NORTH CAROLINA
FAMILY PLANNING MEDICAID WAIVER PROGRAM

Marketing Campaign:
Creating Awareness Among
Low- to Moderate-Income Men & Women
in the
Mountain, Piedmont & Coastal Regions

PART ONE:
FOCUS GROUPS—ASSESSING AUDIENCE NEEDS

Prepared for

North Carolina Department of Health and Human Services

Division of Public Health

Family Planning & Reproductive Health Unit

by

The Stafford Institute

June 7, 2004

A Note to the Reader: Focus group research is qualitative, not quantitative. The conclusions drawn are based on a combination of many sources of primary data gathered in the focus groups, including verbal, facial expressions, body language, laughter, and even silence, as well as the experience of the research team.

The Stafford Institute
611 Pennsylvania Ave. SE #146
Washington, DC 20003
(202) 546-9335
www.staffordinstitute.com
sstafford@staffordinstitute.com

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1. EXECUTIVE SUMMARY

This report discusses the findings of a series of focus groups held to determine marketing directions for the Family Planning Medicaid Waiver Pilot Program to be developed by NC DHHS Division of Public Health Family Planning & Reproductive Health Unit. This program is innovative not only for North Carolina, but for the nation as well.

The purpose of the groups was to hear the voices of a variety of state residents regarding the subject of access to and use of the family planning services available within the program. Participants were asked to explore advertisements in current periodicals, discuss their reactions the Waiver program, make suggestions for the design of the campaign and react to brochures for similar campaigns already in progress in to other southern states.

A series of 6 focus groups of adult men and women from three regions around North Carolina teens were held the week of May 10-14, 2004 in Sylva, Kinston and Durham NC. The study gathered the reactions, opinions and ideas of 47 young adults in 3 locations across the state. The groups were formed to hear the voices of Mountain, Coastal and Piedmont, rural, town and urban. A significant effort was made to achieve ethnic and racial diversity.

Participant's ages were between 19 and 37 years of age. More than half of the participants were parents, a significant number living in single parent or blended families. Many fathers were not living in the households with their children.

Income and education varied, with working poor more heavily represented in rural and town areas. The issue of unemployment was notable in the urban environment. Young college students were present in each group.

The discussions sought to understand the differences between demographic groups, regional groups and genders. From these insights, the development of various elements of a successful social marketing campaign could begin.

The significant findings:

1. Specific, focused targets must be selected to have the best opportunity for success
2. Men very much want to get care for their reproductive health.
3. Public health materials would get more attention if they were updated and included elements that spoke to the young adult audience.
4. The role of private practitioners must be given serious consideration to encourage maximum participation.
5. Separate efforts to reach the Hispanic community should be considered.

2. BACKGROUND AND PURPOSE

The North Carolina Family Planning & Reproductive Health Unit is preparing to launch a groundbreaking program to bring more federal dollars for family planning & reproductive health care to low- and moderate-income women & men. One of only 18 states taking the initiative to make use of these federal funds, North Carolina is one of only two states developing family planning programs for men under the Medicaid Waiver program. The program will create awareness and promote access to family planning and reproductive care to men and women 19-35+ years of age, with incomes under 185% of federal poverty guidelines.

Input from the target audience was necessary at this stage of the campaign to steer campaign development decisions based on the target audience's reactions to the concept and to understand the media messages attract their attention. Data gathered in these focus group discussions was designed for use by the program development and social marketing teams. The results will aid in making decisions about branding, media emphasis and other formative aspects of the program.

While it was recognized that the program would at first be promoted to women already receiving reproductive health care from clinics, the desire to make the program appealing to additional audiences necessitates the development of a marketing program that captivates the attention and interest of non-captive target audiences. The first step in this process is to define and describe the target audiences. Focus group discussions are an idea way to gather such data from a diverse group. Such groups also enable the participants to become engaged in the creative process, producing raw ideas "from the source" which may lend themselves to refinement.

A core tenet of social marketing is listening to the audience. These voices of this diverse audience will now enable the development of the campaign.

3. METHODOLOGY

A. Communities and Facilities

North Carolina is a state of remarkable diversity – of climate, terrain and culture as well as ethnicity, economics – even dialect. The program was designed from the start to capture voices in each of the three widely recognized regions of the state: Mountain, Piedmont and Coastal Plains.

The facilities used for focus groups play a significant role in the outcome. The facility must be a comfortable environment to encourage open dialogue. The location sets a tone from the outset, during recruitment and throughout the conversation. A familiar, friendly, carefully chosen location is inviting the audience. Community locations chosen were:

Region	Town/City	County	Facility
Mountain	Sylva	Jackson	County Health Department offices
Piedmont	Durham	Durham	Downtown YMCA
Coastal Plain	Kinston	Lenoir	Lenoir Memorial Hospital

B. Recruiting Methods

Participants were recruited with a variety of methods:

- Local county health officials were instrumental in making contacts with professionals active in community health care
- A flyer was developed and distributed widely in all three areas
- The flyer was translated into Spanish and distributed through a Hispanic community center in Durham
- Kinston and Sylva county health, local hospital and community colleges posted the flyers
- Radio and newspaper announcements were placed
- An 800 number was established to take calls so that participants could be qualified by age and income and pre-register for the groups
- A $40 stipend was offered to qualified participants to overcome transportation and childcare expenses
- Drinks and snacks were provided

- Recruiting visits were made to grocery and discount store parking lots in target neighborhoods, with particular attention to intercept a balance of racial/ethnic groups

C. Focus Group Participants

Six focus group discussions, three each for men and women aged 19 to 37, were conducted the week of May 10-14, 2004 across the state.

Each group was composed of one gender to foster a more comfortable discussion environment for a sensitive, personal topic. Also, separate gender groups enables a depth of understanding of gender differences in approaches to the subject matter as well as media preferences.

All participants were residents of the county the meeting was held in. A mix of parents and non-parents, married and single, employed and unemployed, and educational attainment were found in each meeting. Members of a group were homogenous in terms of urbanicity and totality of the groups aimed to gather a broad sampling across the many demographic measures.

Group #	Date	Location	Gender	Race/Ethnicity	TOTAL
1	05/10/04	Sylva	Male	White/Hispanic	5
2	05/10/04	Sylva	Female	White	6
3	05/12/04	Kinston	Female	White/Black	8
4	05/12/04	Kinston	Male	White/Black	11
5	05/14/04	Durham	Female	Black	6
6	05/14/04	Durham	Male	Black	13
					49

4. TARGET GROUPS

One of the most significant challenges to developing a successful Family Planning Medicaid Waiver campaign in North Carolina is the addressing the complex web of demographic subgroups. The principles of social marketing have proven the more focused a campaign is on a particular group, the more likely it will succeed. It is crucial to the success of a campaign to have the target crisply defined which will enable the development of strategies and tactics that are highly tuned to the needs of that target audience. Such specificity also enables more accurate tracking of progress and a greater opportunity to make refinements as the campaign progresses that truly make a difference in the quantity of success.

A selection of a focused target also enables a clearer definition of the measures of success for the campaign. Most public health campaigns aim to serve nearly all the people all of the time. A social marketing approach focuses the campaign on a specific target audience (or audiences) and includes measures of success that include timeframes and quantifiable progress *beyond media impressions or counts of pamphlets distributed.* The objective of the campaign becomes the *change in behavior* or the target audience.

Table 1 displays the 96 key demographic subgroups that are considered potential primary targets of the North Carolina Family Planning Medicaid Waiver campaign.

Since the campaign is not well served to pursue 96 individual targets, each with its own strategies and tactics, a prioritization and grouping of the sub-targets will enable the pursuit of the most desirable targets. Measures of desirability for the targets include, among others, the size of the at-risk populations, the level of ease of reaching the targets and the likely speed of behavior change. Table 2 shows some of the data surrounding the relative size of the target populations. The matters about reachability and speed of behavior change are addressed in Section 6, Bridges

	Mountain		Piedmont		Coastal	
Females	Younger Married Parent < Poverty	Younger Single Parent < Poverty	Younger Married Parent < Poverty	Younger Single Parent < Poverty	Younger Married Parent < Poverty	Younger Single Parent < Poverty
	Younger Married Parent > Poverty	Younger Single Parent > Poverty	Younger Married Parent > Poverty	Younger Single Parent > Poverty	Younger Married Parent > Poverty	Younger Single Parent > Poverty
	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty
	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty
	Older Married Parent < Poverty	Older Single Parent < Poverty	Older Married Parent < Poverty	Older Single Parent < Poverty	Older Married Parent < Poverty	Older Single Parent < Poverty
	Older Married Parent > Poverty	Older Single Parent > Poverty	Older Married Parent > Poverty	Older Single Parent > Poverty	Older Married Parent > Poverty	Older Single Parent > Poverty
	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty
	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty
Males	Younger Married Parent < Poverty	Younger Single Parent < Poverty	Younger Married Parent < Poverty	Younger Single Parent < Poverty	Younger Married Parent < Poverty	Younger Single Parent < Poverty
	Younger Married Parent > Poverty	Younger Single Parent > Poverty	Younger Married Parent > Poverty	Younger Single Parent > Poverty	Younger Married Parent > Poverty	Younger Single Parent > Poverty
	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty	Younger Married Non-Parent < Poverty	Younger Single Non-Parent < Poverty
	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty	Younger Married Non-Parent > Poverty	Younger Single Non-Parent > Poverty
	Older Married Parent < Poverty	Older Single Parent < Poverty	Older Married Parent < Poverty	Older Single Parent < Poverty	Older Married Parent < Poverty	Older Single Parent < Poverty
	Older Married Parent > Poverty	Older Single Parent > Poverty	Older Married Parent > Poverty	Older Single Parent > Poverty	Older Married Parent > Poverty	Older Single Parent > Poverty
	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty	Older Married Non-Parent < Poverty	Older Single Non-Parent < Poverty
	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty	Older Married Non-Parent > Poverty	Older Single Non-Parent > Poverty

Table 1. 96 Possible Target Groups

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The data in Table 2 estimates numbers of women only; the numbers of men were considered to be insignificantly different from these estimates for the purposes of this analysis.

Impact of Population Volume

Volume by Gender: The difference in this ratio is not significant enough to be deciding factor by itself in the selection or elimination of either group.

Volume by Region: It is clear that the Piedmont, with nearly 52% of the target population must be given significant consideration in all decisions regarding target definition and selection. The

small proportion of targets in the Mountain region suggests careful consideration be given when these sub-targets are considered.

Volume by Income Groups: Slightly more than half of the targets are in the income group that is newly included in this Medicaid program, a significant factor in considering the formation and selection of targets. This is a measure that might vary somewhat more for men than the other measures; further data might be desirable to provide more accurate estimates of males by per these income groups.

Volume by Age Groups: Table 2 does not report the estimates by Age group. However, the same source indicates that about 75% of the eligible women (and, perhaps somewhat fewer men) are age 20-29.

5. BARRIERS

In order to encourage new or different behavior, a public health campaign must address the barriers that the target audience has towards the specific topic, as well as to new messages in general. Documenting and exploring these barriers will enable the development of a more effective campaign strategy, with tactics that overcome or diminish the intensity of the most significant barriers.

The first step in developing the campaign, *listening to the audience*, enables a richer understanding of these barriers and also begins to identify the differences among the many sub-targets in terms of the strength of the barriers and the techniques that could address them. The exploration of the various barriers significantly informs the formation and prioritization of the targets.

Family planning is a particularly sensitive topic. It brings with it not just opinions but strong beliefs as well as personal histories that can raise the barrier to change. Even with desire to change, social pressures and habits must be overcome. This study's conversations with groups about this topic suggests there will be a challenge to developing a cohesive, comprehensive campaign theme as there are many facets to the program and many barriers to change for each.

The subject does not quiet participants—quite the contrary. Many participants had moving stories to tell and were fountains of ideas and suggestions.

In the exploration of barriers, a key question needs to be considered: What would stop members of the target audience from participating in the program?

While it might be possible to create a highly visible and memorable campaign, it is necessary to enable significant members of the target population to move into the next Stages of Behavior

Change, which are *Contemplation* and *Trial*. So, a refinement to the key question is: What would get in the way of changing behaviors, even if they are aware of the campaign?

The objective becomes working to move as many people as possible in the chosen targets *through/around* these barriers as quickly as possible to achieve behavior change.

As participants discussed the subject in the groups, a variety or recurring questions and statements emerged that informed the definition of three primary barriers to change this campaign must address. Some paraphrased examples include:

Where would I go to get help?
Would I have to wait for a long time at a clinic?
How much would it cost me?
Who else is going to know about my business?
Who is going to see me getting help at the clinic?
Who is going to hear from the clinic staff about my visit? Who are they going to talk to and tell about my problems?
Do I qualify for this kind of "help"?
Don't I make too much money?
Aren't such programs just for women?
I would be embarrassed to take help from the government.
I am too proud to take this kind of help.
I do not understand the campaign; it is not in my "language" (cultural compatibility)
It does not address me…it does not include me.
It's for women.
Medicaid…That's for poor people.

Two significant topics emerged in many of the groups should be given some consideration during the development of this campaign as well as other campaigns:

Why are you doing this instead of helping with basic health care? A number of participants wondered why limited government resources were being spent on such a small aspect of health care, and a secondary matter in terms of need, since many lacked sufficient primary care for illnesses and accidents. One participant in particular asked why men such as him were not asked first as to what health issues needed such financial assistance programs.

What about teens? Why are you helping adults, because it is too late for most of us? Many suggested that this campaign be focused on or include teens where these life-changing behaviors are forming.

Three Primary Barriers

All together, three primary barriers to awareness and behavior change emerged:

1. <u>RELEVANCE</u> of Family Planning Practices as Something I Do
   Nearly all women feel family planning is primarily their responsibility.
   Most men do not think family planning in general is their primary responsibility.
   Planning is not on most people's minds, particularly younger people; spontaneity is their life stage.

2. <u>ELIGABILITY</u> for Government Programs That Provide Me Help
   Many in the upper income (100-185% of poverty level) group and those that have fallen from better times are (understandably) unaware of such programs, and many were surprised by their potential eligibility.
   Women are more familiar with government assistance programs yet some will not consider themselves eligible without re-education.
   Men generally do not think government assistance programs are for them, especially in regards to food, health and shelter; men are more inclined to think that government programs for them are about jobs.

3. <u>PRIVACY</u> and Confidentiality of Care
   Nearly all women feel comfortable discussing private matters with others; however, in smaller communities, this will be a factor to address.
   Most men are particularly concerned with having other people so involved in their personal issues, particularly about matters relating to their sexual activities. It is difficult to imagine a pairing of a demographic group and health topic that is more sensitive to resistance to help and the issue of privacy is a potentially steep barrier.
   Some wondered whether any private doctors would participate in such a program at all creating a concern about their likely participation.
4. <u>CONVENIENCE</u> of Getting Care
   The public health clinics in the coastal and mountain areas were convenient and functional, yet some were concerned with the level of privacy at these locations and wondered whether other counties would provide them with the services so that privacy could be achieved, even at less convenience.
   Long wait times were cited in the urban Piedmont group.

Word Choices

The naming of the campaign and the focus words in any materials or promotional endeavors must recognize these three barriers. Some words will trigger the "relevance" barrier; others will confront the "eligibility" barrier. Additionally, two or more of these words used in combination may cause quick dismissal of the message. Any use of these words must be done with great care and consideration of the net impact on the campaign's ability to reach and motivate the primary targets.

For example, the words "planning" and "plan" are not likely to be effective as they are not relevant to most people who live day-to-day. "Prevention" refers also to the future, not today. Most participants are more responsive to immediacy.

An Additional Relevance Dimension: Immediacy

Many members of these targets filter messages directed at them with this question in mind: "What's In It For Me *Now*" with an emphasis on the "now," particularly among the younger groups. The competitive environment for the Family Planning Waiver campaign includes a juicy hamburger, sexy clothes, a basketball game, a new purse/bag, all things that can be acquired now (or within minutes) and enjoyed right away. This competition for attention and relevance in today's decisions must be considered in developing all of the elements of the campaign. Additionally, most members of the target audience are accustomed to "shopping" for so many other needs, and family planning services are currently not at the forefront of these pursuits.

6. BRIDGES

Communicating with an audience can be likened to building a bridge. These bridges connect two different worlds, that of the "seller" (the health department offering services) and the "prospect" (members of the target audience. Many times, the bridges must span large gaps in terms of language use, needs, wants and priorities. Bridges must directly address the barriers.

Available bridges include branding (e.g. naming, look-and-feel), advertising (e.g., radio, billboards) and promotional activities (e.g. websites, public events). The development and implementation of any of these elements should consider the target audience, its preferences and interests, barriers, and the compatibility of matching various campaign elements.

Much like packing your bags to go to a country that speaks a foreign language, dresses differently, and eats unfamiliar foods, it is important to be prepared. More challenging is that any communication with the audience must be in their native language—it must fit in with their worldview and it must stand out to get their attention.

The bridges must consider what is being offered and how it will best fit within the target's life. Many times, what seems like a tangent to addressing a primary goal is the most effective way to develop productive communications with a target, so a wide range of possibilities should be considered before any selections are made.

Each of the demographic dimensions provides insights into the construction of bridges to reach them:

Males/Females

There are tremendous differences between the genders.

Females are focused on:

Comfort Family

Children Connection
Caretaking

Males are focused on:
Technology Sexy images Heroes
Action "Reality"

Regions: Mountain/Piedmont/Coastal

The data gathered from these focus groups do not show clear distinctions based on the three regions of North Carolina. Instead, the level of urbanicity produces clearer distinctions. However, one key aspect in the regional differences is on the availability of radio/television, where residents of the Mountain region have far fewer options. Magazine availability was also different in the Mountains, where many mainstream selections were not on newsstands, and most options were highly tuned to special interests, such as specific sports car owners.

While it is possible that additional dimensions of differences exist between the regions, identifying them was beyond the scope of this study.

Urbanicity: Rural/Town/Urban

The level of competition for resources plays a key role.

Rural/Small Town residents:
Independence
Isolation

Town/Small City residents:
Community connections
Church and family

Urban residents:
Survive the streets
Wait in line

Older/Younger

This dimension was particularly prominent among women.

Older:
Suffered from the inability to get care at a younger age
Overcame the barriers to get care for reproductive health by necessity

Younger:
More aware of options at a younger age

More able to get assistance at a younger age

Black/White/Hispanic

Data gathered in this project shows few differences between Blacks and Whites with the exception of some of the media preferences. Differences were more evident in urbanicity than by these racial breakdowns. Highly specialized media options are available to reach distinct sub-segments.

Hispanics proved exceptionally difficult to recruit despite significant concentrated efforts to include a proportional Hispanic voice. Language and cultural barriers are very steep and suggest a highly concentrated effort would need to be undertaken to gather valid data.

Income Level <100/Over 100% of Federal Poverty Guidelines

Differences between levels of income are prominent. Both groups are frustrated by lack of resources to improve their lot.

<100:

More free time
Less optimism, cynical
Accustomed to receiving social services, but with low expectations

>100:

Tired
Trying hard, scraping by
Fallen-through-the-cracks feeling; there's no help for me

Parent/Non-parent

This dimension is somewhat more pronounced among women due to their immediate physical and societal responsibility to care for a child.

Non-parent:

Hazy dreams of what life will be
Not yet taking the possibility of parenthood with a magnitude of consideration proportional to its affect; planning isn't sexy or fun
Lacking the wisdom of age

Parent:

Know what they need to be doing to keep things together
Lifestyle is now prioritized by the presence of children

Married/Single

This dimension is particularly distinct between the genders.

Married
Planning
Involved in ongoing dialogue with spouse about current needs and future options

Unmarried
Struggling with responsibility without full support
More emphasis on socializing if male or female without children

Married males are more like female parents than single men in that they have a much higher level of planning and are conscious of consequences and their priorities are more focused on family.

English/Spanish

It is clear that Spanish language materials are necessary. The development of campaign elements highly targeted towards the Hispanic community--not just mere translations of the English campaign—is the best, and perhaps only way, to be effective in reaching this substantial audience.

> "If you ask people in the community about their top health concerns they won't even talk about health. They will talk about the language barrier."
> *Andrea Bazan-Manson, head of El Pueblo,*
> *A triangle area advocacy group for Hispanics*

Reachability

Mountain residents will prove to be more difficult and more expensive to reach due reduced options for communications vehicles. All other sub-targets are reachable with a multi-media approach.

Changeability

As each sub-segment is considered and potentially matched with other sub-segments to form targets, this dimension must be given careful consideration as some sub-segments are more and less likely to take advantage of various services offered in the program.

7. Recommendations

Three key recommendations are offered for consideration.

1. Select Target(s)

Select one target or a collection of compatible targets for primary attention

Alternatively, select two or more targets for primary attention, each receiving specialized attention with specific strategies and tactics to address each target individually; dilutes resources.

By way of example, Table 3 identifies targets for primary attention.

Target Option	Gender	Age	Income	Marital Status	Parental Status
A: Single Men	Males	19-35+	<185%	Single	Parent and Non-Parent
B: Working Poor	Males & Females	19-35+	100-184%	Single & Married	Parent and Non-Parent
C: Working Poor Women	Females	19-35	100-184%	Single & Married	Parent and Non-Parent
D. Working Poor Men	Males	19-35+	100-184%	Single & Married	Parent & Non-Parent
E. Below Poverty Men	Males	19-35+	<100%	Single & Married	Parent & Non-Parent
F. Below Poverty Women	Females	19-35	<100%	Single & Married	Parent & Non-Parent
G. Below Poverty Women Parents	Females	19-35	<100%	Single & Married	Parents

Target G: Medicaid already serves Below Poverty Women Parents

Table 3: Example Primary Targets

The sorting out among the many possibilities is made possible by considering the contrasts identified in this analysis as well as the resources available to the campaign and the campaigns overall objectives and operating environment.

The results of this sorting process will enable the development of a campaign marketing plan.

2. Address the Issue of Private Practice Doctor Participation

Most participants in these focus groups expressed exceptionally eager interest in private doctor provided services. This option addresses head-on the three primary barriers to use of the program, *Relevance*, *Eligibility, Convenience* and, particularly, *Privacy*. A special social

marketing campaign aimed at reaching the practitioners could encourage wide spread availability of the services. The stigma of Medicare is acute among private doctors. Based on feedback from the target groups, the more private doctor participation that can be achieved, the greater the success of the campaign. At this time, this question should be answered: How will the program incentivize significant numbers of private practitioners to participate in the program?

3. A special social marketing campaign designed for the Hispanic community is highly recommended.

Special efforts are required to gather input from this group and then shape a campaign that would have a chance of being effective in changing behavior among members of this group. The language gap, cultural differences and the special options for message distribution all contribute to the opportunity to produce a unique campaign.

APPENDIX A: MODERATORS GUIDE

The following outline was used to guide the focus group discussion:

1. INTRODUCTION .... *5 minutes*

Who we are

Moderators, video

Why you are here

- Topic = Family Planning & Reproductive Health program
    - Providing services to low and moderate income
    - Preventing unintended and mistimed pregnancies
    - New outreach to men
- Represent your part of the state
- Help to create statewide campaign
- Help the state qualify for future federal funding

3. ICE BREAKER—Tell your name and favorite place to vacation............................ *10 minutes*

3. BRIDGES: Review ad messages and find the most effective elements .... *20 minutes*

- Pair off with a neighbor
- Discuss & select ads with elements that best get your attention by showing top 3:
    - Photos/drawings/images
    - Headlines
    - Colors
- Present your best to the group
- Fill out media preferences form

4. BARRIERS: Discussion of using services.. *15 minutes*

- Under this new program, you will be able to be able to get free family planning health care from many private care doctors in addition to public health clinics.

    - Would you use it?
    - What would get in the way of your going to get family planning care?
    - Where do you go now to get family planning and reproductive health information?

5. CREATE: Develop brand/ad concepts.. *15 minutes*

- What might get you to notice the state's campaign to provide no-cost family planning services to you?

- Design a poster that would get your attention and you think would get the attention of your friends.

5. CRITIQUE: Discuss 2 other state brochures/campaigns .... *15 minutes*

- What do you like about them?

- What do you not like about them?

- What do you think would work in NC?