# Develop Social Marketing and Public Education Campaigns to Increase Contraceptive use and Knowledge of the Impacts of Unintended Pregnancy

*Understanding barriers to and attitudes about contraceptive use serves as the basis for the development of effective public education strategies to reduce unintended pregnancies. Methods traditionally employed by public-awareness and advertising campaigns have proven effective in influencing individuals' decisions about which brands to choose when seeking products or services they already have decided to use. However, such methods are not as effective at producing the long-term behavior modification necessary to motivate individuals to either begin using a product or service, or change preconceived notions they hold about a product or service. Changing peoples' decision-making habits about contraceptive use requires "deeper" motivators to effect long-term behavioral change. Prevention First Colorado recommends that research conducted at the federal, state and local levels on strategies to reduce unintended pregnancy be used to develop and carry out community-based social marketing and public education campaigns aimed at increasing contraceptive use and knowledge of the impacts of unintended pregnancy to effect long-term behavioral change.*

## THE NEED FOR SOCIAL MARKETING PROGRAMS TO REDUCE UNINTENDED PREGNANCY

In Colorado, nearly four out of every 10 babies born are the result of an unintended pregnancy – a rate that remained consistent from 1998 through 2005,[1] the most recent year for which data exist, despite advances in contraceptive technology and concerted efforts by government-sponsored and private programs to reduce unintended pregnancy. When pregnancies that result in abortion or miscarriage are added into those calculations, the unintended pregnancy rate exceeds half of all pregnancies that occur. In fact, 12 Colorado counties exceed the four-out-of-10 rate, and in Fremont and Otero counties, more than half of all babies born were the result of unintended pregnancy. (See Table 1 on page 74, "Percent of Births Resulting from Unintended Pregnancies in Colorado by County,[†] 1998-2005.") In an age when it is generally believed that women and their partners have access to contraceptive counseling, drugs, devices and procedures to prevent unintended pregnancy, those figures beg the question: what prevents women and their partners from using contraceptives consistently and correctly when they do not want to become pregnant?

Existing research linking unintended pregnancy to contraceptive use has focused on external barriers such as cost and access as the main obstacles preventing women and their partners from protecting themselves from unintended pregnancy. That focus fails to explain why women who are financially secure, who have health insurance, and who have unrestricted access to health care services fail to use contraception. As such, existing research has lacked detailed analysis of attitudinal and psychological factors that influence behaviors that lead to unintended pregnancy resulting from lack of contraceptive use outright or consistent use over time.

Original research carried out by Prevention First Colorado sought to identify those attitudinal and psychological barriers to understand Colorado women's decision-making regarding contraceptive use. In general, all women who responded to surveys administered by Prevention First Colorado exhibited some risk factors for unintended pregnancy. However, closer analysis of the research findings identified specific population sub-groups that were more at risk for unintended pregnancy depending, among other things, upon:

- a woman's educational attainment, where women who had received at least a bachelor's degree were significantly less likely to have reported having experienced an unintended pregnancy;
- where a woman lives, with women self-identifying as living in rural and small-town communities reporting significantly more unintended pregnancies than women self-identifying as living in urban areas; and
- a woman's health insurance status, with women who were on Medicaid or who had no insurance being more likely to have reported having an unintended pregnancy than women with private or other forms of insurance.[2]

Some barriers to contraceptive use identified in the Prevention First Colorado research could be mitigated through systemic change. For example, ensuring that all contraceptive drugs, devices and methods are wholly covered by all insurance types could eliminate cost as a barrier to contraceptive use. However, many of the attitudinal and psychological

barriers identified through Prevention First Colorado research suggest the need for a targeted, interactive, and community-based social marketing campaign. The intention of the campaign would be to effect long-term attitudinal and behavioral change about decision-making and use of contraceptives.

**Table 1: Percent of Births Resulting from Unintended Pregnancies in Colorado and by County,† 1998-2005[3]**

| Colorado: | | 39.7% | |
|---|---|---|---|
| **County** | **Percent** | **County** | **Percent** |
| Adams | 42.7% | La Plata | 38.7% |
| Alamosa | 46.7% | Lake | 42.7% |
| Arapahoe | 40.3% | Larimer | 38.7% |
| Archuleta | 47.6% | Las Animas | 48.7% |
| Baca | - | Lincoln | - |
| Bent | - | Logan | 49.0% |
| Boulder | 33.2% | Mesa | 44.8% |
| Chaffee | 39.0% | Mineral | - |
| Cheyenne | - | Moffat | 39.1% |
| Clear Creek | - | Montezuma | 40.1% |
| Conejos | 40.5% | Montrose | 39.8% |
| Costilla | - | Morgan | 47.6% |
| Crowley | - | Otero | 55.5% |
| Custer | - | Ouray | - |
| Delta | 49.2% | Park | 39.7% |
| Denver | 41.7% | Phillips | - |
| Dolores | - | Pitkin | 28.7% |
| Douglas | 24.8% | Prowers | 47.4% |
| Eagle | 30.8% | Pueblo | 43.7% |
| El Paso | 43.9% | Rio Blanco | - |
| Elbert | 43.4% | Rio Grande | 49.3% |
| Fremont | 54.1% | Routt | 26.4% |
| Garfield | 40.9% | Saguache | 41.9% |
| Gilpin | - | San Juan | - |
| Grand | 36.5% | San Miguel | - |
| Gunnison | 25.7% | Sedgwick | - |
| Hinsdale | - | Summit | 32.0% |
| Huerfano | - | Teller | 37.4% |
| Jackson | - | Washington | - |
| Jefferson | 34.8% | Weld | 38.8% |
| Kiowa | - | Yuma | 33.4% |
| Kit Carson | - | | |

† Data is unavailable for Broomfield County, which did not exist as an autonomous entity until 2001. Figures are unavailable for counties marked with "-" because of the small number of respondents in those areas.

Social marketing was "born" as a discipline in the 1970s, when Philip Kotler and Gerald Zaltman realized that marketing principles used to sell consumer products could also be used to sell attitudes and to change behavior. Kotler, who has been hailed by Management Centre Europe as "the world's foremost expert on the strategic practice of marketing," and Alan Andreasen, a specialist in consumer behavior and the application of marketing to nonprofit organizations, social marketing, and the market problems of disadvantaged consumers, defined social marketing as

> "[...] differing from other areas of marketing only with respect to the objectives of the marketer and his or her organization. Social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society."[4]

Social marketing has been used extensively in international health programs, especially for contraceptives and "oral rehydration therapy," and is being used with more frequency in the United States for such diverse topics as drug abuse, heart disease and organ donation.[5]

## OTHER STATES AND NATIONWIDE

Social marketing campaigns to prevent unplanned pregnancy have been used for teen pregnancy prevention in both the United States and worldwide. Pregnancy-prevention efforts, however, are not often extended to adult women. There are multiple resources for prevention professionals to employ when creating a social marketing campaign and many examples of prevention campaign successes related to family planning, pregnancy prevention and HIV/AIDS.

Social marketing has been used in prevention efforts such as reducing substance abuse[6] or reduction of alcohol and drug use on college campuses.[7] Many programs emphasize peer education as a successful vehicle for a prevention message[8] and provide step-by-step instructions for how to design and implement a social marketing or public awareness campaign.[9]

In Portland, Ore., Project ACTION[10] ran from July 1992 to December 1994 and encouraged safer sexual behavior among at-risk teens. The program consisted of four components: community mobilization and support; a motivational media campaign; increased condom accessibility by distributing condoms through vending machines placed at common hang-out spots for teens in the community; and youth involvement through peer education.

The Project ACTION campaign was credited with an increase in reported consistent use of condoms with new/casual partners and a decrease in reported sexual activity among the target population during implementation.[11] The campaign was replicated in Seattle and San Jose, Calif.

At a statewide level, Oregon's Family Planning Expansion

Project was a joint effort of a private social marketing firm and the Oregon Health Division. Its purpose was to increase reproductive health options for women in Oregon who live just above the poverty line by linking eligible clients with publicly funded, free family planning services. The project used social marketing to promote the availability of expanded services to a target population.

A multi-state effort to reduce unintended pregnancy was rolled out in 1996 through the "Don't Kid Yourself Campaign"[12] in Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. The campaign was aimed at reducing unintended pregnancy and was funded by the U.S. Public Health Services through a Title X family planning grant program in the six-state region. Grant administrators from each state pooled resources for a regional social marketing campaign.

Women aged 18 to 24 with incomes at or below 200 percent of the federal poverty level were targeted and two pilot sites were selected for the initial test of the program: Salt Lake City and Butte, Mont. The campaign relied heavily on peer modeling of appropriate behavior to build a new social norm around the use of contraceptives.

Radio was selected as the primary medium for the message. Print media were used as to supplement the radio component in the form of posters and drink coasters to get the message into the community. The key messages of the campaign were:

- You are likely to become pregnant if you do not use birth control consistently.
- Birth control helps you wait to have a baby until you are financially and emotionally stable.
- If you are sexually active, get the facts about birth control.
- Sure, birth control can be a hassle. But what about the alternative?
- Birth control is something you should talk about with your partner.

A secondary message was that men should also be responsible for and informed about contraceptive options.

When the campaign was rolled out throughout the six-state region, it met with mixed success. A post-campaign survey revealed that only 15 percent of the targeted audiences across locations were exposed to the campaign. More than three-quarters of those who were exposed to the messages, however, reported talking with friends, boyfriends/girlfriends, or parents about family planning options, and 55 percent reported calling a clinic for more family planning information.[13] Data about a reduction in unintended pregnancy among the populations targeted was not included in a summary of the project.

## CURRENTLY IN COLORADO

Based on the findings of the original research carried out by Prevention First Colorado, a privately funded, two-part social marketing campaign has been developed to provide services to low-income women who are eligible for Medicaid or Title X services.[14] Prevention First Colorado staff conducted four focus groups and 40 individual, private interviews with low-income women who met those parameters to understand in detail the perceived barriers to consistent contraceptive use among that specific population. The research revealed five primary barriers.

1. Many women reported typical side effects when starting a contraceptive method. Because they were unaware that the effects were temporary, they stopped using birth control.
2. Women reported insufficient or no follow-up care after starting a contraceptive method and then did not get answers to questions regarding side effects. Respondents perceived that circumstance was due in many cases to red tape in the health care system. As a result, many of those women stopped using their contraceptive method.
3. Women reported discontinuing contraceptive use because they were influenced by inaccurate information about side effects or reports of pregnancies despite using birth control. They further reported that the majority of the reports came from close friends and family members and not from personal experience.
4. Women's responses indicated a lack of understanding of the risk of pregnancy without use of contraception. That misperception was reinforced if they did not immediately or frequently get pregnant while they were not using contraceptives. In fact, the longer women went without getting pregnant, the less likely they thought that they would become pregnant, despite the fact that their cumulative risk was increasing.
5. Women reported having difficulty remembering to take birth control pills daily, and many thought that if they missed taking a pill at the appointed time, that they should skip that day. Some gave up completely once they missed one or two pills.[15]

That information, combined with other findings from the Prevention First Colorado research, suggested that an effective way to address the inaccurate, incomplete and uninformed perceptions of that population of women would be to develop a community-based social marketing campaign that would provide one-on-one counseling. The counseling would need to address misperceptions about contraceptive side effects and risks in a private and safe setting. As a result, the counseling would replace inaccurate information women have about contraceptives with correct information. Using an in-clinic health educator to provide the contraceptive counseling also could mitigate women's perceptions that

nobody cared about their contraceptive needs, which also was reported during focus-group and interview research carried out by Prevention First Colorado.

The Prevention First Colorado social marketing campaign launched as a pilot program in April 2009. It has been designed to address perceived barriers to contraceptive use among the target population. Those barriers are based in fear or a misunderstanding of the side effects of contraceptive methods and subsequent insufficient follow-up by health care providers regarding those perceptions and inconsistency of use. The first part of the campaign launched in the Park Hill neighborhood of Denver, where a health educator has been placed in a community clinic run by Denver Health, an agency of the City and County of Denver. That health educator is responsible for contraceptive education and counseling and patient follow-up in the family medicine clinic. Doctors in that type of clinic typically have limited time to spend with patients to discuss contraceptive options. Clinic capacity almost universally does not allow for the extensive follow-up needed to help patients manage side effects or other concerns in the critical first three months of contraceptive use. The health educator plays an essential role in supporting women before, during and after contraception is obtained. The health educator acts as a direct link between patient and clinic to discuss contraception. As a result, patients can bypass the perceived intimidating red tape in the medical system, which can make even simple questions difficult to resolve.

The second part of the campaign involves a public-education effort to introduce neighborhood women to the free- or low-cost contraceptive services available in their community and the free services of the health educator. The campaign includes a community outreach effort to identify the benefits of contraception and the availability of medical services to obtain it. Media include direct mail, bus boards, posters, a Web site, print ads, brochures, and oral presentations in either formal neighborhood institutions, such as neighborhood clinics or community centers, or informal neighborhood institutions, such as grocery stores, restaurants, libraries, Laundromats, nail and beauty salons, food banks, or child care centers.

The campaign also is visible within the clinic. Although every patient with an interest in receiving the counsel of the health educator can receive that care, patients generally are directed to the health educator by doctors who determine that a patient would benefit from talking in detail about contraceptive options. Those patients include pregnant women and new mothers, patients receiving a negative pregnancy test who indicate they were not trying to become pregnant, women taking children for a well-child visit, or any other patients whom doctors believe could benefit from contraceptive counseling.

Because research shows that consistent use of birth control pills can be particularly difficult for low-income women due to inconsistent schedules and lifestyle, the health educator counsels women about long-term, reversible contraceptive options such as Implanon® and intrauterine devices (IUDs). The campaign's effectiveness is being measured by the number of consultation appointments generated and the number of patients who receive some form of contraceptive as a result of the counseling provided.

On-going support after patients start using contraception is critical to establishing habits for consistent contraceptive use, and follow-up care will reduce another perceived barrier to consistent use of contraceptives. Later in the campaign, effectiveness also will be measured by the number of women who exhibit continued and consistent use of contraceptives, the length between pregnancies among women who have received counseling and follow up, and whether the rate of unintended pregnancy among women participating in the program decreases.

Elsewhere in Colorado, Women's Health (Boulder Valley Women's Health Center) received a private grant to implement the Contraceptive Continuity Initiative (CCI) in late 2007. That program was designed to encourage women to start and maintain consistent use of a contraceptive method until the time they wished to become pregnant.

The CCI social marketing campaign began with advertising and outreach targeting women aged 18 to 25. The campaign included a Web site, bus boards, print ads, postcards, a "viral" mailer that can be attached to e-mail messages (all created in both English and Spanish), and a standing banner for use at a local farmer's market and other community events. Campaign materials use one of two messages: "I'm not ready to get pregnant, now I'm not worried about it," and, "Life is full of surprises, pregnancy shouldn't be one of them." Both encourage women to make an appointment at Women's Health to discuss their contraceptive options and direct them to the Web site, www.itsup2U.org, for more information.

At the Women's Health clinic, the social marketing campaign focuses on providing education to new and current patients to empower them to make informed decisions about contraceptive use. Trained counselors and clinicians provide the education during a contraception consultation appointment that includes time for patients and counselors/clinicians to share their previous experiences with contraception, their risk for unintended pregnancy, and other lifestyle behaviors that could potentially influence contraception use. Counselors/clinicians then discuss contraception options and respective side effects in a manner that allows patients to make the final decision about what method is best for them.

In addition to promoting informed decisions about contraception, another campaign goal is consistency of contraceptive use. One of the simplest ways to increase consistent use is for patients to use a long-term, reversible method of

contraception like Implanon® or an IUD. Long-term, reversible methods are more than 99 percent effective with typical use; are non-permanent; do not have to be thought about on a daily, weekly, or even monthly basis; and prevent pregnancy for between three and 10 years depending on the method selected.

Consistency also is promoted by scheduling a three-month follow-up appointment for all patients that start a new contraceptive method. During the follow-up appointment, patients are asked to complete a self-evaluation form that includes questions about satisfaction with the method, consistency of use, and any unexpected side effects. Any dissatisfaction with their method is discussed and resolutions are offered. If a patient is unable to return to the clinic for the follow-up, Women's Health staff calls the patient and completes the three-month evaluation by phone.

Women's Health is evaluating the campaign's success by monitoring the number of self-evaluations that are completed by patients after they have started a new contraceptive method, overall satisfaction with that method, and any trends that emerge related to continuity of contraceptive method use. Effectiveness of the social marketing campaign also will be determined by the clinic's ability to meet the main objective of the campaign: demonstrating an increase in the number of patients inquiring about contraception and reducing the number of unintended pregnancies among the targeted population.

## BARRIERS TO IMPLEMENTATION

Social marketing campaigns can be costly and time-consuming. They require fairly large research budgets both to determine an effective message and the appropriate media (including trained professionals) to deliver the message for each target population. For complex issues like preventing or reducing unintended pregnancy, experts in behavior change recommend social marketing campaigns last at least three years, although longer campaigns of up to five to seven years are preferred, as longer campaigns allow for short-, intermediate- and long-term evaluations of the campaign's success and allow for modifications to refine the campaign.

Perhaps most challenging, social marketing campaigns cannot target all sexually active women as a homogenous group to carry out efforts to reduce unintended pregnancy. As demonstrated by Prevention First Colorado research, opportunities to influence women's attitudes toward, decisions about, and ultimate use of contraceptives can be impacted by, among other things, age, income, cultural background, educational attainment, insurance status and geographic location. Consequently, demographic-specific messages should be developed for teens, young women, older women, low-income women, and women of varying ethnicities and races. In addition, the assistance of social marketing professionals is generally necessary to the success of the campaign.

The campaigns currently operating in Colorado reflect private-sector interest in using a social marketing model to reduce unintended pregnancy. However, the current economic downturn raises questions about the long-term viability of charitable foundations and private donations to act as sustainable funding streams. Because community-based social marketing campaigns increase in effectiveness the longer they are operated, the depleting private-sector resources could have a significant negative impact on the sustainability of existing campaigns. A state-funded effort could achieve economies of scale and mitigate some cost barriers. However, revenue shortfalls for fiscal year 2008-2009 and projected shortfalls for fiscal year 2009-2010 severely restrict the likelihood that new projects like a social marketing campaign will be undertaken by the state. As a result, substantial, sustained funding still needs to be secured to target all at-risk groups in Colorado.

The regional, multi-state model discussed above that used Title X dollars presents one option for the state to consider if similar pregnancy-prevention program dollars are included in the federal fiscal year 2010 budget. Similarly, county departments of public health may take lead roles in coordinating regional social marketing campaigns. That could be a viable option for rural counties where, because of population dispersion over great distances, developing community-based social marketing campaigns similar to the two currently active in Colorado may not be an appropriate model. Counties are eligible to receive funds through the federal Temporary Assistance for Needy Families (TANF) program to support efforts to prevent and reduce out-of-wedlock unintended pregnancies, one of the four stated goals of the program.[16] Consequently, counties should consider applying TANF dollars to long-term social marketing campaigns that are designed to meet their community's specific barriers to contraceptive use.

## FIRST STEPS

To develop the most cost-effective social marketing campaigns to reduce unintended pregnancy among target populations in Colorado, certain specific steps should be taken:

1. Analyzing results of current social marketing pilot programs being carried out in Colorado to evaluate effectiveness and opportunities for expansion.
2. Formalizing relationships between public agencies and private organizations currently working to reduce unintended pregnancy, thereby removing duplication of efforts, increasing opportunities to achieve economies of scale, and facilitating exchange of information about best practices.
3. Establish a quasi-public entity tasked with developing a seven- to 10-year funding and implementation strategy to carry out social marketing campaigns aimed at populations that have been identified as most at-risk for unintended pregnancy. Working within the confines of Colorado's constitutional funding restrictions and the current

economic environment, this entity should consider pursuing the authority to assess appropriate fees to generate revenue in addition to soliciting gifts, grants and donations.

Using social marketing campaigns that are designed for unique demographics can effect long-term behavioral change regarding planning for and decision-making about contraceptive use, thereby resulting in a reduction of unintended pregnancies in Colorado.

## REFERENCES & NOTES


**1.** "Colorado Pregnancy Risk Assessment Monitoring System (PRAMS)," Colorado Department of Public Health and Environment, accessed October 2008 at http://www.cdphe.state.co.us/hs/prams/.

**2.** "How She Does it: Contraceptive Use and Decision-Making in Colorado Women," by Laurie E. James-Hawkins, Prevention First Colorado, accessed May 2009 at http://preventionfirstcolorado.org/uploads/How%20She%20Does%20It.pdf.

**3.** "Colorado Pregnancy Risk Assessment Monitoring System (PRAMS)."

**4.** *Social Marketing: Its Definition and Domain*, Alan R. Andreasen, 1994, American Marketing Association.

**5.** "What is Social Marketing?" by Nedra Kline Weinreich, Weinreich Communications, 2006, accessed February 2009 at http://www.social-marketing.com/Whatis.html.

**6.** "Social Marketing and Prevention," *Prevention Briefing*, June/July 2002, Center for Substance Abuse, accessed February 2009 at http://captus.samhsa.gov/southwest/resources/documents/SocMkPrev.pdf.

**7.** "Social Norms Marketing," Web site of the Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, U.S. Department of Education, accessed January 2009 at http://www.higheredcenter.org/environmental-management/change/normative/social-norms.

**8.** "Prevention/Promotion Program Theory," presented by Peer Solutions at the U.S. Centers for Disease Control's Third National Sexual Violence Prevention Conference, May 2004, accessed January 2009 at http://www.peersolutions.org/pdf/Program_Theory.pdf.

**9.** "How to Implement a Social Marketing Poster Campaign," by Nadia Shamsuddin and Robert Becker, 2004, ETR Resource Center for Adolescent Pregnancy Prevention, accessed February 2009 at http://etr.org/recapp/practice/edskills200404.htm.

**10.** "Integrated Social Marketing Achieves Healthier Behavior in the United States," Population Services International, accessed January 2009 at http://www.psi.org/resources/pubs/usp.html.

**11.** "HIV Prevention – Project ACTION," Behavior Works: Changing Behavior for Public Health, accessed February 2009 at http://www.bwpdx.org/programs/hiv-prevention.

**12.** "The 'Don't Kid Yourself' Campaign Case Study," by Nedra Kline Weinreich, Weinrich Communications, accessed January 2009 at http://www.social-marketing.com/dky.html.

**13.** Ibid.

**14.** For Medicaid eligibility parameters, see, "Medicaid Eligibility Requirements" published on the Colorado Department of Health Care Policy and Financing Web site as of February 2009, accessed at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485591. Originally enacted in 1970, the federal Title X Family Planning Program was created to provide "individuals with comprehensive family planning and related preventive health services," according to the U.S. Department of Health and Human Services' Office of Population Affairs in the Office of Public Health and Science.

**15.** "Barriers to Contraceptive Use in the Denver-Area Low-Income Female Population," Laurie E. James-Hawkins, Amy M. Krupinski, Prevention First Colorado, accessed May 2009 at http://www.preventionfirstcolorado.org/uploads/Interviews%20of%20Barriers%20to%20Contraceptive%20use.pdf.

**16.** "TANF Dollars for School-Based Health Centers," *Todd's Tips*, vol. 1, September 2008, Colorado Association for School-Based Health Care, accessed March 2009 at http://www.casbhc.org/publications/ToddsTips/TANF.pdf.