages of your children? \_\_\_\_\_

Thank you for answering our questions. Your information is very helpful to us.

UCSF REPRODUCTIVE HEALTH POLICY STUDY  
TEEN FOCUS GROUP DISCUSSION GUIDE

## INTRODUCTIONS

Thank you for coming and helping us out with this research.

I am \_\_\_\_\_, and I work with the Institute for Health Policy Studies at the University of California at San Francisco. We are interested in learning more about teenagers' actual experiences and ideas about childbearing and family planning, so today we'll be asking you to share some of your feelings and experiences in these areas. The State Department of Health and the Department of Social Services are concerned about what can be done to improve services, and your participation in this study will be especially helpful to them in deciding what changes to make.

Before we get into our discussion, I'd like us to briefly introduce ourselves. I'll begin. [Facilitator: give first name, city of residence, briefly describe family circumstances.] Can we go around the table now and have each of you tell us your first name, the city you live in, and anything else you'd like to say--maybe something about your family.

### I. ATTITUDES TOWARD CHILDBEARING AND PREGNANCY PREVENTION

We'd like to begin our discussion by asking you what you think about the general idea of family planning--that is, planning when to have children and how many to have.

- (1) **Some people say that if it's your time to get pregnant, you will--regardless of what you do. What do you think about this? Does it make sense to really plan when you're going to have kids? How much control do people really have?**
- (2) **What if you get pregnant at a time when you're not ready for it? Is it when you have your children, or how many you have?**
  - (2a) **Have you ever thought you were pregnant but weren't? Did this have an impact on you? (Probe: if you were not using birth control, did it encourage you to get some? If you had been using your contraceptives on and off, did it make you more careful?)**
  - (2b) **What do you and your friends think about a teenager having a baby while they are in middle school? In high school? What things make it a problem for them and for you? Is there anything positive about being a mother at your age? What about for girls in middle school? Do you think about your chance of having a baby when you started to have sex? Did you feel**

you had a high or low chance of getting pregnant?

- (2c) **Did you and your partner (boyfriend) ever bring up the topic of birth control? Who brought it up? If you did talk about it, how did it come up in your relationship? When did this conversation take place? If you didn't talk about it, why do you think you did not? Why do you think so many teenagers do not use protection? (Probe: lack of support, lack of knowledge where to go, lack of planning ahead, fear of contraceptives, fear visit is not confidential.)**
- (3) **Some people in government are interested in changing welfare payments, so that women who have another child while they are on welfare will not get more cash aid. Have you heard about such plans? If such a plan went into effect, would this make a difference in how you think about family planning? Would it make a difference in your use of birth control?**

## **II. PERCEPTIONS OF BIRTH CONTROL AND HOW THEY'RE FORMED; EXPERIENCES WITH BIRTH CONTROL**

- A. Now we'd like to talk more specifically about methods of birth control, and about your own experiences either using or thinking about using birth control. When you came in today/tonight, we asked you to fill out a questionnaire about birth control, and one of the questions we were particularly interested in was what people think about some of the more popular methods. We'd like to talk about some of that now.

**Before we talk about methods, we would like to ask a few questions regarding your experience with finding out about birth control and your decision to get birth control.**

- A1. **Some studies have found that teenaged girls tend to wait more than a year between the time they start to have sex and the time they decide to get contraceptives. Was this the way it was for you? What made you wait before you went to get a method of contraception? How long did you wait? What finally encouraged you to get contraception?**
- A2. **Why do you think that teenagers tend not to use birth control right away (or use less effective methods initially) or only use birth control some of the time? Did you feel any pressures not to use birth control or to only use it sometimes? Did you feel any pressures that made you want to use it? (Probe: role of partner, role of parent, role of friends.)**
- A3. **Even when a teenager does go to get a method, she often stops going to the clinic or doctor after the first time and soon quits using her method. Why do you think that is? (Probe: Is it because she doesn't like her method? Her boyfriend wants her to stop using it? Is it because she feels side effects, even though the clinic/doctor told her not to be afraid?) Was this the way it was for you?**
- A4. **Did your mother, father, or other relative ever talk to you about birth control? How did they bring up the subject? Did they seem comfortable or uncomfortable? What was the message that they gave you regarding the use of protection? What was the message they gave you**

regarding having a baby when you were a teenager?

- A5. **Does your mom or dad (or significant relative) know that you are having sex? Did your (relative) help you to get your birth control? Do you need to hide the fact that you are using protection (family planning)?**
- A6. **Teenagers sometimes say that they are afraid to go to a family planning clinic or doctor because everyone will know their business. Has this been your experience? Did you know that you could get free or very low cost contraceptives in clinics without parental consent? Among your friends, do any believe that they need parental permission before they can get help for themselves from a clinic?**

### **Birth Control Methods**

- (1) **We asked you about the Pill and its safety (that is, whether or not it is harmful to your health). Many people have strong ideas about the safety of the Pill. What do you think? Is it safe to use, or are there problems with it?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Is this something you talk about with your friends? Your family? Your partner?**

**Do these people all feel the same way about the Pill's safety or do some of them have different opinions?**

- (2) **Now let's move on to condoms, and switch to the question of effectiveness--that is, how good the method is at actually preventing pregnancy. What do you think about condoms and their effectiveness at preventing pregnancy?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Do the people you talk to about this--your partner, family and friends--all feel the same way about condom effectiveness or do some of them have different opinions?**

- (3) **Let's move on now to talk about the Shot (Depo Provera) and its safety. What do you think, or what have you heard about the Shot? Is it safe to use, or are there problems with it?**

[As people respond to this, follow-up with questions:]

**How did you learn about this?**

**Do the people you talk to about this--your partner, family and friends--all feel the same way about the safety of the Shot or do some of them have different opinions?**

- (4) **We've talked a little about people's ideas about the Pill, the Shot, and condoms. Now we'd**

like to ask if you always held the same opinions about these methods or if you can remember things happening that changed your mind about any of them? [Rephrase as a specific question if needed: Like with the Pill--did you always feel the same way about it, or did something change your mind? ]

- (5) **We happened to pick just a few birth control methods to ask you about, but there are many others. Are there some that we haven't mentioned that you have considered using and have some ideas about? [FOR TEENAGERS: Probe for withdrawal; or other way that teenager feels that she has controlled her fertility--e.g., some teenagers believe that if you stand up when you have sex, you won't get pregnant.]**
- B. We've been discussing your ideas about different methods, their safety and effectiveness, and some of you have mentioned personal experiences with birth control. We'd like to focus now on your own experiences, and particularly, current or recent experiences with birth control.
- (1) **What's the most recent birth control method you've used? What made you choose this method?**
- (2) **Can you tell us how you decided you needed/wanted birth control at all? Was it a good choice? Were you satisfied with it, or did you have problems with it? (If so, how did you resolve them?)**
- (3) **Was your boyfriend involved in your choice and use of this birth control method? Does your boyfriend make it either easier or harder for you to use birth control? What about family and friends? Do they help or hinder you in any way in your decision about birth control? Or in your use of birth control? Are there any community, cultural, or religious influences on your use of birth control?**

### **III. EXPERIENCE WITH FAMILY PLANNING AND OTHER SERVICE PROVIDERS**

Let's talk more specifically now about where people go to get birth control services and information, and other medical services and information. We're interested both in where you get services (that is, what kinds of providers you use) and what you think of those services.

- (1) **Where have you obtained birth control services or methods (MD, clinic, drug store, friends, etc.)? ASK FOR SPECIFIC NAMES OF LOCAL PLACES!! If you've used condoms and/or foam, do you buy them or get them free from a clinic? Is it convenient? Is cost a problem? How comfortable do you feel about buying condoms?**

**(If people have obtained services from other than family planning providers, probe for whether the birth-control-related service was initiated by the patient or the provider.) [In Latina groups, ask if providers were in the U.S. or another country.]**

- (2) **How did you find out about those places?** (Probe for possible sources of referral: friends, family, other service providers, ads.) **Did anyone find out about family planning services from their AFDC eligibility workers? Can you recall what you were told? Were you told services were free? Were you given any written information (e.g., brochures)?**
- (3) **In visiting service providers have you ever felt pressured to use birth control or to use a particular method? (If so, do you have any sense of why this provider pressured you?) Have you ever been given a method--say, by a doctor or clinic--that you then didn't use?**
- (4) **Have you ever been discouraged from using birth control, or from using a particular method? By whom, or in what setting? For what reasons?**
- (5) **Have you ever wanted or needed birth control and not gotten it? Looking back, would anything have made it easier for you to get and use birth control at that time?**
- (6) **Do you get regular GYN care--pelvic exams, Pap smears, breast exams? Is this important to you? Are you satisfied with the care you get?**

**When you've gone for general health care or GYN care, has your doctor or nurse practitioner brought up the subject of family planning? (If so *or* if not:) How do you feel about this?**

**Have you ever felt that you couldn't get birth control from your regular doctor for any reason? (Examples: maybe because you were uncomfortable discussing it with him/her or you were worried about confidentiality.)**

- (7) **When you've had questions or problems pertaining to birth control, where have you gone for answers or help? (return to provider, go to friend. . .)? Were you satisfied? (With provider:) were you comfortable asking for help? *For Spanish-speaking Latinas: probe for language issues.***
- (8) **Thinking about your most recent visit or visits to get family planning services, what did you like best about that service experience?** (Probes: convenient hours, location; ease of getting appointment; sensitivity; take time with patients; low cost; confidentiality; get choice of MD/NP; short wait; etc.)

**Was there anything you didn't like, or thought was a real problem with these services?** (Probes: generally, opposites of good things.)

**Have you recommended any of these providers to a friend?** (Probe for what types of providers/why.)

#### **IV. SPECIFIC SUGGESTIONS ABOUT IMPROVING INFORMATION AND SERVICES**

Finally, we'd like to see if you have any additional comments or suggestions to make about how information and services could be improved.

- (1) **When you hear or read the term family planning services --like in a radio ad or a billboard--what does this mean to you? (Do people use any other names for this kind of service? Example, if needed: Planned Parenthood. ) What kinds of services do you think are included in family planning? Which of these are the most important to you?**
- (2) **Would you prefer to get family planning services in the context of regular medical care or would you rather go to a specialist (a family planning clinic), or does it not matter ?**
- (3) **Are there ways in which family planning services could be changed that would make it easier or more pleasant to get services?** (Probes: use of same vs different provider as used for other care; transportation; child care; fees/cost; hours; location; different medical provider (sex/race/age/sensitivity); better non-medical staff; drop-in vs appointment; waiting time issues; eliminating pelvic/PAP; bilingual/bicultural staff.) [NOTE: This question should be a brainstorm in which suggestions are written down on an easel and participants get to look over the list and indicate which are the most critical.]
- (4) **Birth control is currently available in clinics, doctors' offices, county health departments, and so forth. Are there other locations that you think would be more convenient than any of these?** (Probes: mobile clinics, school-based, WIC office, mail-order pharmacies.)
- (5) **We've talked about some of the places where you get information about family planning methods and services. Are there other places where people you know get this kind of information? Are there other good ways to reach people?** (Probes: TV commercials/shows, magazine ads/articles, social service program offices. Probe also for specifics throughout and for how likely they would be as individuals to pick up messages in these contexts--e.g., do they get other information from this source?)
- (6) **Would the AFDC office be a good place to get information about family planning? How should the information be made available: should there be brochures, should eligibility**

**workers or other AFDC workers talk to their clients about services? Are there any other welfare or social service programs where it would be good to get information (e.g., GAIN, Cal-Learn)?**

- (7) The State Health Department is interested in running a public information campaign on family planning. They're thinking of using radio, TV, and printed materials to try to answer people's questions about birth control. If they do this, what kind of information do you think they should try to provide?**

## Questionnaire for Teen Discussion Group Participants

We're interested in learning more about women's actual experiences and ideas about child bearing and family planning (planning when and how many children to have).

We'd like to start by getting your opinions about four different types of birth control methods -- the Pill, condoms, the shot (Depo Provera), and female sterilization (having your tubes tied). Your answers to all these questions will be anonymous and confidential.

- (1) How good do you think each of these methods is at keeping a woman from getting pregnant? Please circle your answer for each method.

The Pill is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
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Condoms are:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
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The Shot is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
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Sterilization is:	Very effective 4	Somewhat effective 3	Not effective 2	I'm not sure 1
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- (2) How safe do you think each of these methods is, for a woman's health in general? Please circle your answer for each method.

The Pill is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
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Condoms are:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
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The Shot is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
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Sterilization is:	Mostly safe 4	Mostly harmful 3	Neither one 2	I'm not sure 1
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- (3) Please check if you have ever used any of the following birth control methods. Check all that you

have used.

- withdrawal (man pulls out before he comes)
- rhythm or natural family planning (don't have sex when you're fertile/ovulating)
- the Pill
- condoms
- foam (or similar products)
- the Shot (Depo Provera)
- Norplant
- diaphragm
- abortion
- female sterilization (tubes tied)
- male sterilization (partner had vasectomy)
- IUD
- film (vaginal contraceptive film)
- preventing pregnancy by making love in other ways (oral sex, anal sex)
- other: \_\_\_\_\_
- never used a birth control method

(4) Where have you gone for birth control methods or supplies in the past two years? Check all that apply.

- private doctor, group practice, or HMO
- clinic or hospital that provides general medical care
- family planning clinic
- drug store, grocery store, etc.
- friends or family gave me supplies
- partner got supplies
- other: \_\_\_\_\_
- never used a birth control method

(5) Do you have the kind of Medi-Cal that lets you go to *any* doctor (who accepts Medi-Cal), or did you sign up for a managed care/HMO plan where you have to choose one doctor to stay with?

- I have the kind of Medi-Cal that lets me go to *any* doctor (who accepts Medi-Cal)
- I signed up for a managed care/HMO plan where I stay with one doctor
- I do not know if I have a managed care/HMO plan

(6) When was your last GYN check-up (pelvic and Pap smear)?

- within the last six months
- six to twelve months ago
- 1 - 2 years ago
- more than 2 years ago

- I don't remember at all
- I have never had a GYN check-up

(7) Where was that visit?

- with a private doctor or HMO
- at a clinic or hospital where you can get general health care
- at a family planning clinic
- at some other place: \_\_\_\_\_

(8) Did that doctor or nurse discuss family planning with you or provide you with birth control supplies?

- Yes (GO TO QUESTION 11)
- No (continue with the next question)

(9) IF THAT DOCTOR OR NURSE DID NOT GIVE YOU FAMILY PLANNING ADVICE OR SUPPLIES, when did you last have a visit with a health provider to discuss or get birth control?

- within the last six months
- six to twelve months ago
- 1 -2 years ago
- more than 2 years ago
- I don't remember at all
- I have never visited a health provider for family planning

(10) Where was that family planning visit?

- with a private doctor or HMO
- at a clinic or hospital where you can get general health care
- at a family planning clinic
- at some other place: \_\_\_\_\_

(11) When teenagers go to a doctor or clinic to get the Pill or the Shot, they usually are given a full medical or pelvic exam. Thinking about the teenagers you know, which of the following best describes how they feel about getting this exam? [Please check one.]

- Most teenagers would like to get the Pill or Shot without the exam
- Most teenagers do want the exam
- Most teenagers don't care

\_\_\_ I don't know what most teenagers would prefer

Thinking about yourself, what do you prefer?

\_\_\_ I would like to get the Pill or Shot without the exam

\_\_\_ I do want the exam

\_\_\_ I don't care

(12) Please check any birth control method(s) you are using now.

\_\_\_ withdrawal (man pulls out before he comes)

\_\_\_ rhythm or natural family planning (don't have sex when you're fertile/ovulating)

\_\_\_ the Pill

\_\_\_ condoms

\_\_\_ foam (or similar products)

\_\_\_ the Shot (Depo Provera)

\_\_\_ Norplant

\_\_\_ diaphragm

\_\_\_ female sterilization (tubes tied)

\_\_\_ male sterilization (partner had vasectomy)

\_\_\_ IUD

\_\_\_ film (vaginal contraceptive film)

\_\_\_ other ways of making love (oral sex, anal sex)

\_\_\_ other: \_\_\_\_\_

\_\_\_ I am not using any birth control method now

IF YOU ARE USING A METHOD, please skip question (13) and go to question (14).

IF YOU ARE *NOT* NOW USING A METHOD, please answer question (13).

(13) **Only answer this question if you are not now doing anything to keep from getting pregnant.**

If you are not doing anything to keep from getting pregnant, please tell us your reasons. Check all that apply. Put two checks next to the reasons that are very important.

\_\_\_ I really want to get pregnant

\_\_\_ It would be okay to get pregnant -- I wouldn't mind

\_\_\_ I'm not having sex with men at all these days

\_\_\_ I'm not having sex with men often

\_\_\_ I don't think I can get pregnant (but I have not been sterilized/had my tubes tied)

\_\_\_ I have had a hysterectomy or ovariectomy

\_\_\_ I haven't found a method that works for me

\_\_\_ My husband or partner doesn't want me to use birth control

\_\_\_ My husband or partner won't use a condom

\_\_\_ I don't know where to get birth control

\_\_\_ It costs too much money to get birth control

\_\_\_ I don't like going to a clinic or doctor for birth control because

- I don't get good care
- The staff does not treat me with respect
- The staff does not speak my language
- Other: \_\_\_\_\_
- It's hard to get to the clinic or drug store for birth control because
  - It's hard to get an appointment
  - I don't have transportation
  - I don't have anyone to take care of my children
  - I don't have time
- Other: \_\_\_\_\_

(14) Please give us your age: \_\_\_\_\_ years old

(15) Are you:

- married
- in a steady relationship with a man but not married
- unmarried and not in a steady relationship with a man

(16) How many children do you have? \_\_\_\_\_ children

What are the ages of your children? \_\_\_\_\_

(17) Are you currently pregnant?

- yes
- no

Thank you for answering our questions. Your information is very helpful to us.