JVA CONSULTING, LLC
partners in community and social change

Colorado Department of Public Health and Environment Women's Wellness Connection Media and Marketing Study: Report of Findings

Report to the Colorado Department of Public Health and Environment

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Executive Summary

Background and Methods

The Colorado Department of Public Health and Environment (CDPHE) contracted with JVA Consulting, LLC (JVA) to conduct formative research on marketing tools and marketing outlets among women eligible for the Women's Wellness Connection (WWC) program. While there are several working definitions of formative research that exist in the literature, JVA opted to use the definition provided by CDPHE.[1] This definition focuses research on the behaviors of the target population in order to improve ongoing programs. This particular study for CDPHE concentrated on women eligible for WWC screenings and the medical providers and coordinators who serve them. The purpose of the assessment is to enhance current and future WWC marketing materials through community-focused formative research.

To assist CDPHE in understanding which marketing tools and outlets WWC medical providers and program coordinators (WWC professionals) prefer to use, JVA conducted 24 interviews with WWC professionals. To better understand which marketing tools WWC-eligible women in Colorado are receptive to for health information, JVA conducted six focus groups with lower-income women between the ages of 35 and 64. JVA created all focus group and interview protocols and scripts, which were then reviewed by CDPHE.

A qualitative, mixed-method design was used to gather data from diverse community samples and WWC professionals. The evaluation processes included: (1) reviewing existing evaluations and marketing materials to inform evaluation tool development, (2) conducting 24 unique phone interviews with 28 WWC professionals (four calls had two people on the line for the same interview) across 16 counties in Colorado, (3) conducting six, 90-minute focus groups with a total of 45 community members (each participant also received a short survey on media outlets). The findings from this assessment will enable WWC to critically look at the current marketing tools and outlets used to reach eligible women, in order to ensure an even greater number of women in Colorado have access to affordable health options.

Highlights

Data collected from the interviews and data collected from the focus groups varied greatly. While interesting results came from both approaches, there was enough division between the two data sets that they needed to be analyzed separately.

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[1] Formative research is the basis for developing effective strategies, including communication channels, to influence behavior change. It helps researchers identify and understand the characteristics– interests, behaviors and needs – of target populations that influence their decisions and actions. Formative research is integral in developing programs as well as improving existing and ongoing programs.

The interviews with WWC professionals (coordinators and providers) did not reveal specific marketing materials or outlets that are most effective or most preferred. Findings of this research varied based on site-specific experiences, diverse role definitions and geography. Due to the variety of opinions expressed in the interview data on the topic of marketing in WWC, JVA created a framework to better understand the results and the implications of the data variance for future needs (see Chart B on page 15). Other important information that resulted from the interview data focused on common barriers to reaching women, the need for trust in successful outreach and the need for collaboration in successful outreach.

Findings from the focus groups provided a solid list of the traits of effective marketing tools and a list of places that women trust the most as marketing outlets. The qualities of the most effective marketing tools cited by focus group participants are as follows: useful, eye catching, small/portable, informative but direct, and those that function as a conversation starter. The most effective and trustworthy marketing outlets discussed in the focus groups are: word-of-mouth, bulletin boards, community centers and advertisements (varying by community). Other important findings from the focus groups focused on common barriers to reaching women and what motivates women to respond to marketing. Overall, the undercurrent through the interview data and the focus group data was the need to understand context and community differences.

Introduction

Purpose

One in eight women in the U.S. will be diagnosed with breast cancer in her lifetime. In the year 2013 alone, it is predicted that 12,340 new cases of invasive cervical cancer will be diagnosed.[2,3] WWC desires to spread the knowledge that when women detect breast cancer early, the survival rate is 98%, and when it is detected in its earliest stages, the survival rate for cervical cancer is 92%.[4] Early detection, even before physical symptoms arise, is essential to saving the lives of women across Colorado. For this reason, WWC recognizes that in order to reach women who need services the most, a current evaluation of what really works for marketing and media in Colorado communities is required.

To help WWC better understand its marketing and outreach, specifically the tools and outlets that WWC-eligible women and WWC professionals (WWC providers and WWC coordinators) prefer, CDPHE contracted with JVA Consulting to collect and analyze relevant community

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[2] American Cancer Society. *Breast cancer facts and figures 2011-2012*. Retrieved from http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc0375.pdf
[3] American Cancer Society. (2013). *Cervical cancer.* Retrieved from http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-key-statistics
[4] Women's Wellness Connection. Retrieved from www.womenswellnessconnection.com

opinions. Qualitative research was conducted in a total of 19 counties in Colorado, with diversity in rural and urban representation and in primary language spoken. The findings from this research highlight the most effective marketing tools and outlets for the WWC community, additional important findings on this topic area, and recommendations for next steps. The following report will enable CDPHE and WWC to assess the current marketing tools and outlets used to reach eligible women in order to ensure all eligible women in Colorado who could benefit from this program are better informed about their options when it comes to early cancer screenings and preventive care.

> "[Our] community is very proud. [We] have a hard time asking for free services. Tools are good, but it's knowing your community and how to approach people. [We] trained the front staff to offer WWC to people—if they think women don't have insurance. So reaching out to this community is hard."–Rural interview participant

Organization of Report

The report has been divided into two sections: formative research approach and findings. Within the formative research section, the methodology and protocol behind the interviews and focus groups are explained. Within the findings section, the interviews are analyzed first, followed by the focus groups. Although the same topics were discussed in both research approaches (interviews and focus groups), the results are more effective when reflected on separately. Within each subsection of the findings, the most effective tools, most effective outlets and other important findings from the data are drawn out. A detailed recommendation section is included prior to this report's conclusion, as well. Specific WWC marketing tools mentioned in this report can be found in Appendix A. Specific evaluation tools used by JVA can be found in Appendix B.

Formative Research Approach

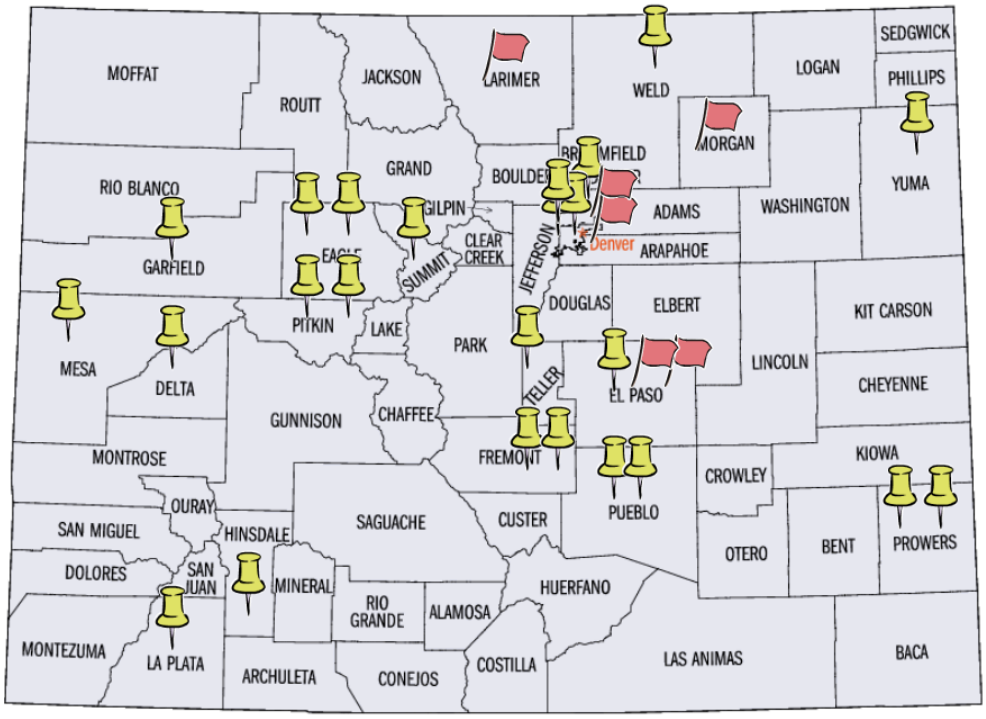
CDPHE understands that the root of effective outreach comes from knowing the current needs, interests and behaviors of the WWC community. The acknowledgement and pursuit of this research approach by CDPHE demonstrates the value it places on community voice and its desire to act based on community needs. Without public input, the realities of what is really going on in the daily lives of WWC-eligible women can often be misunderstood or ignored. JVA strongly supports the use of qualitative research to better understand the depth of women's health issues and to enable leaders to make informed decisions.

Learning more about the needs of the community starts with obtaining a better understanding of what women perceive when they see health-focused marketing and what leads them to follow up when prompted by marketing. Additionally, the WWC community also includes the professionals who enroll women in the program or conduct screenings, and they offer an alternative perspective to how WWC marketing is approached. Thus, to ensure a wide and representative community perspective, JVA conducted a series of focus groups and interviews to

dig deeper into key issues. Evaluation tools were developed using a combination of focus group and market research best practice, JVA expertise and CDPHE feedback. All evaluation tools were reviewed and approved by CDPHE and can be found in Appendix B.

A qualitative, mixed-method design was used to gather data from diverse community samples and WWC professionals. The evaluation processes included: (1) reviewing existing evaluations and marketing materials to inform evaluation tool development; (2) conducting 24 unique phone interviews with 28 WWC professionals (four calls had two people on the line for the same interview) across 16 counties in Colorado; (3) conducting six, 90-minute focus groups with a total of 45 community members (each participant also received a short survey on media outlets). Each process is explained in more detail below. To better understand the scope of this research, the map depicted in Chart A, below, marks the interviews conducted (in yellow push pins) and the focus groups conducted (in pink flags).

Chart A: Map of Research



Push pins=interviews; Flags=focus groups

Interview Approach

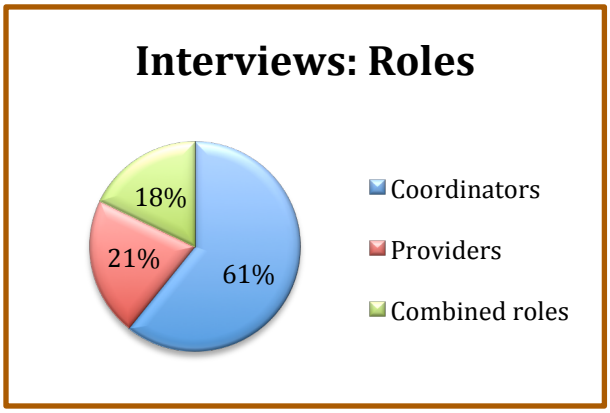
Interviews with WWC professionals throughout Colorado allowed JVA to obtain an additional perspective on the WWC marketing materials and outlets, and to understand how marketing fits into the work of WWC professionals on a daily basis. To assess the viewpoints of the WWC professionals, JVA developed a detailed interview script, which was preapproved by CDPHE (see Appendix B). WWC professionals were asked about their experience in recruiting, enrolling, or screening WWC-eligible women; if and how marketing tools from WWC are used; thoughts on

the best outlets to reach new women; and barriers to reaching women in their community. CDPHE provided JVA a list of WWC coordinators, from which JVA scheduled 24 unique interviews.

Who was interviewed? JVA conducted 24 interviews with a total of 28 individuals. On four occasions, interviews were conducted with two interviewees sitting in on the same phone call. Another four of the 24 interviews were conducted via an online survey, as these individuals wanted to share their opinions but could not be interviewed due to time limitations. While the surveys asked the same questions as the phone interview, JVA understands that the survey offered a different environment in which to answer questions. However, as the survey answers aligned with the interview responses, the four surveys have been and will continue to be counted in the analysis and results within this report.

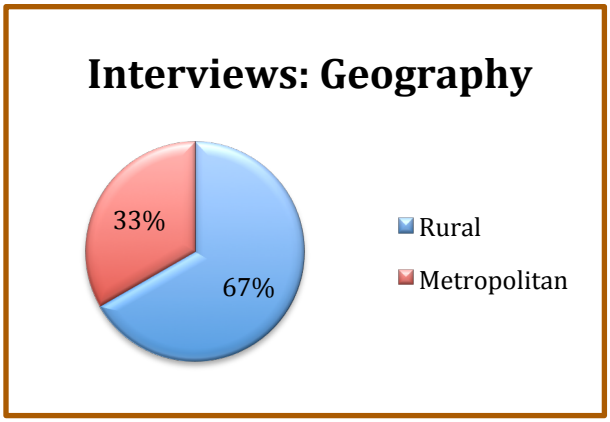
Interviews were conducted with WWC professionals across 19 different cities, 16 different counties and three major types of organizations (hospitals, community clinics and local public health agencies). JVA found that in order to garner valuable opinions on marketing tools and outlets, a variety of WWC coordinators and WWC providers needed to be involved. While coordinators and providers might have very different roles in certain environments, there are also regions and locations where the roles blend together. Some coordinators defined their role as "director," "outreach provider," "manager" or "coordinator" of the WWC program (and often other programs as well). There were a few instances in which the coordinator also acts as a provider, by conducting exams, which is dependent on his/her medical title (see Table 1).

Table 1



JVA aimed to reach a large rural population through the interviews, especially as focus groups proved difficult to coordinate in rural areas (this issue is detailed further in the "focus group approach" below). In total, 16 interviews were conducted in rural areas and eight interviews were conducted in metropolitan areas (see Table 2).

Table 2



Methodology

In order to elicit honest opinions from the WWC professionals, confidentiality and informality of the interviews was key. JVA stressed that the interview should be considered an informal discussion in order to prevent concern over a need to prepare. Similar to the focus group methodology, which will be discussed in the next section, flexibility to context was necessary. To achieve this in a phone interview, a semi-structured interview script was created. This format ensured that the same questions were asked to every provider, but offered enough flexibility to adjust for different perspectives or draw out items that were of particular interest to certain providers, if relevant to the research.

Recruitment

WWC providers were recruited with the help of CDPHE, as CDPHE provided the original contact list for WWC provider locations in Colorado. When contacting potential interviewees, JVA sent out individualized emails to set up a 30-minute slot for interviews with interested individuals.

In the process of recruitment, JVA recognized the need to speak with coordinators as much as providers, as the range of experiences in WWC varied often due to the position held. In addition, it should be noted that WWC professionals from rural areas were more likely to respond to an interview opportunity than those in metropolitan areas.

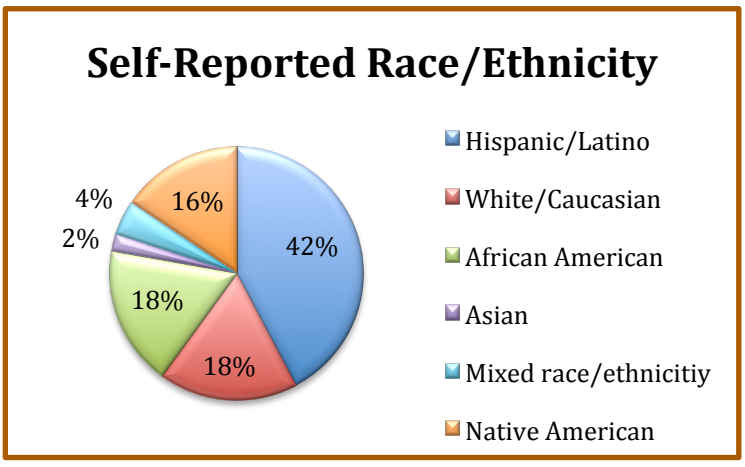
Focus Group Approach

To assess the community perspective, JVA created a focus group script, which also outlined the JVA methodology and protocol to be used for the WWC focus groups. A focus group recruitment plan was submitted to CDPHE, which outlined the expected process that would be used to recruit WWC-eligible women to participate in the groups. Both documents can be found in Appendix B of this report.

The focus groups were developed for two purposes: (1) to evaluate effective communication tools for WWC-eligible women and (2) to evaluate effective communication outlets for WWC-eligible women. To do this, recruitment flyers were created in English and Spanish. To ensure women were eligible for the focus group, a pre-approved phone screening was conducted, in which all interested callers were screened for the eligibility requirements. When interested participants called, the screener also asked questions to determine basic demographics (e.g., household income and size and ethnicity).

Who participated? After focus group recruitment (discussed in more detail below), the focus

Table 3



groups were conducted throughout Colorado. JVA facilitated six focus groups lasting 90 minutes each, which represented diverse populations of hard-to-reach women in Colorado (45 participants total). Among these participants, JVA was able to speak with women who self-identified as Hispanic/Latino, African American/black, Native American, Caucasian, Asian and mixed race/ethnicity[5] (see Table 3). The focus groups were conducted in communities across the state, including Denver (twice), Colorado Springs (twice), Fort Morgan and Fort Collins.

Methodology

JVA takes a participatory approach to focus group facilitation in order to gain honest answers and ensure that community participants know their voice is valued and their feedback will be used. This participatory method is rooted in the belief that the deepest understanding of data lies within the participants themselves. Thus, efforts were made to engage participants in the discussion by reminding them that their input is important and will impact how health programs like WWC are marketed in their community. JVA makes this participatory approach possible through the use of small-group work in which participants brainstorm and discuss responses prior to sharing as a group, and the use of an interactive display board to visualize trends within the group responses.

This participatory style of focus groups also requires that context is taken into consideration at all steps of the evaluation, and thus requires a level of flexibility and cultural competency to adjust to participant needs and backgrounds. In this instance, when focus group participants spoke about a topic that was not addressed in the script, JVA allowed room for flexibility in the facilitation in order to ensure all facets of the conversation were addressed and any nuances within the communities were attended to.

Recruitment

Recruitment for focus groups was completed through multiple methods: flyers posted in key locations and organizations; direct communication with community health partners and American Cancer Society (ACS) community coordinators; dialogue with various JVA community connections (e.g., discussions with nonprofits serving low-income community members); and the use of telephone screeners (if the interested caller was an eligible community member). Participants were given a $15 Visa gift card and a meal during the focus group sessions as an incentive to participate and as a thank-you for their time. All flyers, which were preapproved by CDPHE, highlighted the incentives and referred to the focus group as a "discussion group for women."

Recruitment began with a focus on key regions of Colorado, with priority placed on NE rural communities (primarily the hard-to-reach areas of Morgan, Weld, Logan, Washington and Yuma

[5] Participants were asked, "How would you define your race or ethnicity?" as part of the telephone screening process.

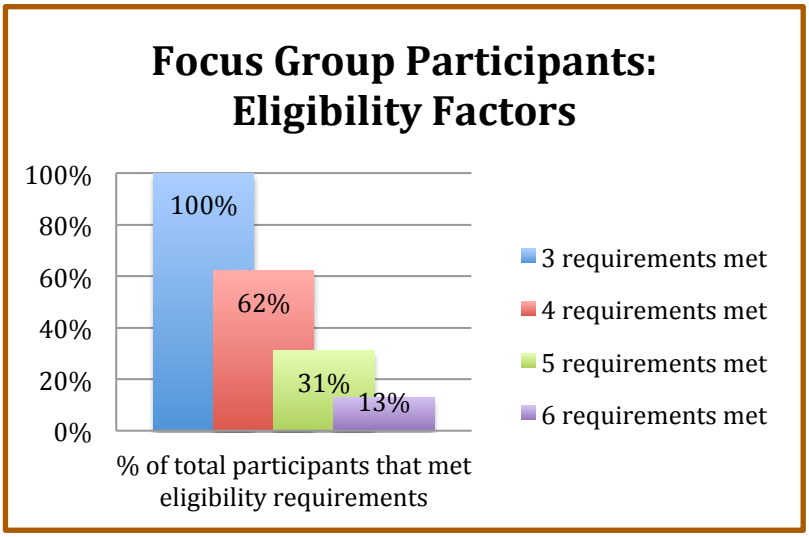
counties) and SW rural communities (primarily Delta, Montrose and Ouray counties). JVA addressed this need by initially reaching out to the ACS community coordinators via a simple survey that was used to better understand the regions within which they work. Flyers were distributed using a "traditional" distribution process in which they were emailed to key leaders and key organizations, ACS-recommended facilities and individuals, and any other locations found that work with the eligible populations across the state. JVA reached out by phone and email to hospitals, clinics, churches and nonprofit organizations in the targeted areas, to see if they could distribute flyers and to create local buy-in for the groups. Within two weeks of heavy outreach, JVA determined that this traditional approach was not reaching the numbers of women necessary to hold focus groups and that new methods would be essential for outreach.

In addition, due to WWC's desire to conduct two Spanish-language focus groups in Colorado, flyers were also created in Spanish and were simultaneously sent to organizations that work in and with larger Spanish-speaking neighborhoods (primarily in Northern Colorado, Colorado Springs and Denver). When this approach did not result in numbers needed for successful focus groups, direct outreach was made with organizations across Colorado that work with Spanish-speaking families and/or women. However, even direct conversations, direct outreach and JVA attendance at local gatherings to recruit did not substantially increase interest in the focus groups for this population. Again, new techniques were needed to recruit Spanish-language focus groups at this stage.

Recruitment: what worked.

After a difficult first month of recruitment, four approaches began to develop that helped to recruit women who were eligible and in the target populations: 1) minimizing the number of eligibility requirements to participate, 2) direct dialogue with leaders of organizations that work with eligible populations (to bring a focus group to their clients), 3) soliciting help from the community mavens[6]

Table 4



[6] The term "maven" is used in this research to describe a woman, often found in each community, who consistently is aware of local events and spreads the word to everyone in her network. A maven is an informal organizer.

who could advocate for the focus group and instill trust in women, and 4) continuing with the monetary incentives and free meal incentives.

- **Eligibility.** The first successful recruitment strategy had to do with decreasing the eligibility requirements**.** When the traditional methods of focus group recruitment proved insufficient, JVA met with CDPHE to discuss possible solutions. JVA and WWC agreed to focus on three key requirements for focus group participants, rather than the six that were initially requested.

  The original requirements:
  1) Women ages 40–64
  2) Income at or below 250% of the poverty line
  3) Legal residence
  4) Insurance status (currently uninsured or underinsured)
  5) Last mammogram screening date over two years ago
  6) Last pap smear screening date over three years ago

  The three priority requirements:
  1) Women ages 35–64
  2) Income at or below 250% of the poverty line
  3) Legal residence

  After the three priority requirements were determined, JVA and WWC decided that interested participants would only need to meet the priority requirements but would still be asked about the non-priority requirements (#4–#6 above). Reducing the number of requirements women needed to meet to be eligible was helpful because of the difficulty in finding women who were eligible for all six original requirements. As can been seen in Table 4, located on page 10, 100% (45 participants) met the three priority requirements and 62% (28 participants) met four requirements (the three priority plus one additional requirement).

- **Direct organizational outreach.** The second successful recruitment approach was found in direct outreach to community leaders. Specifically, the focus group in Fort Collins and one of the groups in Denver were established due to direct communication with leaders of organizations that work with eligible women. Through WWC's contacts, JVA was connected with an organization in Fort Collins that works with community *promotoras.*[*] JVA was able to bring a focus group to the eligible *promotoras* and their friends, which

[*] A person who acts as a bilingual liaison between health care providers and patients through various activities such as: patient education, referrals to health services, making home visits, etc.

resulted in a full focus group that was conducted in a combination of Spanish and English. A similar approach was also used in Denver with an organization that provides services and community resources for Native American families and individuals. JVA, having formerly worked with this organization, was able to bring the focus group to women there through an internal flyer the organization promoted. Despite the success in these two cases, JVA had also used the same approach to reach out to an additional 50 (approximately) organizations to host a focus group with their clients, but had little success. Out of these 50 groups, only two organizations felt confident that their clients were of the correct age group and income level and would be interested in participating. Common barriers in this approach were:

  - Difficulty in knowing about or asking about legal residence status for Spanish-speaking clients, or a resulting lack of interest (on the part of the client) in participating. This barrier was especially difficult once the legal residency requirement was discussed with organizational leaders.

  - Few organizations hosted regular meetings for women of this age range. Often, regular community groups met with either majority younger populations (parenting groups or women's shelters) or with majority older populations (senior groups, senior homes or recreation centers).

- **Community mavens.** The third successful approach for recruitment was soliciting the support of a community maven who was able to initiate a reliable word-of-mouth approach for the focus groups. For example, fifty percent of the first group held in Colorado Springs was made up of women who saw a flyer at a location they knew, while the other fifty percent were recruited through direct outreach by the ACS community coordinator in this region. In this case, the ACS community coordinator, due to her strong connections in the community, acted as a community maven to initiate word-of-mouth. The focus group in Fort Morgan was also filled in this manner, with the support of a community maven who not only helped JVA host the group at her church, but also ensured that six women would join her in the focus group. The last group, held in Colorado Springs, also relied on a maven—a local graduate student who helped out by posting flyers at local barbershops and garnering interest from African American networks. Her efforts helped to recruit twice the number of participants than any other group, and helped this focus group fill in only five days.

  The word-of-mouth approach described above was highly successful and reached women that would not have been interested otherwise. For example, response from Morgan and Logan counties was extremely low, with only two calls coming in from this area. When one woman called and seemed willing to find a group of six women to join her in this group, it seemed to be unlikely that it would result in an actual group. However, to the facilitator's surprise, this woman was able to gather a group of women to participate, even though not all of them were aware of the monetary incentive.

These groups would not have been successful without the direct communication with key community voices and the power of word-of-mouth.

- **Incentives.** The fourth successful method in recruitment came from offering the monetary incentive and free meal. However, this alone was not enough. If this method was sufficient on its own, traditional flyering might have proven more successful. Combined with the three methods highlighted above, however, the incentives helped ensure that interested participants showed up for the group.

Recruitment: what did not work. Throughout the project, it was clear that outreach and recruitment were not reaching the targeted audience and not resulting in sufficient interest in focus groups. Methods that did not work well were: traditional flyers, traditional recruitment methods and Spanish-language flyers.

- **Traditional flyers.** As mentioned above, traditional flyers did not result in the necessary interest for specific focus groups. It is hard to say if this was due to a flaw in the wording, hesitation on the part of women to call, skepticism or lack of interest from women in certain age groups, or too much/too little information on the flyers.

- **Spanish-language flyers.** Another method that was not effective was traditional flyering in Spanish. Interestingly, even in areas where flyers did garner some response in English (Colorado Springs and Denver) there was little to no response to the Spanish flyers. Flyers in Spanish were distributed to key locations for this population, but still did not elicit any response. Further steps were taken by JVA to recruit from the Spanish-speaking community through direct outreach to key organizations. This appeared promising, as the organization staff was optimistic that women would want to participate, however, there was still no response or interest from community members. One large barrier to recruiting from this population was the legal residence eligibility requirement. The flyer stated this requirement in very small writing in the bottom corner, so people reading the flyer quickly likely did not notice it. However, it might be deduced that there were other barriers to reaching these targeted Spanish-speaking populations with publicly advertised focus groups, regardless of whether or not the flyer mentioned immigration status. Please see the "findings" section from the Fort Collins focus group (below), which addresses some of the mistrust found among this population.

***Recommendations based on recruitment efforts*.** The recruitment process provided evidence that hard-to-reach women in the targeted age and income groups cannot be recruited via traditional outlets and that word-of-mouth recruitment through community organizations or community mavens is often necessary. Recruitment was particularly difficult in the SW rural communities and the Spanish-speaking communities. It is interesting to note that the focus of the recruitment efforts was on the same populations that WWC often struggles to reach out to as well. Based on

the experiences in this area in the past three months, JVA recommends that trustworthy delivery points for marketing should come through community mavens in addition to local organization-level correspondence.

Findings

Data collected from the interviews and data collected from the focus groups varied greatly. While interesting results came from both approaches, there was enough division between the two data sets that they needed to be analyzed separately. For example, there were particular marketing tools and outlets that were observed to be most effective for community members in the focus groups, but there was not a clear distinction of which marketing tools were most useful in the interviews with WWC professionals. In addition, the findings led to other important information that is not directly related to the topic of "tools" or "outlets," but is complementary to the topic of media and marketing. In the following section, the findings from the interviews will be discussed first, followed by the findings from the focus groups.

WWC Interviews

The interviews with WWC professionals did not reveal marketing materials or outlets that are a) most effective or b) most preferred. Despite the lack of consistent responses in the interviews, there were some common themes and trends.

Due to the variety of opinions on the topic of marketing and media in WWC, JVA created a framework to better understand the data and the implication of the data variance, which is explained below. However, reasons for this disparity in data could be due to the following:

- Size of WWC provider locations varied greatly across the state (from hospitals to small clinics to community-specific nonprofits).
- Staffing at WWC provider locations varied across the state (varying numbers of people coordinating the program and people providing services within the program).
- Roles, responsibilities, and expectations of providers and coordinators varied across the state (providers and coordinators viewed their roles differently depending on the city, context and capacity given/responsibility expected). The coordinators and providers interviewed also managed WWC in distinct ways. Not all position titles implied the same roles or responsibilities, thus some interviewees knew much less about how to reach eligible women in their community than others.
- A variety of levels of community connections were present in those interviewed. Related to the diversity of roles issue above, sites that use WWC services are made up of very different entities across the state, ranging from hospitals to multi-site clinics to small rural clinics. Thus, not all WWC interviewees are connected to their community on the same level. Similarly, WWC professionals differed greatly in the

amount of time they spend with WWC patients, with some seeing WWC-eligible women up to four hours a day and others seeing them just a few times per month.

Interview Framework

JVA created an interview framework (see Chart B) to better understand the data variance that resulted from the interviews. The framework separates data into four categories: low/moderate usage (of marketing tools for WWC) with high awareness (of marketing tools for WWC); low/moderate usage with low awareness; high usage with low awareness; and high usage with high awareness. The categories help categorize the interview data into more tangible and useful groupings. This structure also allows the data to be useful for future marketing endeavors despite the lack of trends that developed from evaluating the effective marketing tools and outlets for WWC professionals. Each category in the following framework highlights a representative quote from the interview data and an outcome of how data in that category should be observed.

Chart B: Interview Framework

Low/moderate usage, high awareness *"The clinics just don't have the info to give out—I have 6,000 patients a year and we don't have anyone extra to call these patients* [to tell them] *that are due this year to come back and get screened."* Outcome: Focus on external factors; possible frustration	**High usage, high awareness** *"The brochures and info cards...what I have done is print labels and put them on the front, and I've placed the info cards in the eligibility office and I put them in a basket...patients seem to be very responsive to that."* Outcome: Actionable and reliable feedback
Low/moderate usage, low awareness *"I think it's their effort to want to understand, as they would rather just delay sometimes and not take care of their health. I think it's a lack of time, it does happen with a lot of patients they just will say they don't have the time."* Outcome: Marketing results (or lack thereof) attributed to client	**High usage, low awareness** *"Communicate with the staff, not the patients—sometimes with the nurses, I haven't seen any materials there—not sure, maybe not popular."* Outcome: Focus on internal factors; lack of connection to marketing that is available

Low/moderate usage, low awareness. This category, located in the bottom left quadrant of the framework, highlights the WWC professionals who rarely use WWC marketing tools and also have little understanding of a) what tools are available and b) what benefit marketing tools can add to their programming success. The quote in the chart above was selected because it

represents the view that lack of enrollment of new women into WWC is not connected to the provider's efforts for marketing or marketing needs in any regard. Another example, below, comes from a coordinator who understands the benefit of WWC to women in her community but has not connected the idea of marketing to this concept:

"This program…can save your life. If [a woman] goes in for a mammogram and it is abnormal, she does not have to worry about the cost of a biopsy—free is really good around here. Times are tough, so it helps tremendously—so many women haven't had [the tests], as they say they can't afford it…why haven't [they] gone?"

The outcome in this category, where marketing results (or lack thereof) are attributed to client(s), illustrates the belief that enrollment is affected by outside factors and marketing does not play a role. The tendency to "blame" the client for a lack of desire to be screened, rather than for lack of awareness of the program, could come from previous negative experiences or previous research. A few interviewees that fell into this category mentioned a personal lack of awareness of WWC marketing tools, but didn't mention any efforts to learn about the tools.

- **Solution**. To approach the WWC professionals in this category, education on which tools are available, how they are used, and why they are useful, is essential. A clear and easy process for using marketing tools in any WWC role can assist in future marketing strategies.

Low/moderate usage, high awareness. This category highlights the WWC professionals who do not use, or rarely use, WWC marketing tools, but have an understanding of a) what tools are available and b) what benefit marketing tools can add to their programming success. The quote in the chart above attributes a lack of marketing awareness to a lack of time to contribute to it.

The outcome in the chart states that those who fall into this category often attribute external factors (not enough staff members, too little time, etc.) for their lack of WWC marketing tool usage and often hint at a sense of frustration that marketing tools are not effective or not used. Providers in some locations said that they did not have the time needed to explain marketing materials or brochures to patients. Some locations with this high awareness requested more materials, or easier access to materials.

- **Solution.** This category should be addressed with a targeted selection of tools that could be easily adapted to local needs or cultural preferences. While providers in this category may not be using the marketing tools consistently now, there is a strong interest in increasing access to deliberate and effective methods that fit into their busy routines.

High usage, low awareness. This category, in the bottom right quadrant, highlights the WWC professionals who use WWC marketing tools, but have little understanding on a) what tools are available and b) what benefit marketing tools can add to their programming success. The quote in the chart above highlights a provider who places part of the burden of marketing on other internal staff because she/he does not know much about the marketing tools.

The outcome in this category demonstrates that these WWC professionals focus on internal factors often because of their lack of comfort or awareness with the available tools. For example, providers in this category often defend this lack of awareness about tools by saying that staff members are not using them or that patients do not think they are beneficial.

- **Solution.** This category should be addressed with clear marketing tools and outlets that are recommended, along with providing staff members with recommended ways to use or display the tools, and the purpose of those different approaches. Because tools may only be used at outreach events such as health fairs, providers should be given information about how these tools could be expanded to daily use.

High usage, high awareness. This category highlights the WWC professionals who use WWC marketing tools and understand a) what tools are available and b) what benefit marketing tools can add to their programming success. The quote in the chart above represents an individual who knows which tools are being used in the clinic, which are being reviewed the most, and which ones seem to be popular. This interviewee had even adapted the tools slightly with a printed label.

The outcome in this category emphasizes that the feedback received from WWC professionals in this category is actionable and reliable. This is the sector from which marketing approaches should be developed. While the other three sectors in the framework are necessary to understand how marketing distribution might differ across WWC providers in Colorado, this category highlights the effective and preferred tools and outlets for WWC.

- **Solution.** While the data from WWC professionals in this category are not representative of the entire group, some successful items/qualities are listed below. Photos of the WWC marketing tools that are referenced can be found in Appendix A.

Effective marketing tools for WWC professionals ("high usage/high awareness"):

- *WWC Pocket Pals* (see Appendix A, item#4). A number of individuals stated that their patients consistently pick up the Pocket Pals: "it's small, user friendly, they will use it [and] they want to use it all the time."

- *Smaller items are better.* Unless the marketing is on a wall-sized poster, multiple individuals believe that "big [marketing tools] very seldom get picked up–no one will take the time to read them unless they have particular interest."

- *Tools need to state why women should get screened*. Several individuals noted the need for marketing tools to address fears that women might have about screenings. One suggestion for messaging was: "take care of you, so you can take care of the family."

- *Tools should be easily adaptable to local needs.* A few rural locations are printing their local address and phone number on WWC marketing tools or retyping the eligibility requirements on different paper.

Preferred outlets for WWC marketing materials ("high usage/high awareness"):

- *Waiting rooms.* Most tools are distributed in the waiting room for patients to pick up or take home. Materials are also often given directly to patients during visits.

- *Health fairs.* Large events are typically mentioned as a main outlet for WWC marketing.

- *Face-to-face interactions and word-of-mouth*. This is often done through good customer service, prompt return calls, and personal follow-ups or follow-up reminders: ***"****We follow up regularly and in a year when they need to be re-screened. Once you have gained that trust, they are willing to call from a reminder letter—they know they are getting the help that they need."*

- *Media influence.* Local media has helped to create awareness and enroll new patients (when radio or television campaigns had been used previously).

- *Collaboration with other family providers.* Many WWC professionals are making use of possible partners to refer women to WWC: *"[we should be] trying to work with the local CICP [representative], instead of using CICP [for screenings], women should use my services—let her keep as much in her pocket as she can."*

Other Important Findings:

In addition to the framework above, the interview data provided interesting information that did not directly fall into effective and/or preferred marketing tools or outlets, but is relevant to the topic. The following topics are generalized from the interviews, as they often spanned several of the categories created in the framework above.

Barriers to reaching women. The first interesting result, outside of framework findings above, is that WWC professionals often agree on which barriers are difficult to overcome when trying to enroll women in the program. This result came from interviewees who had some experience in outreach, whether for WWC in particular or for other health programs in their community. Not all interviewees were able to speak to this topic. Primary barriers stated were:

- **Education is needed with marketing**. Within some communities, there is a belief that women do not enroll in WWC because of lack of understanding of how it works, why it is important, and what it offers. Related to this, other barriers to educating women about WWC are communication barriers such as literacy levels, language and breaking down the complexity of the program.

- **Fear.** Fear of the unknown, or perhaps fear due to lack of background knowledge on what the screenings are like or what their purpose is (related to education), can impede outreach. Other reasons mentioned for fear might be from age or from immigration status.

- **Financial burdens**. For various reasons, many interviewees believe that financial burdens can lead to a de-emphasis on health care and prevent women from seeking help. Transportation can also be an issue, in both rural and urban communities.

- **Rural needs**. Specific to one rural interviewee, but highlighted later in the focus group material as well, was the idea that marketing to neighboring counties might be beneficial. One rural coordinator has observed that women from a neighboring county *"want [to enroll] in [WWC] here, but I don't think grant will cover this, because it's 35 miles [away]. We don't have good marketing and can't reach people we need to reach."* This interest from a neighboring county could possibly be due to a theme that was discovered in a rural focus group, which is that some women leave town for their health care for greater privacy.

Trust is essential to outreach. WWC professionals, especially those who have been involved in community outreach, know that trust is necessary for women to register and follow up about WWC services. Regardless of the marketing materials used or the outlets through which they are distributed, trust is key for WWC-eligible women to follow up. One coordinator stated that in the process of WWC *"you develop that trust—you gained a friend…on my side, that is a good feeling—to help them—that is important."*

Some WWC professionals, including one rural coordinator who stated that *"our biggest problem right now is tapping into the Latino population, language barriers-illiteracy issue—you need the inroads…need familiarity with someone in the community, [which is] what we are lacking right now,"* also link the aforementioned barriers directly to lack of trust, and the need for non-marketing inroads into their communities.

Collaboration is necessary to outreach. Another common finding from the interviews is that collaboration is either already happening through WWC provider sites, or is something that WWC professionals wish to do more of. Examples of collaboration include working with CICP staff, hospital staff, eCaST data reports, ACS coordinators, or other family healthcare providers to refer women to WWC. Collaboration is useful to recruit WWC-eligible women because for some it is the only way they can reach women who do not know about the program, and who they would not see otherwise.

"If there were more marketing towards WWC, we could do more collaboration with nearby hospitals because we do have women who are in very remote areas. Maybe their doctor doesn't know about the program...and in terms of marketing I think if we did a better job of getting things out…in more remote communities, that would be helpful because there is a significant population that is not being screened because their provider doesn't know [about WWC] and they are struggling to find out ways to get screened." –Rural interview participant

WWC Focus Groups

Women in the community focus groups engaged in an enjoyable, yet straightforward, discussion about marketing tools and outlets, which led to a mixture of expected and unexpected findings that are highlighted below. The focus groups began by dividing participants into two small groups tasked with creating a pile of the "most effective"/"best" marketing tools (a sample of marketing tools was presented to each group). After categorizing the tools, the discussion turned to identifying what makes these tools effective (as well as why others might be "ineffective") then to discussion on the trustworthy places they might encounter these tools, and finally into other issues of trust and motivation when it comes to marketing for health programs. The focus group script can be found in Appendix B for further details.

Marketing Tools

The focus group participants generally seemed to enjoy interacting with, talking about and evaluating the marketing tools that were presented to them. In each group, there was a clear differentiation between the effective tools and the ineffective tools, but there was some variance between groups on which tools they felt were effective. The qualities that emerged to describe the most effective marketing tools are listed below.

What qualities make for a good tool? The following ideas summarize the ways that focus group participants most frequently described the effective marketing tools.

- **Useful.** Focus group participants were quick to pick up tools that are useful, such as the WWC chapstick, WWC nail file/emery board, or the WWC notepad (see Appendix A, items #5, #6, #7). However, while the utility of an object did lead women to immediately pick up a tool and look at it, it did not mean that they retained the information displayed on the object. For example, many women stated that they often forget whom the object was from or what it was advertising once they put it in their purse.

- **Eye catching**. Participants came to consensus that bright colors and fewer words were key traits of an eye-catching tool. The ¼-page hot pink WWC flyer often caught participants' attention, primarily due to the bright color (see Appendix A, item #1). This particular marketing tool also illustrates how less is more when it comes to text, as it allows the purpose of the tool to be easily understood. Lastly, words that stand out, such as "free," according to one woman, *"will always get you to stop and read it."* More information on the varying interpretations of the word "free" can be found in the "other important findings" section below.

- **Small/portable**. The idea of a tool being "purse-size" was important for two reasons: it was easily transportable and it was discreet enough to take home and read or follow up with later. To one focus group participant, *"if you really want people to start asking about their health, it needs to be stuff they can take home and read over."* Magnets or pens were also brought up as marketing tools that work in this regard.

- **Informative but direct.** Clear information and direct messages are desired to understand marketing tools *"in a glance."* The ¼-page hot pink WWC flyer is also illustrative of this type of messaging (see Appendix A, item #1). Another example is the eligibility packet from WWC, which contains the eligibility requirements and a business card tied together with a ribbon (see Appendix A, item #3). In this regard, many participants in the focus groups liked the eligibility packet because it listed the requirements for program eligibility clearly and without ambiguity.

- **Conversation starters.** Focus group participants, as stated earlier, are not just picking tools up for themselves, but often for others in their lives. They liked the idea that buttons, ribbon pins or rubber bracelets could be conversation starters, because if "*somebody is going to ask me where I got that,"* then it's a good thing. For an example of buttons and ribbon pins, see Appendix A, items #2 and #3.

What qualities lead to an ineffective tool? The following ideas summarize the ways that focus group participants most commonly described ineffective marketing tools, or the tools that did not catch their attention in the first activity.

- **Confusing messages or ideas**. When messages are hard to interpret, or when the marketing tool is too busy to understand what the message is about, women in the focus groups did not want to take the time to understand it. They would often leave these marketing tools to the side.

- **Paper that gets thrown away**. Regular thin paper is often forgotten about or thrown away. Even the popular ¼-page hot pink WWC flyer was noted as paper that is easy to discard (see Appendix A, item #1).

- **Too personal in public areas**. Some women were less likely to pick up a marketing tool, even if the intention was entirely to educate, if it was too obviously personal. In the focus groups, this discussion came up in the context of the types of marketing tools participants might see at a health fair or event. In this case, if the topic was too personal (in most cases, "too personal" implied something that was too complex, sensitive, or not well-known, such as "polyps"). A solution to this, according to one focus group, is *"[some women] don't like to ask questions…they are too embarrassed, so if they can take it* [a marketing tool], *put it in their purse, then ask questions later if they want to,"* it is helpful.

- **Things that "don't speak to me."** Women in the focus groups continually mentioned wanting marketing tools that catch their attention because of their own concerns. If breast cancer is already a concern, the marketing tool that addresses it directly will catch their eye. If it is directed toward African Americans, and the community member happens to be African American, it may be more likely to appeal to her interest.

Marketing Outlets

In the focus groups, the idea of marketing outlets was approached as part of a transition from discussing effective marketing tools to discussing trustworthy places women would actually see these tools or respond to them.

Most trusted outlets. In this part of the discussion, there were many overlaps of places and people that women trust the most as their "marketing outlets."

- **Word-of-mouth**. Participants in the focus groups never failed to bring up their use of, and their trust of, word-of-mouth. Without even recognizing the method as an outlet, word-of-mouth came up multiple times throughout the discussions. One focus group participant stated: *"I might take something home with me for a neighbor or pick something up if I know [a friend] who doesn't have [health] insurance."* Trusted people in the community, who may be family, friends, or part of local/personal cultural networks, are often the go-to sources for health programs and events.

- **Bulletin boards**. Bulletin boards that are in trusted locations were consistently brought up as marketing outlets in the focus groups. However, these should ideally be boards where women know they can trust the material (i.e., someone who works at the location reviews the flyers before they are posted). Locations mentioned included schools, churches and libraries.

- **Community centers**. Cultural hubs, local hubs, or resource hubs are examples of places that community members go for information and are places at which they trust the information they are given. The locations brought up often were places at which the woman already had a personal connection, for example, a nonprofit might come up only if that participant had used the organization for something else and grown to trust it. In some cases, the workplace was brought up, but this was not a consistent response.

- **Advertisements (TV, online, radio, local newspaper).** Advertisements were seen as good marketing outlets by women in the focus groups, however, the extent of the trust placed in these sources often varied by community. Examples of advertisements that women trusted were ones where women could connect a personal "face" with the message, as this increased trust. The "face" was often referred to as a local celebrity, the TV show "The Doctors," Dr. Oz, etc. Social media was rarely mentioned in the focus groups.

***Media survey results*.** At the start of each focus group, a short survey was conducted to determine which media sources women used the most. Results of the survey are described below and interpreted in Table 5–8 (page 23 and page 24).

- **Television**. The most popular television stations mentioned were on basic cable. The Spanish-language stations mentioned are combined for Table 5, but represent Univision, Telemundo and Azteca America. Most women in the focus groups watch TV on cable as well (see Table 6). When asked if they usually listened to the commercials on the TV or the radio, the majority responded with "sometimes" (see Table 7).

Table 5

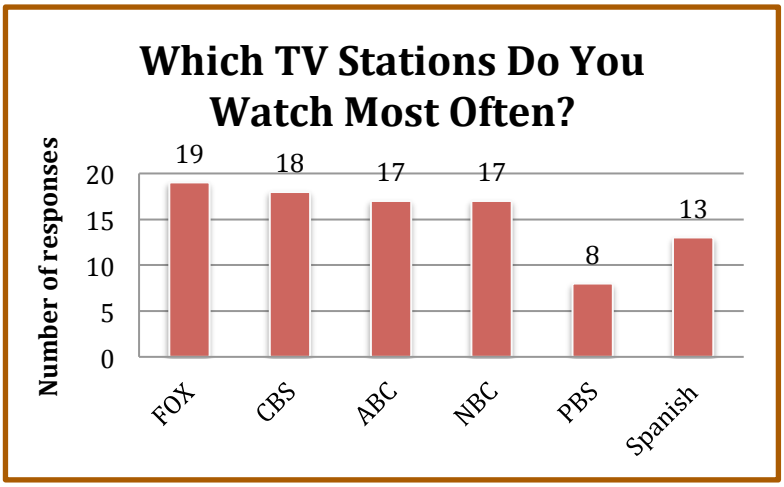


Table 6

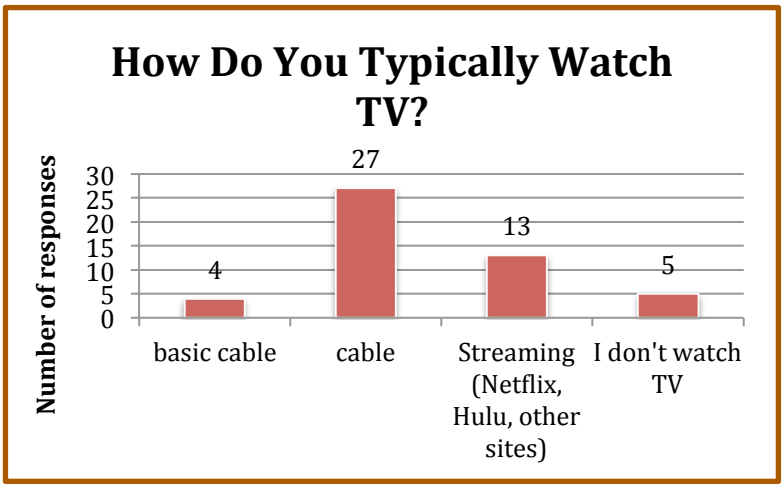
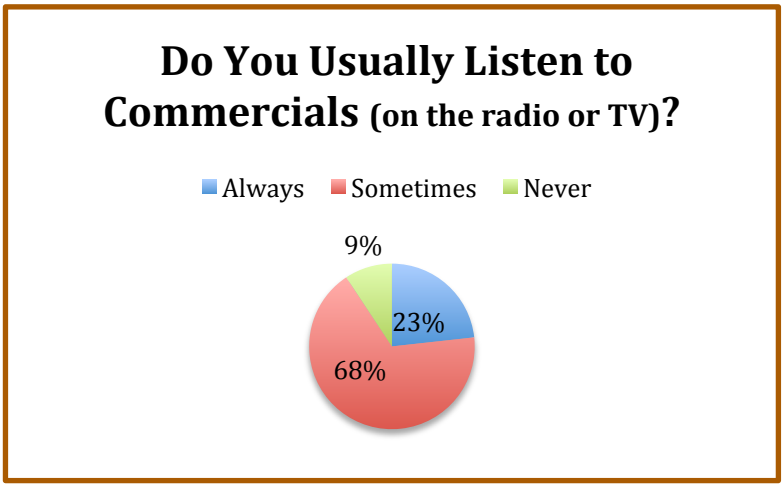


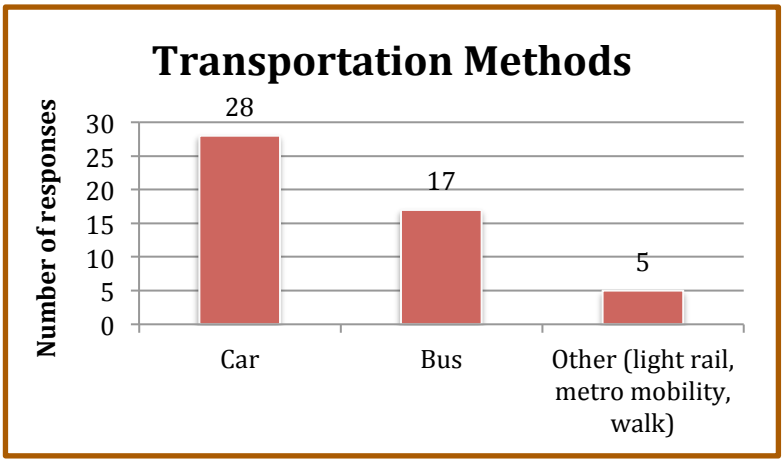
Table 7



- **Radio.** The survey question regarding radio stations allowed respondents to fill in the blanks for the stations they listen to the most often. Answers varied greatly and are listed below according to city. The number in parenthesis is the number of respondents for that answer in that city.
  - *Denver:* Mix 100.3 (7), Alice 105.9 (4), KBPI 106.7 (2), KLove 91.1, KS 107.5, KYGO 98.5, KTLC 93.3, KDLC 1220AM

- *Colorado Springs*: KRCC 91.5 (5), KRDO 105.5 (4), Magic 98.9 (4), Fox 103.5 (3), 96.1(2), KYGO 98.5(2), 96.9 (2), 102.7, "Internet radio," "Talk Radio," KLite 106.3, Rxp 103.9, 92.9, KTLF 90.5

Table 8



- *Fort Collins*: KLove 88.3 (2), KJJD 1170am (2), TRI 102.5 (2), KLove91.1, The Party 95.7, Kiss FM 96.1, KRKS 94.7, KS107.5, The Point 99.9, The Eagle 107.3

- *Fort Morgan*: KPRB 106.3 (4), TRI 102.5, 98.5 KYGO, The Party 95.7, Kiss FM 96.1, "Slacker radio online", "Pandora online", KJHM 101.5, KHOW 630AM, "Tex Mex"

- **Transportation.** Most women in the focus groups use a car for transportation, which could include driving alone or getting rides from others (see Table 8).

Other Important Findings

In addition to the findings above, the focus group data illustrated interesting results that did not directly fall into effective marketing tools or outlets, but are relevant to the topic. As noted earlier, the common thread in all of these results is the need to understand local communities.

Barriers to women hearing about health programs. Women in the focus groups commonly remarked on reasons why marketing might not always be successful. Often this conversation focused on reasons why they would not respond to a marketing tool or follow-up to an advertisement.

- **Geography.** For rural locations in particular, geography can be a large barrier to getting women screened. In Fort Morgan, discussion arose about how people are contacted when they live in remote areas. One topic discussed was how the local school reaches out to families who live outside of town, based on a survey the students take at the start of the school year. One woman said that when she used to live in Brush, which is outside of Fort Morgan, there were hand-delivered bags filled with community information and local resources that were brought to each home in the area.

- **Money and insurance.** The cost of care can prevent many women from seeking out potential preventive screenings. The word "free" can draw attention, but there is often skepticism about whether free is really free, or if hidden costs will come up later.

- **Avoidance of doctors.** Some women stated that they avoid going to the doctor (for cost reasons) and will ask the opinion of everyone in their network about health concerns prior to making an appointment for care (the doctor is often a last resort or for emergencies).

- **Bilingual but not offering care to undocumented individuals (mistrust).** In the Spanish-speaking focus group, women expressed strong and personal distrust of a flyer that was written in Spanish but whose program required a person to be documented. Even though the women in the group themselves were documented, they felt so tied to this issue that they expressed a strong distrust for the organization, saying that they wished the services could be provided to everyone. While the sample marketing tools in the focus group did not cite the need for "legal residence," the focus group participants knew that legal residence was a requirement to participate in the focus group, and the topic naturally arose.

- **Fear (immigration, cultural/historical)**. For some communities, a fear of government may impact their view on certain programs. Fear of U.S. immigration law was strong, even for Spanish-speaking participants who are documented residents or citizens themselves. The fear was a community fear, and appeared to influence trust of government programs for all women within the group. For a group with Native American women, there was also a hesitance and mistrust associated with government. Some women in this focus group spoke about the difficult history of their community and their resulting fear of providing their personal information to a government program.

- **Communities/Individuals not connected to local hub or maven.** Groups within communities that are hard to reach can feel doubly isolated. For example, in Fort Morgan, the immigrant populations did not appear to be connected to the same networks as the rest of the women in this focus group. Unless those immigrant groups are connected to the local hubs, they might be missing out on resources.

What motivates women to respond to marketing? Later on in the discussions, participants were asked to speak about factors in their lives that have led them to respond to health program marketing or follow-up to advertisements. Some of these factors were personal while some were marketing-related.

- **Encouragement from community and family.** One of the most common factors that motivated women in the focus groups to purse health care was the encouragement of community, family and friends. Some of this encouragement came because of family history: *"My mother was just diagnosed with breast cancer…so now everyone's on me to get on it."* For others, the family history of a friend is enough to spread encouragement: "*My friend's mom passed away from breast cancer, so I just keep checking on her to see if she got her exam yet."*

The importance of personal networks was visible in the focus groups when women expressed how they would often pick up marketing tools for other women in their life. This habit was common for women in all focus groups: *"If I know the symptoms and I hear someone complaining about symptoms or pain, I would remember and recommend that they check it out."* This finding represents a notable shift from the traditional view of marketing that assumes the person being exposed to messaging is the one who should be influenced to act. Designing collateral that encourages messages/materials to be passed along to others allows for message trust to be developed, and for deeper community exposure.

- **Life changes**. Women in four focus groups mentioned that life changes have motivated them, or are currently motivating them, to get their health checked out. For example, individuals in two groups mentioned that other diseases or issues have "forced" them to be seen by a doctor, such as diabetes, needing a mastectomy, or detecting breast cancer. For two groups, the issue of age as a motivating factor arose, with one woman in Colorado Springs stating that: *"I felt invincible when I was young, but not anymore."* While some stated that fear increases with age, those who were healthy expressed gratitude and others a realization that early detection is the key: ***"****the sooner you find out the better chances to defeat it. We need to educate on this."*

  Another life change that participants in two groups spoke to was the idea that one's children can have an impact on health in both positive and negative ways. For example, a mother may not take care of herself because she is busy with children, or, alternatively, children could push a woman to take better care of herself. One woman, who also happened to be a nurse, stated, "*at the worst, I'm a nurse and I don't take care of myself. I take care of other people first."* Related to her family history, one focus group participant stated she was a bit fatalistic in her younger years, thinking she may not live to see her children grow up, but changed her mind later, as she said: "*I started thinking I have to take care of myself for the [two sons I have left at home]. That's when I started going to the doctor."*

- **Local or 1-800 contact number.** In the second focus group, the participants naturally (without prompting) mentioned the desire to see a 1-800 number on a flyers or marketing tools for a health program. JVA then asked the remaining focus groups about this topic to determine if the desire for a 1-800 number was consistent among participants. Interestingly, participants' desire for such a number was divided, as described below.

  For two groups (Colorado Springs and Fort Collins) that were asked this question, there was agreement that 1-800 numbers implied that the call would be answered and they trusted that they would be directed to a local representative. For the group in Fort Morgan, there was agreement that a 1-800 number would be best, as they did not want a local person from town to answer questions on personal health issues. One woman

said, "*from a rural county perspective, [you would call a 1-800 number and] say 'oh it's somebody from out of town, they will be a total stranger'…that's a good thing."*

However, participants in three groups (Denver, Colorado Springs, Fort Collins) preferred the idea of calling a local number because with a 1-800 number, there might not be a local assistance area available, you might get the "run-around," and personal "TLC" is missing (or someone overseas or an automated call system might answer). The last group in Colorado Springs decided that the best answer is to have both options (a local number and a 1-800 number) available.

- **Financial clarity**. There is prevalent mistrust of programs or opportunities that present themselves as "free," despite the agreement between groups that "free" is eye-catching. The mistrust in the term "free" comes from the knowledge of hidden costs and offers that are too good to be true. In addition to hidden costs, there are additional suspicions that were mentioned such as: the assumption that registration will require a lot of personal information, personal information will have to be shared online (reactions from a Denver group), that insurance might be necessary (or that one has to be completely uninsured), that it might be free to start (screenings for example), but next steps might not be affordable. "Free" seems to carry different definitions to different people, ranging from attractive to questions on sliding scales, flat fees that are ignored, insurance needs, etc. Overall, there was strong agreement between groups on the need to be specific about what is free, for whom it is free, and how it is free. Suggestions (from the focus groups) for how to handle the ambiguity of the word "free" are: "no cost" or "no health insurance needed".

  Other questions about financial clarity arose in the discussion group, focusing on *who* is it free for, and *how* is it free. First, the fact that something is marketed as *affordable* does not mean it is affordable to *everyone*. Second, the question of legal residence arose in the Fort Collins group, which began to inquire about legal residence status affecting free services. Third, the Native American focus group in Denver stated that recently, when a health program advertised at a community event, there were so many qualifiers to participate in the program that no one could actually participate: "*One of the groups came to do free mammograms, but when we called, there were a lot of qualifiers. There were too many restrictions– it wasn't for us."*

- **Understanding of cultural associations/ "free" government programs.** Interestingly, three focus groups mentioned some sort of hesitance or questioning around affordable or free government programs. One argument, which demonstrated the mistrust in these types of programs, is that there "*is usually a cap…not all qualify."* Another argument, specific to the military base community in Colorado Springs, brought up mistrust related to military health care despite it being free. Lastly, cultural hesitations were expressed in the Native American community, with a participant stating, *"As a Native, I would worry*

about the government wanting my person[al] information. I don't want the whole world to know if I had cancer, just family and friends."

However, two focus groups placed greater trust in programs offered by the government. In the focus groups in Colorado Springs and Denver, some women, due to former use of government assistance programs, felt that an offer from a government-sponsored program provided more assurance and fostered stronger trust than others. In these examples, the women saw the government as a source of legitimacy and understood why the program might actually be free of cost.

- **Understanding of cultural associations/negative associations with government.** While not mentioned in every group, four unique focus groups discussed a certain level of distrust associated with government programs, due to certain opinions held by participants within these groups. The first example of a negative association was in the legal sense. To a Denver group, the law could "scare people," and to the other Denver group, the negative images associated with "the law" were colored by Native American cultural perceptions related to race, power and history. To the group in Fort Collins, the association of the government with immigration laws was strong, even when legal residence was not a personal issue to the participant. For example, one focus group participant stated: "*when I still just had a Visa, I wanted to ask if someone could accompany me to [a government office], since I don't speak English. Out of everyone, I could only find one translator, but since he was undocumented, he would not even come with me."* The mistrust of the government affected the majority of women in this group, even though they themselves had nothing to fear directly. This fear seemed to be present at the greater community level. The one outlier in this group was a 35-year-old who grew up in the area and stated that she disagreed with the fear around the issue of immigration, possibly because it *"depends on if you grow up here or not."*

  Additionally, comments such as "clinical," "cold" and "official" were used to describe government logos, CDPHE's logo in particular, by many of the focus group participants. The idea of a person becoming a "number" or a "statistic" brought comfort to one participant in a particular group (as it implied anonymity) but another said that this feeling takes away from individualization of needs, and essentially eliminates the "TLC" she desired.

  However, the mistrust experienced by many was in opposition to the sense of trust expressed by women in three focus groups. The women who trusted government programs stated that, by associating a health program with the government, the integrity does not have to be questioned, as the government has *"our best interests at heart."* Two groups had individuals that saw the focus groups themselves as a sign that the government does positive things, which in one case helped *"improve [my] opinion of government."* The other individual, after initially speaking about a more general mistrust of government programs, added that CDPHE conducting focus groups in the community

shows "*the good they do*" and realizing that "*many people don't realize all of the services the health department has, other than just a [STD] test…people just don't think of them.*"

- **Incentives.** Focus groups participants were not directly questioned about what type of incentives could encourage them to attend an event or respond to a flyer, but the topic came up naturally in four different focus groups, and three groups focused on one idea: fun. The topic of fun centered on community events for women's health screenings (such as a "mammogram night"). Previous events in different communities were brought up as something women hoped to go to again, or something that seemed to be a good idea. One rural group described a former community event for mammograms, which was held in the evening after work, with fun games and food. The participants who had been to this event remember hearing about it on the radio and in the newspaper, and described it as lighthearted and supportive. Both Denver groups, despite being in urban settings, had similar experiences with fun events and expressed the desire for more such occasions that might even be family friendly, offer "swag bags," help out with transportation, and be a sort of "community party." Three groups said that cash incentives would be helpful for these events as well.

- **Cancer is not taboo**. When focus group participants were asked if the sentiment they felt toward the ideal marketing tools changed if the tool was regarding a cancer program or cancer-screening program, the vast majority said nothing would change. The facilitator in the focus groups brought up the topic, but for most participants, there was little understanding on where any hesitance toward talking about cancer would come from. This does not mean that everyone thought cancer was suddenly not scary, or that they were comfortable with "everyone knowing" if they were diagnosed with cancer, but that cancer was discussed as a reality. One participant stated that cancer is "*no longer a death sentence*" because, as another woman stated*, "more and more people are being diagnosed [or] connected to someone who has been, so that's prompting more people to get checked."*

Conclusion

Recommendations

Based on the research outlined above, JVA recommends that specific marketing tools and outlets be used as a mode to reach women with information about the WWC program, while understanding that issues of trust, community and culture are interwoven together to influence whether that outlet or tool will be received well or not.

Outreach to Eligible Women

To reach more eligible women about the WWC program, WWC should ensure that the marketing tools have the following qualities:

- Informative, direct, eye-catching
- Messages that can be understood "in a glance"
- Easy-to-find contact information for follow up at home
- Eligibility criteria clearly stated
- Messages that encourage word-of-mouth; encourage women to encourage each other

WWC should also ensure that the marketing outlets used are considered within each city or community, in order to ensure that the truly hard-to-reach women have a greater chance of interacting with the marketing. Community-level context and cultural differences based on different experiences within sub communities is important to acknowledge when creating marketing to reach a wide range of women. This can be done through two methods:

- Attention to trustworthy outlets in each community (local hubs)
- Embracing word-of-mouth outlets and encouraging women to encourage each other to get screened, to pursue preventive care, or to follow up about a free health program such as WWC.

In addition, JVA recommends that WWC make use of community mavens where possible, especially in the harder-to reach-communities in Colorado. Through the use of already-established community connections, community coordinators and hospital staff, collaboration can be a strong method for finding community leaders that should be encouraged and will help to spread WWC's benefits by word-of-mouth and targeted marketing tools.

Ensure WWC Professionals Have an Impact

In addition to the creation of targeted and community-focused marketing tools and outlets for WWC, it is important to understand how WWC professionals play a role. WWC professionals can, despite their range in experiences and involvement in outreach so far, have an effect on ensuring more women access WWC services. As mentioned above, collaboration is one method for increased impact, as referrals to WWC can come from any health worker or hospital employee if marketing materials are given to them. While acknowledging the diversity of WWC professionals across the state, and the range of their capacities, two approaches can help them use their skills in outreach:

- Provide resources to ensure outreach can be tailored to local needs.
- Provide resources to ensure local women can act as trusted introductions to the program.

Final Thoughts

The goals of CDPHE and WWC were to identify the most effective and preferred marketing tools and marketing outlets for the WWC community. While the results from the WWC professionals (coordinators and providers) varied based on site-specific experiences, role definitions and geography, the interview framework (Chart B, page 15) should be understood prior to conducting any future marketing endeavors. The results from the focus groups made up of WWC-eligible women provided a list of the traits of effective marketing tools, and a list of places that women trust the most as marketing outlets. However, the undercurrent of both sets of data was the need to understand context and community differences. In addition to community context, another significant result from the data was the need for targeted word-of-mouth in order to address the harder-to-reach women about WWC services. This report has demonstrated that word-of-mouth is already happening within communities and that women are already using this method as the primary source for information and to determine trustworthy initiatives for follow through. This finding can be integral in moving forward with targeted and effective WWC marketing.

WWC recognizes that early cancer detection is key to saving lives of women across Colorado, which is why effective marketing for WWC is so imperative. The research outlined within this report shows that the women in the focus groups are already talking about these issues and are encouraging each other to start their screenings. Effective marketing has a sizable role to play in not just ensuring the right marketing tools end up with the women who need to know about WWC, but in order for the women who share materials with their networks to have an impetus to share them at all. This formative research coordinated by the Colorado Department of Public Health and Environment proves that the diversity and context of the communities being served must be understood in order to effectively market to the populations they encompass.

Appendix A. WWC Marketing Tools

1) ¼-page flyer (hot pink)

2) "Ask me" button

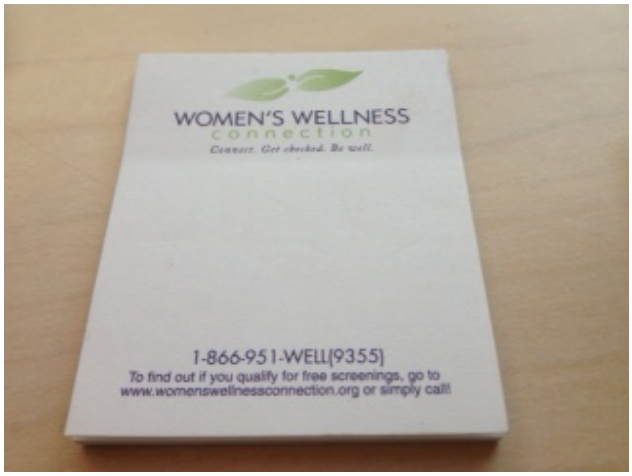
3) Eligibility packet (with ribbon pin and business card)

4) Pocket Pal

5) Chapstick

6) Emery board/Nail file

7) Notepad



Appendix B. Evaluation Tools

(Included as separate document)