ALTURA CENTERS FOR HEALTH

REPRODUCTIVE HEALTH NEEDS ASSESSMENT

With a Focus on Selected Areas of Tulare County

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Table of Contents

Introduction 2
Methods 5
Needs Assessment Results 7
Part I. Tulare County Overview 7
Community Profile 8
Demographic and Socioeconomic Indicators 8
Health-Related Indicators 12
Other Key Indicators: Youth Attitudes and Experience 21
Part II. Access to Reproductive Health Services 24
Resources 24
Utilization 27
Part III. Community Input 29
Community Survey 29
Community Focus Groups 39
Key Informant Interviews 42
Summary 48
Attachments 50
List of Key Informants 50
Family Planning Community Survey 52

INTRODUCTION

"Many girls here don't see a life for themselves beyond motherhood."
– Key Informant Interviewee

Family planning services have numerous benefits as it allows individuals to achieve desired birth spacing and family size, as well as personal education and career goals, and contributes to improved health outcomes for children, women and families.[1] Family planning is also important because it may be the entry point into the health care system; women of reproductive age often report that their family planning provider is also their usual source of care.[2] That is because family planning care typically involves much more than just contraceptive services—for instance, screening for cervical and breast cancers and sexually transmitted infections and referrals to a variety of health and social services that women might otherwise forgo.[3]

In California, federal Title X funds along with the state Medi-Cal and Family PACT (Planning, Access, Care and Treatment) programs are the main source of support for providing high quality, culturally sensitive family planning services for low-income, under-insured and uninsured individuals. In addition to offering family planning methods, Title X-funded service sites provide contraceptive education and counseling; breast and cervical cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) testing, referral, and prevention education; and pregnancy diagnosis and counseling.[4] A diverse network of public and private nonprofit health and community service agencies delivers Title X services such as the providers described later in this report.

Importantly, as part of the continuum of reproductive health services, California law requires state-funded sexual health education to be comprehensive, medically accurate, objective, and age and culturally appropriate. Title X funds provide a critical source of infrastructure not paid for under Medi-Cal and private insurance, such as staff salaries, patient education, and community education about family planning and sexual health issues.[5] These public funds help avert unintended pregnancies, reducing the need for abortion services.

Despite improved access to reproductive health services, increased use of contraception, and education and support programs, national data show nearly half (49%) of all pregnancies are unintended;[6] among teens aged 15 to 19 years, however, that figure rises to 75%.[7] Although adolescent birth rates in California dropped by 11% between 2015 and 2016 (and have fallen since 2000), Tulare County continues to face challenges to lowering the birth rate among teens. The county's adolescent pregnancy rate—discussed in the next section of this report—is one of the highest rates in California: 32.6 compared to 15.7 statewide.[8]

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[1] https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#one
[2] Frost J. U.S. women's use of sexual and reproductive health services: trends, sources of care and factors associated with use, 1995–2010. New York, NY: Guttmacher Institute; 2013.
[3] Frost J et al. "The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings." *Journal of Health Care for the Poor and Underserved* 19 (2008): 778–796.
[4] Fowler, C. I., Gable, J., Lasater, B., & Asman, K. (2020, September). Family Planning Annual Report: 2019 National Summary. Washington, DC: Office of Population Affairs, Office of the Assistant Secretary for Health, Department of Health and Human Services.
[5] By law, Title X funds are not the sole source of income for providers. Rather, Title X funding is leveraged throughout the health centers in its network.
[6] Finer LB, Zolna MR. "Unintended pregnancy in the United States: incidence and disparities, 2006." *Contraception* 2011;84:478–85.
[7] Centers for Disease Control and Prevention. Pregnancy Risk Assessment Monitoring System (PRAMS). September 2019.
[8] California Department of Public Health. Adolescent Sexual and Reproductive Health, Tulare County, 2016.
https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Data/Adolescent/County-Profile-Tulare_2016.pdf

Nationally, about two-thirds of women at risk for unintended pregnancy[*] are estimated to use contraceptives consistently and correctly throughout the course of any given year; these women account for only 5% of all unintended pregnancies. By contrast, the 18% of women at risk who use contraceptives inconsistently or incorrectly account for 41% of all unintended pregnancies.[9] In California in 2010—the last year for which the figures are available—the federal and state governments spent $1.8 billion on unintended pregnancies; of this, $1,062 million was paid by the federal government and $689.3 million was paid by the state.[10]

While family planning is cost-effective, affording economic benefits for both families and society due to personal and public cost savings associated with fewer unplanned children,[11] studies have shown that unintended pregnancy is associated with maternal depression, increased risk of physical violence during pregnancy, and children who experience poor mental and physical health during childhood, and have lower educational attainment and more behavioral issues in their teen years.[12] Adolescent pregnancy is a special concern because the negative consequences associated with unintended pregnancies are even greater for teen parents and their children.

In addition to differences by age group, reproductive health differences exist by education level and ethnic groups that have applicability for Title X services in Tulare County given its large proportion of Hispanic/Latina population and educational and other disparities. For example, between young adult Latina and non-Latina white women about 30% of Latinas will give birth by age 20, compared with 14% of non-Latina white women.[13] These disparities have far-reaching economic and societal consequences including the ability to advance education and career goals.

Purpose and Scope of this Report

This report focuses on the estimated need for Title X reproductive health services in selected communities in Tulare County—principally, the cities of Tulare and Woodville and surrounding rural communities that comprise the service areas of Altura Centers for Health (ALTURA). The purpose of the current study was to update our previous Title X needs assessment conducted for ALTURA in 2017. We examined relevant community health, demographic and socioeconomic indicators and other community characteristics, and engaged in a community input process to identify the highest unmet needs for family planning services. The assessment meets the Title X requirement for community needs assessments and can guide ALTURA and its partner organizations and other stakeholders in improving access to services.

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[*] We use "unintended" and "unplanned" interchangeably in this report.

[9] Sonfield A, Hasstedt K, Gold RB, Moving Forward: Family Planning in the Era of Health Reform, New York: Guttmacher Institute, 2014.

[10] Sonfield A, Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010*, New York: Guttmacher Institute, 2015.

[11] The Alan Guttmacher Institute. Fulfilling the promise: public policy and U.S. family planning clinics. New York: The Alan Guttmacher Institute, 2000.

[12] Research compilation cited at https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#seven

[13] Martinez G, Daniel K, Chandra A. (2012). Fertility of men and women aged 15-44 years in the United States: National Survey of Family Growth, 2006-2010. Hyattsville, MD: National Center for Health Statistics, in Caal S et al. Reproductive Health Care through the Eyes of Latina Women: Insights for Providers. *Child Trends.* August 2012.

Acknowledgements

We wish to thank ALTURA for inviting us to take another look at family planning needs, utilization and resources available to women and men in Tulare County, and for facilitating our access to staff, community partners and stakeholders. We are immensely grateful to the many individuals who took the time and interest to participate in interviews and small-group discussions, sharing their experiences and perspectives about family planning and making suggestions for expanding access and improving services. We are also very appreciative of the various organizations that hosted the online community survey and encouraged clients and community members to participate. Special recognition is also due to the Youth Department staff at Community Services Employment Training (CSET) for arranging for us to meet virtually with some of the agency's Youth Adult Groups and others who provided a candid and rich source of information regarding attitudes, experiences and opinions about family planning.

Barbara Aved Associates (BAA) provides strategic planning and program evaluation for health and human service organizations, including several in Tulare County, and conducted this needs assessment. Barbara Aved, PhD, MBA, served as principal investigator, and Mechele Small-Haggard, MBA, and Jared Funakoshi, BS, of BAA contributed to the data analyses. Dr. Aved was a former Chief of the Office of Family Planning in the California Department of Health Services.

METHODS

"Teen pregnancies? I've never heard anyone in my work world in Tulare County say preventing it should be a priority." – Key Informant Interviewee

DATA COLLECTION

Community needs assessments, including those specific to reproductive health, involve gathering, analyzing and *applying* both quantitative and qualitative data and other information for strategic purposes. These methods provide the necessary input to inform planners, providers and other decision makers about the challenges they face in improving health status as well as programs and services, and the priority areas where support is most needed.

SECONDARY DATA: PUBLICLY-AVAILABLE STATISTICS

Data to create a Community Profile were collected from all applicable existing public data sources and included demographic, economic and reproductive health status indicators, including service availability. Some recently available data collected for other sources, such as the Hospital Council of Northern and Central California *Central Valley Community Health Needs Assessment – 2019*[14] were reviewed for inclusion in this report when relevant.

Organization/Provider Data Retrieval and Interviews

Organizations and providers offering family planning services to Tulare County residents in the target communities were identified, and information about the type and availability of their services were gathered from websites and, in some cases where information was scant or unclear, interviews with agency representatives.

PRIMARY DATA: COMMUNITY INPUT

To gain a better understanding of how consumer perspectives and family planning programs and services could be improved, input from selected Tulare County communities was solicited through focus groups, key informant interviews and a Family Planning Community Survey. While some of the study population samples are relatively small, they are suitable for this qualitative community research.

Key Informant Interviews

Interviews using a semi-structured set of questions with additional, follow-on questions to obtain more in-depth information were conducted with 17 individuals who were available from a list assembled by ALTURA and the consultant and who agreed to participate in a telephone interview (see Attachment 1). The interviews provided an informed perspective from those who work directly with the public and/or determine some of the policies that affect reproductive health and family planning services in Tulare County. These individuals were able to offer information about local resources and gaps in services, high-priority needs and barriers, and offer suggestions for positive change. The Key Informant input was

[14] https://www.hospitalcouncil.org/sites/main/files/file-attachments/final_central_valley_chna_3.18.pdf?1553209460

recorded in writing by the consultant during the telephone call then transferred to conventional summary notes and reviewed, coded and summarized for analysis based on thematic topics.

Community Survey

We developed a survey for the general community in English and Spanish that solicited residents' opinions about most-important reproductive health needs and concerns, use of services, barriers to access, and suggestions for community health improvements (Attachment 2). Certain questions that serve as markers for access to services were also included. Because of the ongoing COVID-19 pandemic restrictions, the survey was formatted for SurveyMonkey and made available online only. ALTURA used its Facebook platform to distribute the survey to solicit community input, asked some of its community partners where groups of interest would best be reached (e.g., First 5 Tulare County Tulare City School District) to also post it on their Facebook to help raise awareness, distributed flyers in community food boxes, and purchased a Facebook/Instagram targeted ad.

Focus Groups

To ensure adequate representation of young people, four virtual "focus groups" were conducted with young adults (primarily ages 18-30) associated with Community Services Employment Training (CSET) programs. The sessions were held during regularly scheduled CSET Youth Group meetings in January and February via Google Meet video-communication and each lasted an hour. A common set of semi-structured questions was used for all of the sessions, with appropriate follow-on questions to capture fuller information and encourage discussion. For consistency, the principal study author facilitated the sessions. While the groups constituted a convenience sample, they were reflective of Tulare County gender and ethnicity, and represented a population of special interest for Title X.[15] The focus group input was handled similar to the input from the Key Informant interviews.

[15] Similar to our previous needs assessment, it was not possible in the current project to hold focus groups with high school-age students/ adolescent participants.

FINDINGS

"You can't do a superficial job of sex education; kids are just going to fill the [information] gaps on the streets." – Focus Group Participant

This section of the needs assessment is organized into three parts. Part I provides a profile of selected Tulare County community indicators relevant to Title X. Part II provides a summary of access and utilization of reproductive health services. And, Part III presents the results of the community input process.

Part I. Tulare County Overview

Centrally located in the Central Valley of California, Tulare County—the 18th most populated county in the state out of 58 counties—is composed of 8 incorporated cities and 71 unincorporated communities. In 2019, the county was home to an estimated population of 466,195, about 58% (or 270,393) of whom were ages 18-64. With a median age of 31.4 years, Tulare County residents are one of the youngest regional populations in California.[16] The map below indicates with circles the primary communities served by ALTURA Centers for Health.

Map 1. Tulare County with Main Cities/ALTURA Sites Encircled

16 https://censusreporter.org/profiles/05000US06107-tulare-county-ca/

Map 2. Tulare County, California

Despite its agricultural prominence, certain pockets of affluence and the benefits of living in close supportive communities, disparities exist for many Tulare County residents who struggle with economic and health-related challenges, many made worse by the ongoing COVID-19 pandemic. These include low educational attainment, living in poverty, limited access to affordable services, and poorer-than-average rates for a number of community indicators. For instance, according to the California Department of Public Health, Tulare ranks 49th highest in the state in the rate of births to 15-19 year-olds, a rate described more fully below.[17]

Community Profile

Demographic and Socioeconomic Indicators

Much of Tulare County's population is rural, where it can be difficult to receive health care, including family planning services. While overall city population changes vary from year to year, Tulare County city/county population estimates with annual percent change between January 1, 2019 and January 1, 2020 show a slight growth for the county overall (Table 1).

Population Characteristics

Table 1. Population Estimates of Tulare County Cities

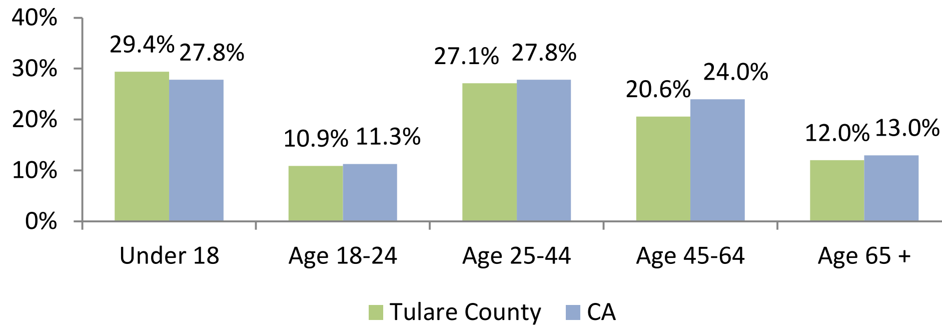
County/City	Total Population		Percent Change
	1/1/2019	1/1/2020	
Tulare County	461,589	466,339	1.0
Dinuba	25,689	25,994	1.2
Exeter	11,009	11,030	0.2
Farmersville	11,396	11,399	0.0
Lindsay	13,153	13,154	0.0
Porterville	59,490	59,655	0.3
Tulare	66,457	67,834	2.1
Visalia	137,696	138,649	0.7
Woodlake	7,691	7,773	1.1
Balance of County	144,007	144,489	0.3

Source: State of California, Department of Finance, *E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2019 and 2020.* Sacramento, California, May 2019.

[17] California Department of Public Health: 2015-2017 Birth Statistical Master Files. https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/ICS_TULARE2019.pdf

Tulare County's population is relatively young (Figure 1).[18] In 2018, the median age was 29.1, with 24 as the median age for native-born residents.[19]

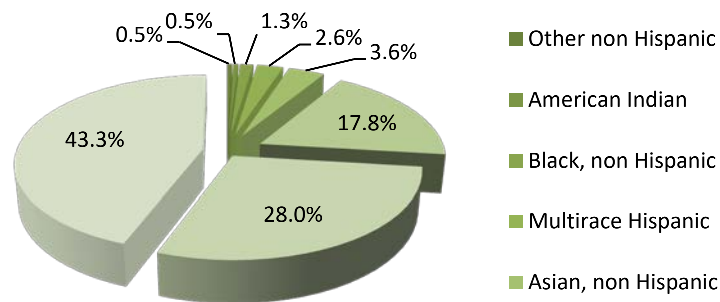
Figure 1. Population Projections by Age Group, 2019



State of California, Department of Finance

The majority (71.3%) of the population in Tulare County is white with 65.2% of the people Hispanic (of any origin). The chart below (Figure 2) displays the details of the eight main race/ethnic groups represented in Tulare County as a share of the total population.

Figure 2. Tulare County Race/Ethnic Origin, 2018



Source: U.S. Census Bureau. American Community Survey

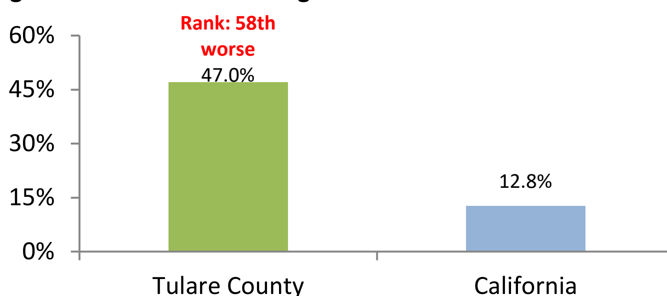
Data on language show over half (51.3%) of persons age 5 years and older in Tulare County in 2015-2019 reported speaking a language other than English at home (vs. 44.2% statewide).[20] This information is important to understand how well people in the community speak English to ensure that information about public health, laws, polices and services are communicated in languages that community members understand. As an example of how this might impact people in the long run, of Tulare City School District's total 2019-20 K-12 enrollment, 7.1% of the English-Learners were considered at-risk of becoming a "long-term English learner in the next 4-5 years" compared to 5.7% statewide.[21]

[18] Total Estimated and Projected Population for California Counties. http://www.dof.ca.gov/Forecasting/Demographics/Projections/
[19] U.S. Census Bureau. ACS 5-year estimates. https://datausa.io/profile/geo/tulare-ca/#demographics
[20] U. S. Census Bureau, American Community Survey, 5-Year Estimates. https://www.census.gov/quickfacts/CA
[21] California Department of Education. https://dq.cde.ca.gov/longtermel/EverElType.aspx?cds=54&agglevel=County&year=2019-20
Note: the percent values are calculated as a percent of the total-ever English Language learners.

Poverty

Poverty is a major cause of poor health and a barrier to accessing health care when needed. Some of the ways in which it contributes to ill health are immediately obvious: for instance, lack of healthy foods may lead to susceptibility to chronic disease. Indigence is also a predictive factor in teen pregnancy rates, which, in turn, increases the risk of poverty and poor health outcomes of the teen parent(s) and their offspring.[22] Poverty during pregnancy can also have adverse effects on child outcomes.[23] Poverty is a pressing issue for Tulare County: in 2013-14, 59.2% (vs. 41% statewide) of Tulare County mothers with a recent birth were living with families in poverty;[24] in 2015-17, nearly half (47%) of children ages 0-18 were living in areas of concentrated poverty, compared to the 12.8% state average (Figure 3).[25]

Figure 3. Children 0-18 Living in Areas of Concentrated Poverty, 2015-17



Source: U.S. Census Bureau, American Community Survey

Table 2 reports the estimated percentage of Tulare County households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant because it assesses vulnerable populations that are more likely to have multiple health access, health status, and social support needs.

Table 2. Percent of Households Receiving SNAP Benefits, 2018

Report Area	Total Population	Non-Hispanic White	Black	Asian	American Indian / Alaska Native	Other Race	Multiple Race	Hispanic or Latino
Tulare County	10.6%	19%	2%	1%	0%	0%	2%	75%
California	5.0%	28%	14%	6%	1%	6%	1%	45%

Source: California Department of Social Services, CalFresh Data Tables (Oct. 2018) as reported in kidsdata.org.

Unemployment

Beyond the obvious relationship to family income, the ability to have employment can have a significant impact on an individual's self-esteem and well-being. While nearly 90% of Tulare County's labor force was

[22] Tepp KP, et al. Innovative Approaches to Address Social Determinants of Health Among Adolescents and Young Adults. Health Equity Volume 2.1, 2018

[23] Halfon N, Hochstein M. Life course health development: An integrated framework for developing health, policy, and research, Milbank Quart, 2002, vol. 80 (pg. 433-79)

[24] California Department of Public Health, Maternal, Child and Adolescent Health (MCAH) Division, & University of California, San Francisco, Center on Social Disparities in Health, *Maternal and Infant Health Assessment (MIHA) Survey* (March 2018).

[25] U.S. Census Bureau, American Community Survey (Dec. 2018).

employed in January 2021,[26] the proportion ranged in the communities that primarily comprise ALTURA's service area, from 9.5% in Ducor to 32.5% in Terra Bella (Table 3 below).

Table 3. Percent of the Tulare County Population Unemployed, Selected Cities, January 2021 (in alphabetical order)

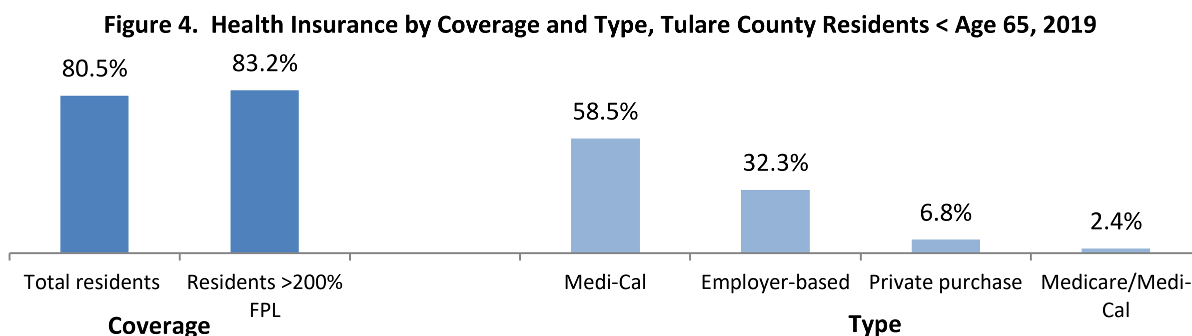
Area Name	Unemployment Rate
Tulare County	11.3%
Ducor CDP*	9.5%
Earlimart CDP	16.2%
East Porterville CDP	25.9%
Lindsay city	18.8%
Pixley CDP	21.3%
Porterville city	12.9%
Strathmore CDP	20.6%
Terra Bella CDP	32.5%
Tipton CDP	13.8%
Tulare city	9.3%
Woodville CDP	18.7%

Source: California Department of Labor.
*CDP is "Census Designated Place" - a recognized community.

Health Insurance

CHIS data[27] regarding health insurance coverage in Tulare County show 80.5% of all residents under age 65 have health insurance; the proportion increases to 83.2% for those living at 200% or less of the federal poverty level (Figure 4). The same data source reports the main reasons for not having coverage by those currently uninsured as not offered by employer/insurance dropped or cancelled (35.5%); cost (35.4%); and change in working status or family situation (26.2%).

Figure 4. Health Insurance by Coverage and Type, Tulare County Residents < Age 65, 2019



Source: 2019 California Health Information Survey (CHIS)

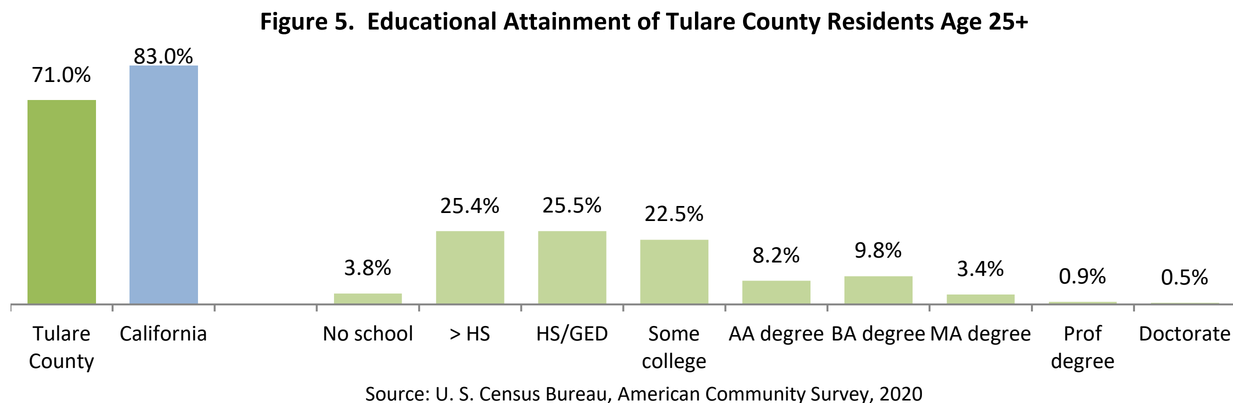
Educational Attainment

In general, higher levels of education equate to the ability to earn higher wages, experience less unemployment and enjoy increased family stability. The community indicator typically used to measure educational attainment is "persons aged 25 and older with less than a high school education." In Tulare County, 71% of people aged 25 years or older, compared to 83% statewide, either graduated from high

[26] California Department of Labor.https://www.labormarketinfo.edd.ca.gov/data/labor-force-and-unemployment-for-cities-and-census-areas.html
[27] UCLA, 2019 California Health Information Survey (CHIS).

school or completed the Graduate Equivalency Degree (GED) or some equivalent certification/credential. Figure 5 also shows residents' various levels of educational attainment.

Figure 5. Educational Attainment of Tulare County Residents Age 25+



Source: U. S. Census Bureau, American Community Survey, 2020

Research shows low educational attainment—particularly dropping out of school—increases the risk of school-age pregnancy. The Tulare County dropout rate in 2018 was 29% compared to 17% statewide.[28] Adolescent mothers and fathers who drop out have limited perceived control and personal power, decreased choices, limited career opportunities, increased risk of unemployment and low wages. High levels of school engagement have been found to be associated with postponing pregnancy.[29] In 2015, 23.9% of Tulare County births were to mothers with no high school degree, compared to 16.3% statewide.[30]

Health-Related Indicators

Births

In 2020, there were 6,084 live births reported for women in Tulare County.[31] The average age of women giving birth in 2019 was 28.06, the lowest in the state except for Kings and Kern Counties (which were 27.82 and 27.98, respectively).[32] The county's birth rate (i.e., the general fertility rate) is about 20% higher than the average for the state (Table 4).[33]

Table 4. Birth Rate, 2017*

Tulare County	California
72.8	58.7

Source: CDC. Natality public-use data.
*Rate per 1,000.

[28] https://www.towncharts.com/California/Education/Tulare-County-CA-Education-data.html
[29] The influence of high school dropout and school disengagement on the risk of school-age pregnancy. *Journal of Research on Adolescence 8(2):187-220, 1998.*
[30] Maternal and Infant Health Assessment (MIHA) Survey Data Snapshots, 2013-2015. California Department of Public Health; 2018.
[31] https://healthdata.gov/dataset/live-birth-profiles-county/resource/72f64767-657a-4a14-8aab-e2bfd902d207. Note: Nov.-Dec. 2020 are estimates are based on 2019 actual for those months.
[32] https://wonder.cdc.gov/controller/datarequest/D149;jsessionid=CA8B18F7595B5D5DBC44B28BE886?stage=results&action=hide&measure=D149.M004
[33] California Department of Public Health, Birth Statistical Master Files; California Dept. of Finance, Population Estimates and Projections; CDC WONDER Online Database, Natality Public-Use Data (Mar. 2020) as reported in kidsdata.org.

While about half (46.6%) of the births in California were to women of Hispanic origin, in Tulare County close to three-quarters (72.7%) of births were to this group (Table 5).

Table 5. Births by Race/Ethnicity, 2017

	Tulare County	California
Hispanic	72.7%	46.6%
White	19.8%	26.9%
Black	1.1%	4.9%
American Indian	0.8%	0.3%
Asian/Pacific Islander	3.2%	15.6%
Multiracial	1.6%	2.5%

Source: California Department of Public Health.

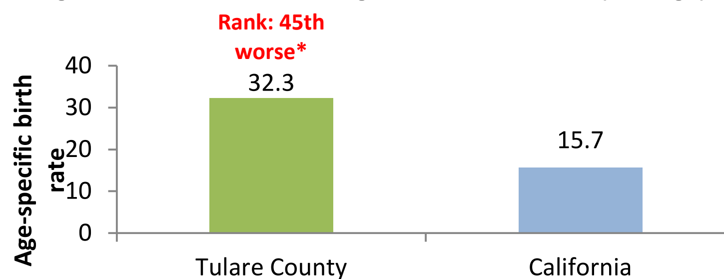
Births to Teen Mothers

Studies have detailed the negative consequences associated with unintended pregnancies for teen parents and their children. These concerns include preterm delivery and low birth weight, maternal depression and missed educational opportunities (increased risk of early dropout from school) locking the young mother into a poverty syndrome. Pregnant adolescents are also more likely to smoke and use alcohol than are older women, increasing the risks associates with those health behaviors.[34]

While across the state adolescent birth rates are declining—due in part to more comprehensive sex education, better access to birth control and better contraception methods—the rates in some California counties—remain very high.

2018 data show California with a rate of 13.6 births per 1,000 females ages 15 to 19.[35] Tulare County's three-year average adolescent birth rate was 32.3 in 2015-2017, twice the statewide rate of 15.7, ranking the County second from the bottom of California counties (Figure 6). The extent of difference between the county and statewide adolescent birth rates has not significantly changed in the last decade.[36]

Figure 6. Births to Mothers Aged 15-19, 2015-2017 (Average)



*Among the 46 California counties with >20 teen births in the reported year.
Source: California Department of Public Health
Rates are per 1,000 female population

Also of significance, Tulare County's *repeat* teen birth rate—calculated as the percentage of all births to mothers aged 15-19 with one or more previous live births—of 21.3 exceeds the statewide average of

[34] Amjad S, et al. Social determinants of health and adverse maternal and birth outcomes in adolescent pregnancies: A systematic review and meta-analysis. *Ped Perinatal Epidemiology.* December 2018.
[35] https://www.cdc.gov/nchs/pressroom/states/california/ca.htm
[36] 2019Health Status Profiles, California Counties. California Department of Public Health.

17.0.[37] The national figure for repeat births is 18.3%.[38] Repeat teen births pose greater challenges because additional births can further constrain the mother's ability to attend school and obtain job experience.

The 2014-2020 teen birth rates from Tulare and Alpaugh zip codes are shown in Table 6. Note that because Woodville straddles zip codes 93274 (Tulare) and 93257 (Porterville), and does not have its own zip code, birth rate data were not able to be included here.

Table 6. Number of Teen Births and Birth Rate, by Selected Tulare County Zip Codes, Age 15-19

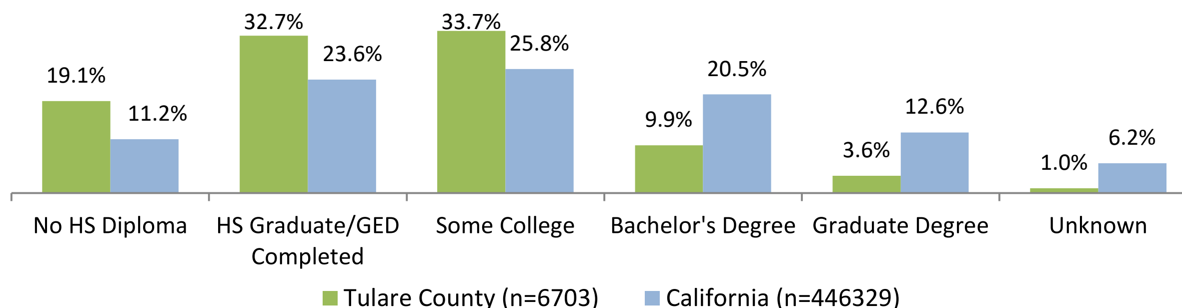
Year	Zip Code	Births	Rate[2]
2014-2016[1]	93201	11	59.1
2017-2020	93201	11	44.4
2014	93274	117	37.2
2015	93274	94	29.9
2016	93274	84	26.7
2017	93274	86	27.4
2018	93274	73	23.2
2019	93274	73	23.2
2020	93274	77	24.5

Sources: California Comprehensive Birth File, California Department of Public Health. American Community Survey, 2015-2019, U.S. Census Bureau. Data provided by Tulare County HHSA, Public Health, January 2021.
[1]Data for this zip code were aggregated into 3-year time periods to de-identify due to small numbers that have the potential to disclose protected health information.
[2]Birth rates are births per 1,000 females aged 15-19.

Births by Education and Marital Status

Maternal socioeconomic disparities, such as maternal education at the time of birth, strongly affect child health. Among mothers aged 25 and over in Tulare County who gave birth in 2019, 19.1% did not have a high school/GED diploma, a proportion nearly twice the state as a whole (Figure 7).[39] Births to *unwed mothers* with less than high school graduation were even higher, 40%, ranking Tulare County among the highest in the state.[40]

Figure 7. Mother's Education at the Time of Birth, 2019



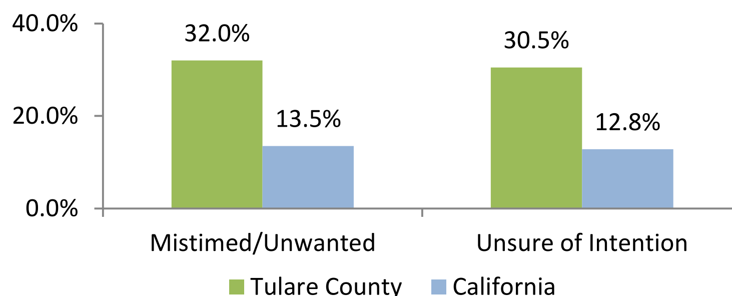
Source: California Department of Public Health Birth Files.

[37] Ibid.
[38] Vital Signs: Repeat Births Among Teens — United States, 2007–2010. *MMWR*. April 5, 2013;62(13):249-255
[39] California Department of Public Health. https://cal-vida.cdph.ca.gov/VSQWeb/ReportBuilder/BirthReport
[40] 2020 American Community Survey as reported in https://www.towncharts.com/California/Top-25-Counties-in-California-ranked-by-Percent-Of-Unwed-Mothers-With-Less-Than-High-School-Education.html

Pregnancy by Intendedness

Studies such as the National Survey of Family Growth (NSFG), have estimated that 62.9% of births among U.S. women are intended; the remainder, 37.1%, are estimated to be unwanted or mistimed.[41] Research also indicates that compared to women who intended each pregnancy, women who were ambivalent, did not intend each pregnancy, or had intermittent intendedness were more likely to be single, younger, Black and report lower importance of motherhood and religiosity.[42] In Tulare County, data from the UCSF Maternal and Infant Health Assessment (MIHA) found that just under one-third (30.5%) of women responding to the survey indicated their recent birth was "mistimed or unwanted" while another 12.8% said they were unsure of the pregnancy intention—findings similar to women statewide (Figure 8).

Figure 8. Pregnancy Intention Among Women Age 15-44 with a Recent Birth



Source: UCSF MIHA Survey (2013-2015 average).

While results would vary by race/ethnic and age groups, applying the proportion of reported Tulare County pregnancies s not reported as mistimed or uncertain to the 6,084 live births in Tulare County in 2020, suggests 3,315 could be the result of unintended, unwanted or mistimed births, providing a potential picture about pregnancy intendedness and the importance of contractive use.

Intendedness and reasons for not using contraception at the time of conception varies by Hispanic/non-Hispanic origin, which has relevance for Tulare County as 72.7% of the county's births in 2015 were to women of Hispanic origin.[43] Among all women in the NSFG survey who had an unintended birth in the prior 3-year period, the number one reason for not using contraception at the time of conception was "Did not think I could get pregnant." While 35.2% of non-Hispanic or Latina women gave this reason, half (49.4%) of the Hispanic or Latina respondents did so, indicating a greater lack of knowledge about pregnancy among this group. Access to family planning education and clinical services remains the key.

Prenatal Care

While the percentage of women receiving prenatal care in the first trimester is lower in the county than in the state, the percent of adequate/adequate plus prenatal care—and the proportion of infant deaths—generally matches the statewide average (Table 7).

[41] https://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf
[42] Shreffler KM et al. "Variation in pregnancy intendedness across U.S. women's pregnancies." *Matern Child Health J*. 2015 May;19(5):932-8.
[43] California Dept. of Public Health, Birth Statistical Master Files; CDC WONDER Online Database, Natality Public-Use Data, (Mar. 2020), as reported in kidsdata.org.

Table 7. Prenatal Care and Birth Weight, 2015-2017 (average)

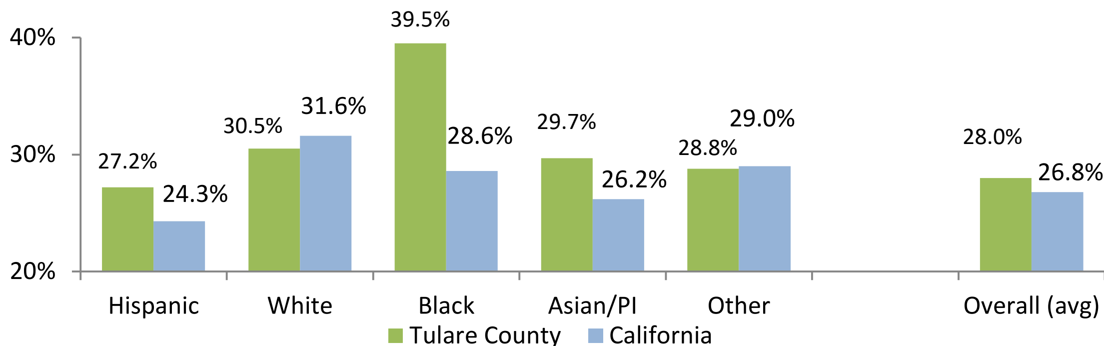
Measure	Tulare County		California
	Rank Order	Percent	Percent
First trimester prenatal care	37	73.4%	83.5%
Adequate/adequate plus prenatal care	23	78.2%	77.9%
Low birth weight infants	38	7.0%	6.9%

Source: California Department of Public Health, Health Status Profiles 2019.

Birth Interval

Access to contraception is associated with adequate birth spacing and reducing the risk of adverse birth outcomes. Closely spaced births are an important issue because short birth intervals—although not necessarily causally—can have health consequences for both the mother and infant.[44] (An inter-pregnancy interval is considered short if it is less than 18 months.) Among all women giving birth in Tulare County in 2012—the last year for which these data were available—28% vs. 26.8% statewide experienced a short birth interval.[45] As Figure 9 shows, white and Black mothers had slightly shorter birth intervals than the county average.

Figure 9. Mothers with Inter-Pregnancy Intervals Less than 18 Months



Source: California. 1991-2012 Birth Cohort and Birth Statistical Master Files

Avoidance of short intervals can be achieved through postpartum provision of contraception. A large majority, 84.9%, of Tulare County MIHA respondents described above reported postpartum birth control use at the time of the survey, a slightly higher proportion than statewide at 81.0%.[46]

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[44] Klerman LV. Another chance: preventing additional births to teen mothers. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy; 2004.
[45] Improved Perinatal Outcome Data Reports Tulare County Profile, 2012. State of California. 1991-2012 Birth Cohort and Birth Statistical Master Files.
[46] https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Tulare_2013-2015_MaternalCharacteristics.pdf

Medi-Cal as Payer

Close to 75% of Tulare County women in the MIHA survey reported Medi-Cal as their primary source of prenatal insurance; statewide, Medi-Cal paid for 50.1% of the births.[47] A more recent state survey of births by payer [48] revealed a similar proportion for California births, 50%, a state/county difference that has remained relatively unchanged over at least the last decade and a half.

Sexually Transmitted Diseases[49]

Sexually transmitted diseases are largely preventable when individuals have adequate knowledge and access to reproductive health services. The human papillomavirus (HPV) is the most common sexually transmitted infection. HPV is so common that nearly all sexually active men and women will become infected with it at some point during their lives, most of which will have no harmful effects.[50] Two HPV vaccines are currently available to protect both males and females against infection. The HPV-associated cancers accounted for 3.2% of all cancers diagnosed in females and 1.9% of all new cancers diagnosed in males California in 2010.[51] The most common are cervical cancer among women and oropharyngeal cancers among men. Table 8 below displays the incidence or cases of the STDs and county ranking order regularly reported as morbidity indicators by the California Department of Public Health. The case rates shown in the table are per 100,000 population.

Table 8. Tulare County STD Incidence by Cause

	County Rank Order (Total Case Rate)	Crude Case Rate	
		Tulare County	CA
HIV/AIDS Incidence (age 13+)[1]	12	104.2	397.7
Chlamydia incidence[2]	21	547.3	583.0
Gonorrhea incidence females[2]	24	151.4	132.2
Gonorrhea incidence males[2]		162.7	199.4
Early non-primary non-secondary Syphilis females[2]	45	2.2	5.4
Early non-primary non-secondary Syphilis males[2]		5.9	33.6

Sources: [1]County Health Status Profiles 2019. California Department of Public Health. Data are 2015-17 averaged.
[2] 2018 STD Surveillance Report. STD Control Branch. California Department of Public Health.

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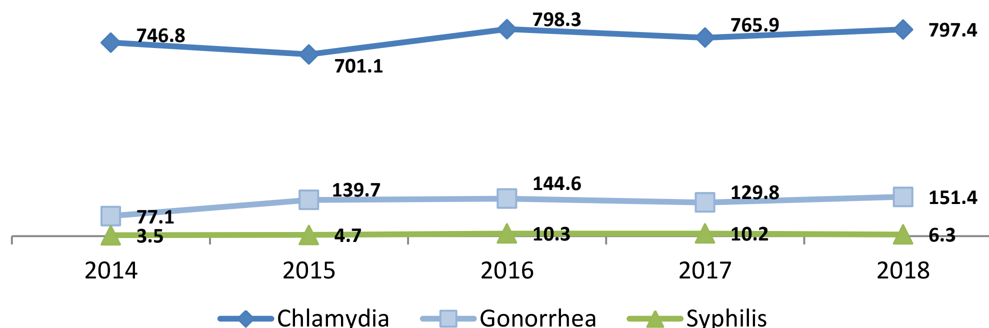
[47] https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Tulare_2013-2015_MaternalCharacteristics.pdf
[48] Kaiser Family Foundation Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2019.
[49] For consistency with the Title X grant from Essential Access Health and the Centers for Disease Control, "sexually transmitted diseases" is used throughout this report. However, it should be noted that this term is used interchangeably in public health and similar work with "sexually transmitted infections" which is becoming more preferred.
[50] https://www.cdc.gov/std/hpv/stats.htm
[51] Cook SN et al. Human Papillomavirus (HPV)-Associated Cancers and HPV Vaccination Coverage in California. Sacramento, CA: California Department of Public Health, Chronic Disease Surveillance and Research Branch, June 2014.

Although chlamydia is only one of many STDs, it is the most common bacterial STD in the U.S. and one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.[52] Like other STDS, it is associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death.[53,54] Chlamydia often has no symptoms, and people who are infected may unknowingly pass the disease to sexual partners. The 5-year (2014-2018) case rate of chlamydia for Tulare County appears to be on the rise as illustrated in Figure 9.[55]

Figure 10. STD Rates Among Women Age 15-44 in Tulare County



Source: California Department of Public Health, 2018 STD Surveillance Report
Rates are per 100,000 population

Clients who seek HIV counseling and testing services and clients who seek family planning services are often the same individuals. According to the Centers for Disease Control and Prevention, young people are the most likely to be unaware of their infection.[56] At the end of 2018, 50 people in Tulare County were newly diagnosed with HIV infection and 479 (up from 234 in 2010) adults and adolescents were living with diagnosed HIV infection (Table 9).[57] While the number of deaths of persons with HIV remained relatively stable in recent years, the rate of new cases and the rate of persons living with HIV infection have increased (Figure 11).

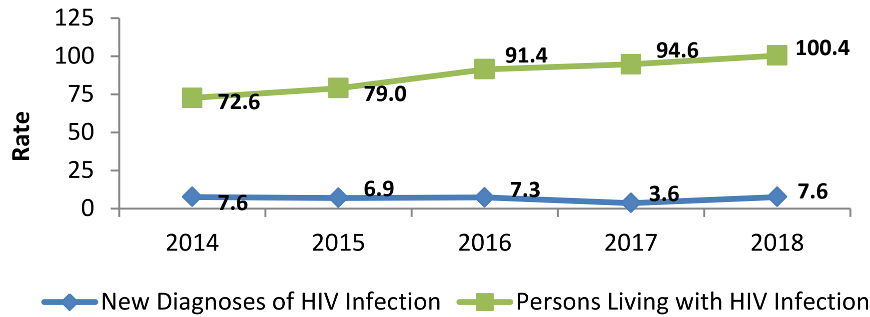
Table 9. Persons with Diagnosed HIV Infection, Tulare County, 2010-2014

	2014		2015		2016		2017		2018	
	No.	%	No.	%	No.	%	No.	%	No.	%
New Diagnosis	35	0.7%	32	0.6%	34	0.6%	17	0.3%	50	1.0%
Persons living with HIV	334	0.3%	367	0.3%	428	0.3%	447	0.3%	479	0.4%
Deaths from HIV	9	0.5%	11	0.6%	19	1.0%	12	0.6%	10	0.5%

Source: California Department of Public Health, 2018 STD Surveillance Report
Rates are per 100,000 population

[52] Genuis SJ, Genuis SK. Managing the sexually transmitted disease pandemic: A time for reevaluation. *Am J Obstet Gynecol*. 2004;191:1103-1112.
[53] Meade CS, Ickovics JR. Systematic review of sexual risk among pregnant and mothering teens in the USA: Pregnancy as an opportunity for integrated prevention of STD and repeat pregnancy. *Soc Sci Med.* 2005;60:661-678.
[54] Haggerty CL, et al. Risk of sequelae after Chlamydia trachomatis, genital infection in women. *J Infect Dis* 2010;201:134-155.
[55] https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx
[56] HIV in the United States: *At A Glance. https://www.cdc.gov/hiv/statistics/overview/ataglance.html*
[57] California HIV Surveillance Report—2018. California Department of Public. Health.
https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2018.pdf

Figure 11. Rates of HIV Diagnosis and Persons Living with HIV, Tulare County, 2010-2014



Source: California Department of Public Health, 2018 STD Surveillance Report
Rates are per 100,000 population

Cervical Cancer

Related preventive health services include services that are considered to be beneficial to reproductive health, are closely linked to family planning services, and are appropriate to deliver in the context of a family planning visit; these include cervical and breast cancer screening which saves lives. In 2017, in California, 1,503 women (rate of 7.3 per 100,000 women) were diagnosed with cervical cancer, and 490 women (rate of 2.3) were estimated to have died from this disease needlessly.[58] With respect to race/ethnicity, Hispanic women experienced the highest incidence rate. The cervical cancer incidence and deaths rates—which have not been published since 2014—are somewhat higher in Tulare County than in California (Table 10). The Tulare County Medical Service Study Area (MSSA)—defined as communities that do not have adequate medical services—of Farmersville/Goshen/Visalia was among the MSSAs in California with higher proportions of advanced stage cervical cancers in 2009-2013.[59]

Table 10. Age-Adjusted Rates of Cervical Cancer, 2010-2014, Tulare County

	Tulare County		California
	No. of Cases	Rate	Rate
Incidence rate	95	9.66	7.31
Death rate	36	3.69	2.24

Source: California Department of Public Health, Cancer Registry.

Unlike many cancers, cervical cancer can be prevented[60] and the incidence reduced through public health interventions such as education on risk factors, especially HPV infection. Mortality could be reduced and virtually eliminated through regular screening and early detection of the disease through a Pap smear—one of the important preventive services covered by Title X.

Current Pap smear screening rates are not available for Tulare County; CHIS, for example, has not included this question in its population-based interviews since 2007. At that time, 85.3% of women in Tulare County reported having a Pap screening within the last 3 years, 5.1% reported it had been more than 3 years since their last test, and 9.6% reported never having had the test—proportions similar to

[58] California Department of Public Health, Cancer Registry. https://www.ccrcal.org/retrieve-data/data-library/#205-wpfd-annual-statistical-tables-by-site-1988-2017
[59] https://www.ccrcal.org/wpfd_file/summary-of-mssas-with-higher-proportions-of-advanced-stage-cervical-cancers/
[60] Kinde I et al. Evaluation of DNA from the Papanicolaou test to detect ovarian and endometrial cancers. *Sci Transl Med* 2013 January 9;5(167):167.

statewide screening results.[61] Statewide, in 2018, 77.6% of women ages 21-44 were reported as having a recent (within 3 years) Pap test, a proportion that decreased 3% from 79.6% in 2015.[62] According to the Screening and Risk Factors Report by State (directly estimated 2018 BRFSS data), California ranks 45 and none of the 50 states has achieved the Healthy People 2020 Objective of 93% Pap test screening for women ages 21-65.[63]

Breast Cancer

Breast cancer was the most common type of cancer by rate of new cancer cases in California (all races/ethnicities) in 2017.[64] The county's 2015-17 age-adjusted rate of death from female breast cancer of 17.4 (down from 20.6 in the prior 3-year reporting period) was slightly more favorable than the statewide rate of 18.9.[65] The Tulare County Medical Service Study Area (MSSA)—defined as communities that do not have adequate medical services—of Farmersville/Goshen/Visalia was among the MSSAs in California with a significantly elevated percentage of advanced stage breast cancer[66]—possibly suggestive of less access to early screening and detections services.

Evidence suggests that mammography screening reduces breast cancer mortality.[67] While the majority of the breast cancers diagnosed in California's Every Woman Counts program were among women 50 through 59 years old,[68] it is important to note that like cervical cancer screening, family planning clinics provide access to referrals for mammograms. The percent of women ages 40-69 receiving a mammogram is a widely endorsed quality of care measure. Screening data from RWJ *County Health Rankings*[69] show 37% of Tulare County women ages 65-74 (compared to 36% statewide) received an annual mammography screening in 2017 (Table 11).

Table 11. Mammography Screening by Race/Ethnicity, Tulare County Women ages 65-74

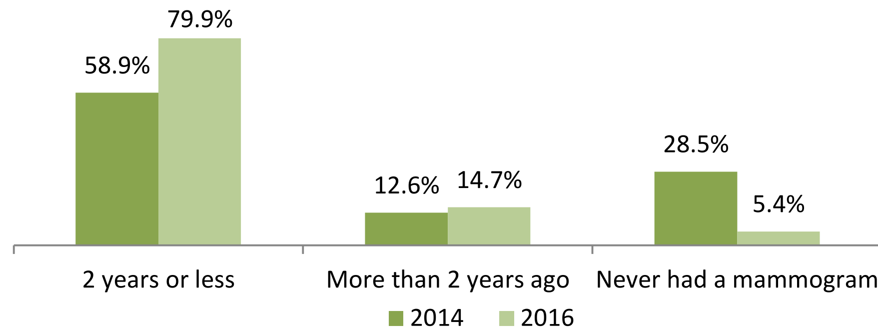
	Percentage Screened				
% Total With Annual Mammogram	American Indian	Asian	Black	Hispanic	White
37%	23%	31%	26%	36%	38%

Source: RWJ County Health Rankings, 2017

The increase in the percentage of Tulare County women 40 years and older who reported a recent mammogram to CHIS—79.7% in 2016 compared to 58.9% in 2014[70] (Figure 12) suggests an increased awareness and use of mammogram screening services.

[61] UCLA, California Health Information Survey, 2007.
[62] https://www.americashealthrankings.org/learn/reports/2020-health-of-women-and-children/state-summaries-california
[63] CDC, Behavioral Risk Factor Surveillance System, 2018.
https://statecancerprofiles.cancer.gov/risk/index.php?topic=women&risk=v17&race=00&type=risk&sortVariableName=default&sortOrder=default#results
[64] https://gis.cdc.gov/Cancer/USCS/DataViz.html
[65] County Health Status Profile, California Department of Public Health
https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/ICS_TULARE2019.pdf
[66] http://ccr.ca.gov/Data_and_Statistics/GISBreast/PDFTables/Table1_sig_high_MSSAs.pdf
[67] Elmore JG, Armstrong K, Lehman CD, Fletcher SW. Screening for breast cancer. *JAMA*. 2005;293(10):1245-1256.
[68] https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Every%20Woman%20Counts%20Reports/2018_EWC_Annual_Report_FY2015-16.pdf
[69] RWJ County Health Rankings. https://www.countyhealthrankings.org/app/california/2020/downloads
[70] UCLA Center for Health Policy Research, California Health Interview Survey, 2016.

Figure 12. Mammogram History, Respondents Age 40+ Tulare County



Source: California Health Interview Survey, 2016
*Statistically unstable due to small sample size.

Domestic Violence

Domestic violence has risen since the restrictions imposed by COVID-19, and according to a recent statewide assessment the problem is exacerbated by a shortage of services and lack of appropriate training among health care providers and law enforcement.[71] In 2019, the Tulare County Sheriff's office reported 1,048 calls related to domestic violence, 41% with a weapon involved.[72] Just over six percent (6.2%) of the women in Tulare County responding to the UCSF Maternal Infant Health Assessment survey (2013-2015 average) reported physical or psychological intimate partner violence during their most recent pregnancy.[73]

Other Key Indicators: Youth Attitudes and Experience

California Healthy Kids Survey

The California Healthy Kids Survey (CHKS) is part of the largest, most comprehensive effort for guiding school improvement efforts on learning supports and barriers as well as overall youth development, health and well-being. The most recent findings,[74] from which the following selected data were pulled, provide insights from selected middle school (7th grade) and senior high school students in ALTURA's service area that informs this assessment. Although the CHKS includes a Sexual Behavior Module, this module was not administered by any of these schools (nor was it at the time of our previous assessment).

Youth's feelings about school connectedness—an academic environment in which students believe that adults in the school care about their learning and about them as individuals—are an important CHKS indicator because students are more likely to succeed and less likely to engage in high-risk behaviors or drop out when they feel connected to school through a meaningful relationship with a teacher or some other adult. While the majority of 7th graders in the three Tulare County schools displayed in Figure 13 reported positive feelings about these measures, approximately one-quarter did not agree or agreed very little that they were listened to, cared about or thought of as becoming a success. In general, students

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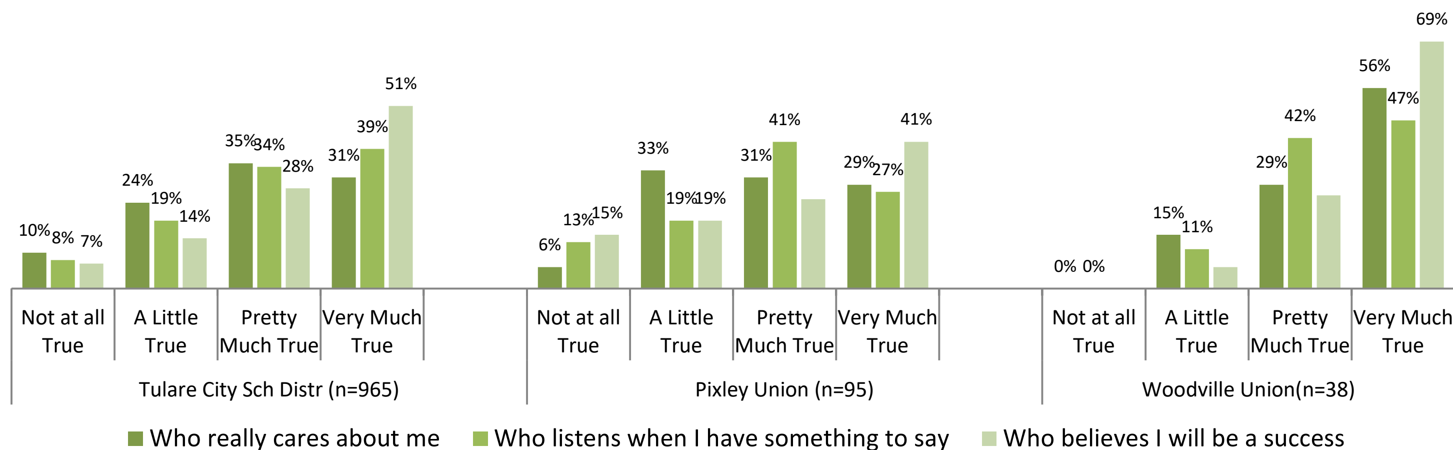
[71] Kaiser Family Foundation Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2019.
[72] California Department of Justice Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance (July 2019).
[73] https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Tulare_2013-2015_MaternalCharacteristics.pdf
[74] Tulare County. California Healthy Kids Survey, San Francisco: WestEd Health & Human Development Program for the California Department of Education.

responding to the CHKS at Woodville Union Elementary School responded more favorably than students at either Pixley Union Elementary School or Tulare City School District.

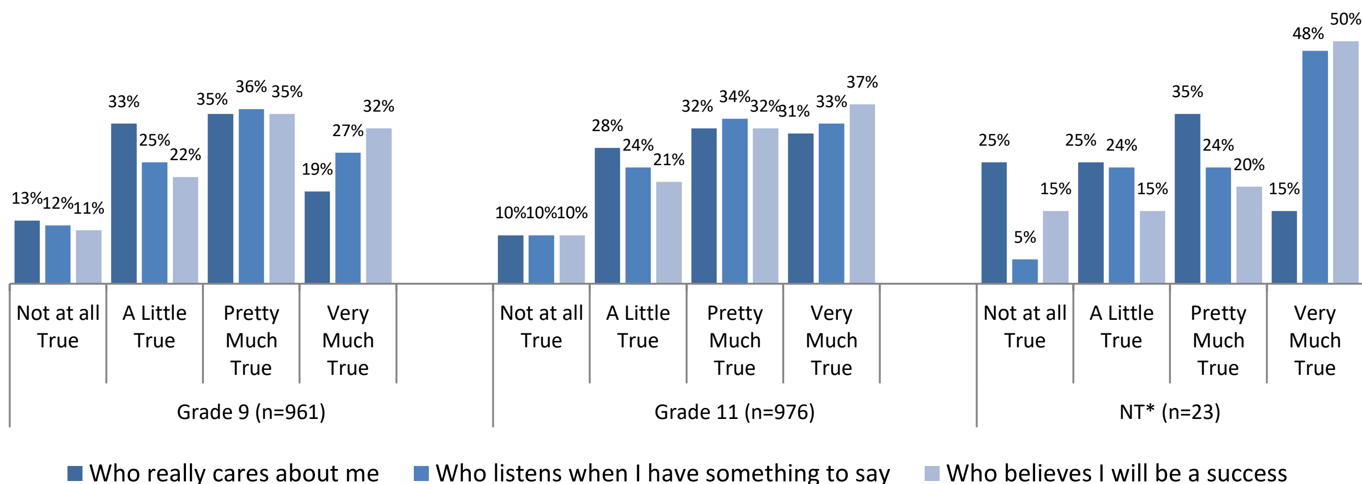
Figure 13. School Connectedness Measures Reported by Selected Tulare County School 7th Grade Students



Source: California Healthy Kids Survey. Tulare City School District 2017-18; Pixley Union and Woodville Union 2018-19
The question asked was: "At my school there is a teacher or some other adult who….."

The same 2018-19 CHKS school connectedness measures were less positive among Tulare Joint Union High School students; 46% of 9th graders, 38% of 11th graders and 50% of alternative school students disagreed or slightly disagreed that they were cared about. The three student groups were a little less negative in their perceptions about being listened to or thought of as becoming a success, however; between 24% and 37% of them expressed doubts about being taken an interest in (Figure 14)

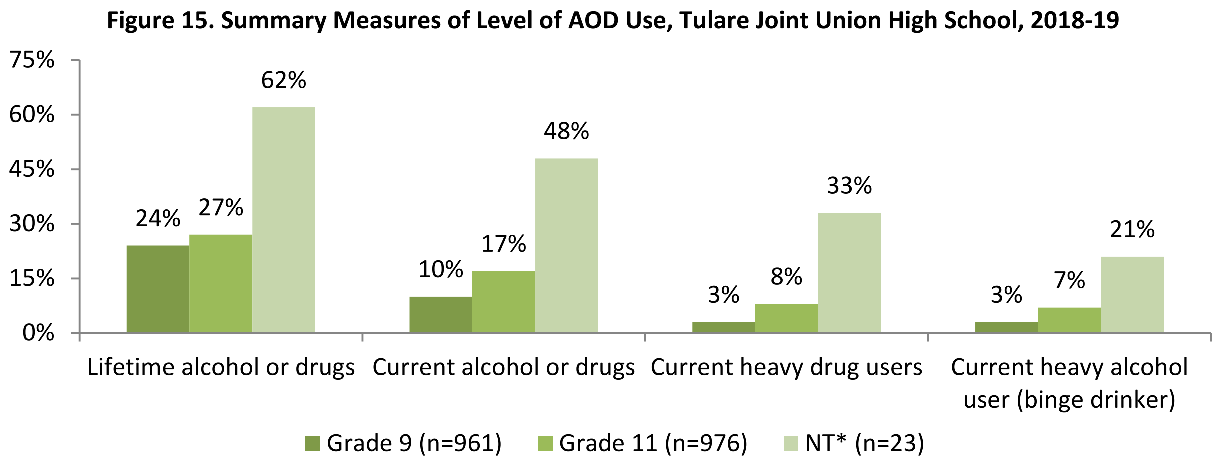
Figure 14. School Connectedness Measures Reported by Tulare Joint Union High School Students, 2018-19



Source: Source: California Healthy Kids Survey.
The question asked was: "At my school there is a teacher or some other adult who….."
*Note: NT includes continuation, community day, and other alternative school types.

Similar to measures of school connectedness, alcohol and other drug (AOD) use is another marker for sexual behavior that needs assessments examine. Despite inconsistencies in the manner in which substance use and risk are sometimes measured, research suggests that the use of alcohol or drugs is related to sexual behavior that is high-risk for HIV/STDs. Additionally, risk-takers may be more likely to use alcohol or drugs on any given occasion and more likely to engage in unprotected intercourse.[75,76] As Figure 15 shows, Tulare Joint Union High School students, and particularly the group "other alternative school type students," self-reported relatively high rates of current AOD use in the most recent California Healthy Kids Survey.

Figure 15. Summary Measures of Level of AOD Use, Tulare Joint Union High School, 2018-19



Source: Source: California Healthy Kids Survey.
Note: "Current" experience is past 30 days.
*NT includes continuation, community day, and other alternative school types.

[75] Hingson RW. Binge Drinking Above and Below Twice the Adolescent Thresholds and Health-Risk Behaviors. *Alcoholism* 42(5): 904-913 May 2018.

[76] Gilman AS, et al. Risky Sex in High-Risk Adolescents: Associations with Alcohol Use, Marijuana Use, and Co-Occurring Use. September 2017. *AIDS Behav* 22, 1352–1362 (2018).

Part II. Access to Reproductive Health Services

"People want the resources to do things for themselves; they just don't always know how or where to go." – Focus Group Participant

Resources

While prenatal and contraceptive services are generally accessible in the county, other studies have suggested there is a "significant shortage of providers of specialty care and even fewer specialists who accept Medi-Cal."[77] Tulare County's large area, rural pockets and lack of public transit add to the challenge for clients to travel to larger towns for health care appointments. Our examination shows that while individuals in the cities of Tulare and Woodville, the primary focus of ALTURA services, as well as the rest of the county, do have access to family planning and other reproductive health services through the organizations described below, limitations remain—including the ability for someone seeking services to easily find information about them through the internet.

The organizations with an asterisk (*) are Family PACT providers *and* receive Title X funds.

Altura Centers for Health*

Altura Centers for Health, a nonprofit community-based organization operates 8 federally qualified health centers (FQHC) in Tulare County, and provides comprehensive medical, dental, mental health and ancillary healthcare services. Clinic services are provided in Tulare, Woodville and surrounding rural communities and include 3 school-based mobile clinics which due to COVID-19 are temporarily closed. Family PACT services are currently provided at 6 sites: Main Clinic, South Tulare Clinic, West Tulare Clinic, Pediatric Clinic, Mobile Clinic 1 and Mobile Clinic 2. Approximately three-quarters (70.5%) of the patients are residents in the 93274 zip code (the city of Tulare). Only the main clinic on North Cherry Street is open on Saturdays; all other sites operate Monday through Friday 8:00 a.m. – 5:00 p.m. ALTURA provided services, including family planning and reproductive health services, to 27,769 patients in 2019, 95.7% of whom were living at 200% or less of the federal poverty level. English is a challenge for close to one-third (29.9%) of them, reported as being best served in a language other than English. Close to half (46.3%) of ALTURA female patients are women aged 15-44, with 52.1% reported as receiving cervical cancer screening; 459 (39.1%) of the health center's 1,174 prenatal patients delivered in 2019.[78]

Family Health Care Network (FHCN)*

Family HealthCare Network is a nonprofit community-based organization that operates 41 Federally Qualified Health Centers (FQHC) throughout Tulare, Fresno, and Kings Counties that provide comprehensive medical, dental, behavioral health and specialty healthcare services. There are 12 Tulare County sites and 1 Kings County site that include Title X family planning services: Cutler-Orosi, Farmersville, Goshen, Ivanhoe, Porterville, Springville, Terra Bella, Three Rivers, Woodlake, Hanford,

[77] Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities. Kaiser Family Foundation. (November 2019)

[78] https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE#titleId (2019) ;https://ALTURA.org. ; and https://opa.hhs.gov/sites/default/files/2021-01/title-x-family-planning-directory-december2020.pdf

and three Visalia sites. The agency provided services, including family planning and reproductive health services, to 214,458 patients in 2019, 93.1% of whom were living at 200% or less of the federal poverty level. Just under half (45.7%) of the female patients were women aged 15-44, with 63.4% reported as receiving cervical cancer screening; 3,186 (55.5%%) of the health center's 5,737 prenatal patients delivered in 2019. FHCN did not report any school-based health center patients in 2019.[79]

Tulare County Health and Human Services Agency*

Tulare County HHSA offers Family PACT clinic and education services at Visalia Health Care Center located on North Dinuba Street and in Farmersville at the Health Care Center on East Visalia Road (however, not at the Public Health Annex on South K Street as appeared on the website). Information provided on the website addresses only the Visalia site which is open Monday – Friday 8:00 – 4:00, closed on weekends. Virtually all (99.3%) of the County services provided are listed as medical services, including family planning and reproductive health services, and in 2019 6,743 patients were served, 96.9% of whom were living at 200% or less of the federal poverty level. Over one-third (39.1%) of the female patients were women aged 15-44, with 64.3% reported as receiving cervical cancer screening; 108 (55.9%%) of the 193 prenatal patients delivered in 2019. The County is not currently providing family planning (or any other) community outreach due to the COVID-19 pandemic and staff being redirected to those related activities.[80]

Planned Parenthood*

The information in the following paragraph was included in our previous Family Planning Needs Assessment but could not be verified in the current project as no telephone calls from any of Planned Parenthood's organizational levels (county/state/national) were returned; moreover, it proved impossible to connect with any local clinic personnel by phone.

The Planned Parenthood site in Tulare County is located in Visalia and is open 3 full days/week (Tuesday-Thursday) during daytime hours. The clinic provides family planning education; the full range of birth control methods including the morning-after pill; pregnancy testing, counseling and referrals; STI testing, treatment and vaccine; and HIV testing and counseling. Currently, the clinic does not provide physical exams, pelvic exams or Pap smears. This health center does not provide abortion services; it provides counseling and referrals (including to the Planned Parenthood site in Fresno) for women who choose that option.

College of the Sequoias (COS), Tulare Campus

The COS Student Health Center is open from 7:45 am to 4:45 pm Monday through Friday. Family planning-related services are limited to pregnancy testing with counseling and referral; condom giveaways, and HIV/STD testing and education. Students wishing to receive exams and contraceptive services are referred to local agencies/providers.

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[79] https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE#titleId (2019) ; https://www.fhcn.org/about-us/ ; and https://opa.hhs.gov/sites/default/files/2021-01/title-x-family-planning-directory-december2020.pdf

[80] https://tchhsa.org/eng/index.cfm/public-health/family-planning-access-care-treatment-pact/nd ;https://opa.hhs.gov/sites/default/files/2021-01/title-x-family-planning-directory-december2020.pdf ; and https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE#titleId

Aria Community Health Center

Aria Community Health Center (formerly named Avenal Community Health Center), like other Federally Qualified Health Centers (FQHC), serves a predominantly low-income population as 92.6% are at or below 200% of the FPL. Just over 42% of its 19,169 female patients received a cervical screening service in 2019. While Aria reported serving a total of 32,982 individuals at all sites in 2019, its service area includes parts of Fresno, Kings and San Benito Counties in additional to Tulare County. No medical or clinic services except chiropractic are listed as offered services on the agency website.[81] One needs to click on "locations" to get an idea of the medical services offered. In Tulare County, the clinic sites include Dinuba (the only location where "family planning" is explicitly mentioned among the services); Porterville (four medical sites; no service descriptions); Lindsay (three sites but unclear what is offered); Avenal (Pap smear exams are the only indication of a family planning-related service); and Tulare (one site, no description of services).

Kaweah Delta Healthcare District

Kaweah clinics are located in Woodlake, Lindsay, Exeter, Dinuba and Visalia, all of which are open Monday-Friday, 8:00 – 5:00; the Lindsay and Exeter sites also include Saturdays. Except for the Sequoia Health and Wellness Center (the Visalia site) where "family planning" is listed among the services offered, family planning, women's health or reproductive health services are not shown as being available on the organization website.[82]

Medical Providers Who Accept Medi-Cal

Tulare County residents covered by Medi-Cal receive health services through enrollment in a Medi-Cal managed health plan; the plans contract with private providers, including community health centers, which deliver direct services, including family planning. The health plan options for beneficiaries in Tulare County are Anthem Blue Cross Partnership Plan and Health Net Community Solutions, Inc.[83] When eligible individuals enroll (join) a medical plan, they choose a primary care provider (doctor or clinic). The Medi-Cal website shows 588 Medi-Cal Managed Care "Doctor Results" for Tulare County; however, this is misleading. The list actually includes Fresno, Kings and Kern Counties, and it is not made clear whether the physician is in private practice or associated with a health center.[84]

Access to Abortion Services

There are no providers in Tulare County offering abortion services. Women who elect to use this option must be referred to Fresno (about 45 miles away). As described in the community input section of this report, cultural norms, religious beliefs, family pressure and transportation and childcare difficulties are barriers for women seeking abortion – some of the same barriers that might prevent providers who may be willing to provide the service from offering them.

[81] https://ariachc.org/tulare/
[82] https://www.kaweahdelta.org/
[83] https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx
[84] https://www.healthcareoptions.dhcs.ca.gov/choose/find-provider

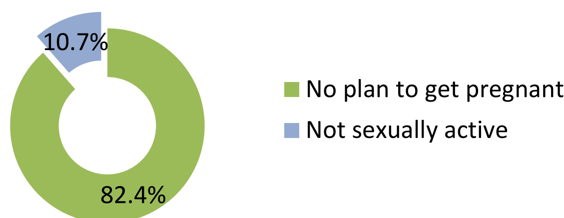
Utilization of Family Planning Services

Despite the availability of reproductive health services, some individuals face barriers when trying to access these services. Notable barriers to accessing clinical family planning services commonly include financial constraints, transportation difficulties, limited hours of operation, and lack of family planning service providers in rural areas according to numerous studies. Adolescents, particularly, face barriers including cost, provider acceptance of contraceptive services for teens, and having inaccurate information about birth control methods.

Information from the California Health Information Survey (CHIS), and the Family Planning Community Survey described in the next section of this report (see especially pp. 34-35), offer a picture about utilization of family planning services in Tulare County. Although the CHIS data for many of these measures are considered statistically unstable due to small sample sizes, they are population-based and should be largely considered reflective of the community for needs assessment purposes.

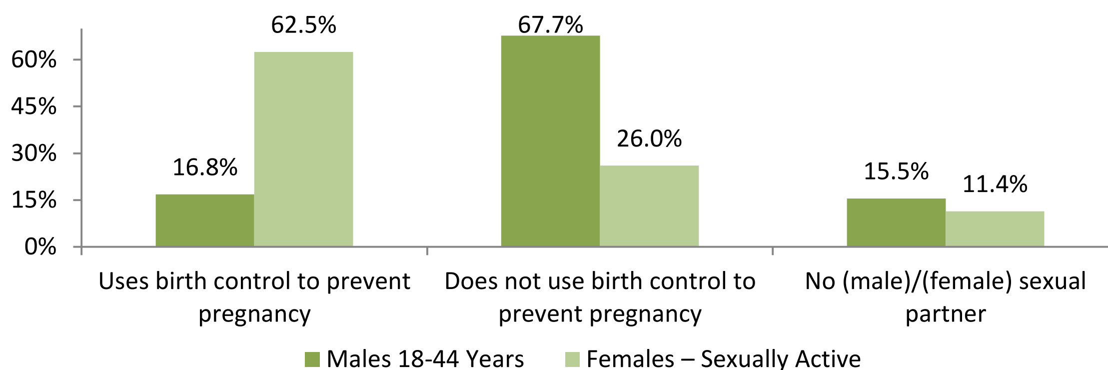
According to the 2019 CHIS, most (82.4%) Tulare County women of childbearing age stated they were not planning to get pregnant at the time of the interview (Figure 16). Yet, only about two-thirds (62.5%) of them reported using a birth control method to prevent pregnancy (Figure 17). Notably, about the same proportion of men (67.7%) reported the opposite experience: *not* using a birth control to prevent pregnancy.

Figure 16. Pregnancy Plans, Tulare County Females Ages 18-44



Source: CHIS, 2019
Data are considered "statistically unstable" due to small sample size.

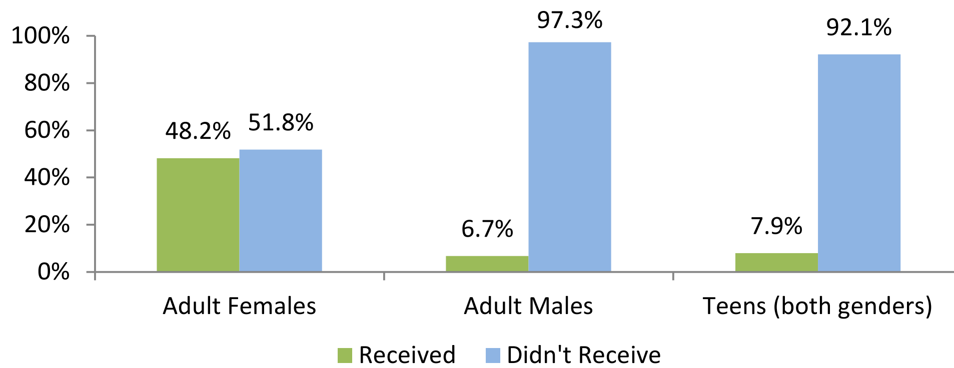
Figure 17. Use of Birth Control to Prevent Pregnancy, Tulare County



Source: CHIS, 2019
Data are considered "statistically unstable" due to small sample size.

Whether through school, sports and other physicals, postpartum exams or paired with a well-baby visit, CHIS asked adults and teens if during the past 12 months they had received counseling or information about birth control from a doctor or medical provider. While close to half (48.2%) of the adult women said they had received birth control information or counseling from their doctor, the contraceptive counseling experience of men and teens was markedly different—the greatest majority had *not* been offered the information (Figure 18).

Figure 18. Percentage of Teens and Adults Ages 18-44 in Tulare County Who Received Birth Control Counseling or Information



Source: CHIS, 2019
Data for males and teens are considered "statistically unstable" due to small sample size.
Respondents were asked, "During the past 12 months, have you received counseling or information about birth control from a doctor or medical provider?"

Because the CHIS responses for the source of family planning services—private doctor, clinic, etc.—were basically unusable in this 2019 survey, we have not included the data here. Similarly, women's main reasons for not using birth control were too confusing to be reportable, and men's main reasons, said to be "no need/don't want" (50.8%) and "trying to get pregnant/want a baby" (25.5%), appeared questionable. The main birth control method or prescription respondents received was not asked in the recent CHIS.

Part III. Community Input

"Sex education at home when I was growing up was 'Don't have sex, don't come home pregnant.' That was it." – Focus Group Participant

One of the most important aspects of a needs assessment is obtaining information and views from community members themselves. This involves surveying a representative sample of the community to inquire about needs, use of services and service gaps, barriers, and suggestions for improvement. These conversations and opportunities for input also explore the factors that affect the design of programs and services to address effectively the identified issues. This report draws on and was enriched by findings from a community input process that included focus groups, interviews and a community survey.

Community Survey

Description of Respondents

The link to the online *Family Planning Community Survey* we developed for this needs assessment was distributed to ALTURA and its partners and other organizations to reach a wide sample of residents, particularly those in the ALTURA service areas. A total of 217 surveys was returned, three-quarters (76.5%) completed in English and one-quarter (23.5%) Spanish (Figure 19).[85]

Figure 19. Community Surveys Received by Survey Language Type (n= 217)

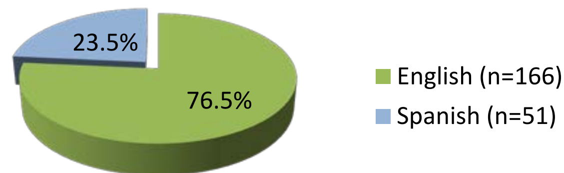


Table 12 on the next page displays selected characteristics of the survey respondents. Because the respondents represent a convenience sample, they may not be representative of the entire target population of Tulare County or necessarily even the service areas served by ALTURA. For example, only 2.4% of the respondents identified as being from Woodville, which may have more to do with access to a computer than willingness to participate in a survey. The survey results do, however, provide important information that was sought from the subset of the larger Tulare County population and help illuminate the challenges and opportunities for ALTURA Centers for Health and other local family planning advocates.

The survey respondents were most likely to report their age group as 25-44 (48.6%) followed by ages 18-24 (24.1%); adolescents age 17 and under comprised 5.6% of the total. Females completed the greatest majority of the surveys, 87.9%. Of the individuals who answered the question about ethnicity, the

[85] By contrast, the return rate to the community survey in the previous needs assessment was 367. However, the earlier survey was distributed in hard copy only – something not possible this time due to COVID-19.

greatest majority, 86.1%, identified as Hispanic or Latino/a. Residents of Tulare completed 59.6% of the surveys, Visalia residents 17.8%; other than the small proportion (2.4%) from Woodville, residents of Porterville, Exeter, Lindsay and Pixley made up the remaining 20.2% of the "Other" category. Over half (56.0%) of the survey respondents were covered by Medi-Cal, with private insurance reported as 26.4%; 8.3% said they were uninsured.

Table 12. Characteristics of the Community Survey Respondents

Characteristic	Respondents	
	Number	Percent
Age (n=216)		
17 and under	12	5.6%
18-24	52	24.1%
25-44	105	48.6%
45 and older	47	21.8%
Gender (n=214)		
Female	188	87.9%
Male	26	12.1%
Other	0	0
Hispanic/Latino origin (n=216)		
Yes	186	86.1%
No	30	13.9%
City or community (n=208)		
Tulare City	124	59.6%
Woodville	5	2.4%
Visalia	37	17.8%
Other	42	20.2%
Type of health insurance (n=216)		
Medi-Cal	121	56.0%
Private	57	26.4%
Uninsured/self-pay	18	8.3%
Other	20	9.3%

Usual Source of General Health Care

About three-quarters of the survey respondents identified a specific source for their last health check-up. ALTURA was cited in 45.3% of the English-completed surveys and in 65.8% of the Spanish-completed surveys. Family Healthcare Network was cited in 28.3% and 7.9%, respectively. An additional one-quarter of both English- and Spanish-language respondents reported "other" sources of care, including a few each, in order of mention, for Adventist Health, Women's Community Clinic, Advanced Medical Care Center, Exeter Women's Health, Visalia Medical Clinic and "private MD."

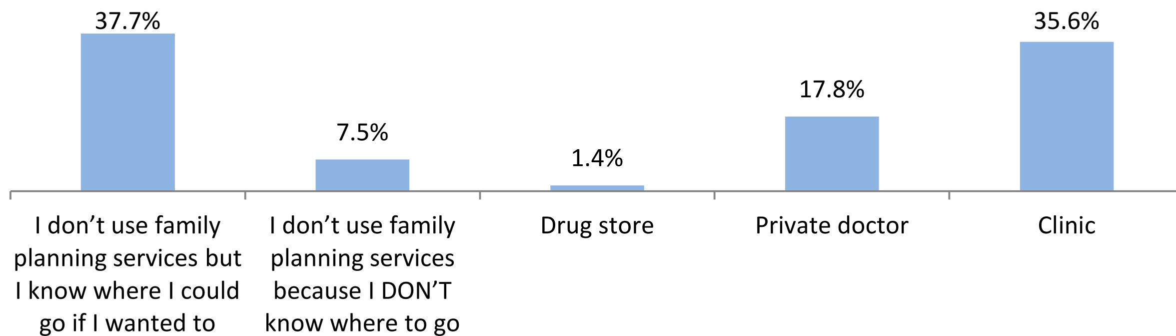
Interestingly, 20% of the English survey respondents (but none of the Spanish ones) misinterpreted the question and wrote in a date, i.e., telling us *when* vs. where they'd gone for their last regular health check-up.

Source and Awareness of Family Planning Services

When family planning services were used, they were most commonly reported to be accessed through one of the area community clinics (Figure 20), 50% of the time at an ALTURA site, 21.2% at FHCN, and 11.5% at Women's Clinic where the source was named. There were no notable differences between the responses of the English and Spanish surveys.

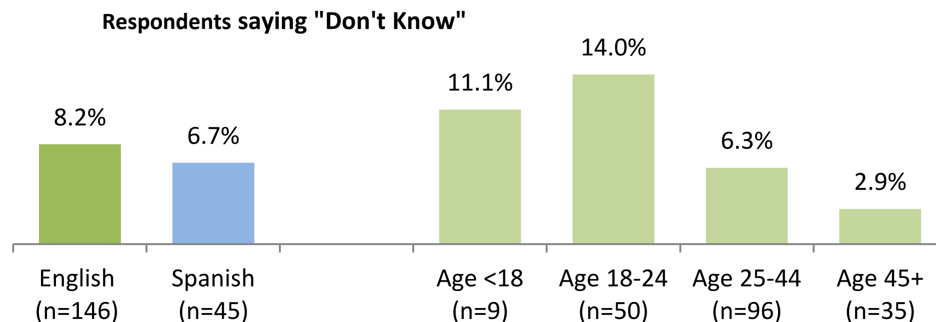
Just over one-third (37.7%) of the respondents reported not using family planning services but *knowing* where they could go if they wanted to, while 7.5% not using family planning services said they did *not know* where they could go if they wanted to use the services. Figure 21 below on this page shows the variations by language and age group who reported *not knowing* where they could go.

Figure 20. Source for Family Planning Services



Respondents were asked if they knew where they could get family planning services (defined as *birth control, pelvic exams and Pap smears, testing or treatment for sexually-transmitted diseases*) in their area. In general, most (93%) of the survey respondents replied they were aware of locally available family planning resources, with a slightly higher proportion responding in English being unaware, 8.2% vs. 6.7%. Looking at the results by age group, it is notable that the 18 to 24 year-olds reported the highest proportion of unawareness (Figure 21). This finding is important as birth rates are highest for women in their 20s[86] (whether the pregnancies were intended or unintended). The age group with the most awareness was individuals 45 and older.

Figure 21. Percentage Unaware of Available Family Planning Services, by Survey Language and Age Group

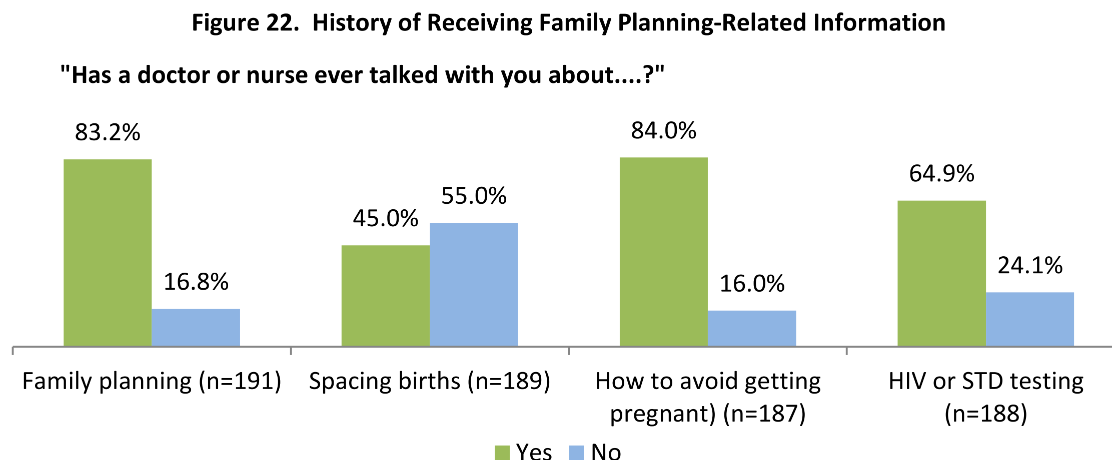


[86] Age-Specific Birth Rates, California, 2017, California Department of Finance population estimates.

Communication about Family Planning

While over 80% of the survey respondents recalled at least one conversation they had had with a doctor or nurse about family planning and avoiding pregnancy, fewer than half (45.0%) indicated not having any discussion with a health professional about spacing births (interestingly, almost twice the proportion of respondents completing it in Spanish did recall being told about birth spacing in the context of a family planning discussion). The proportion of respondents who had received information about HIV or STD testing was also relatively low (Figure 22).

Figure 22. History of Receiving Family Planning-Related Information



Of five ways for receiving information about family planning, "a face-to-face meeting with a health provider" was the most preferred way (in green) and "receiving printed information at a community event" the least preferred way (in blue color) as shown in the ranking in Table 13.

Looking at each of the communication methods *individually* to see their ranking, this table also shows that while 34.9% of the respondents ranked "printed material at a community event" as their least preferred way, 26.8% ranked it their *most* preferred way. Taking a look at another method, "virtual provider visits," for example, about the same proportion who ranked it most favorably ranked it least favorably (45.7% and 43.1%, respectively).

Table 13. Preferences for Receiving Information about Family Planning

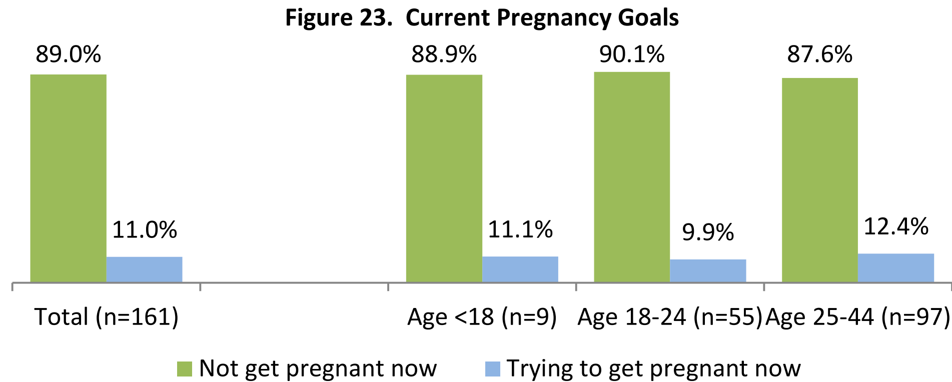
Ranking (1=most preferred) (2=least preferred)	Face-to-face with a provider	Virtual visit (video/tel.) with a provider	Use an app on a smart phone	Internet, finding it on my own	Printed material at a community event
1	**59.6%**[1]	20.5%	23.5%	22.8%	26.8%
↕	10.9%	25.2%	12.8%	12.4%	12.1%
	9.0%	10.6%	20.1%	24.8%	16.8%
	5.8%	19.9%	17.4%	15.9%	8.7%
5	14.7%	23.2%	26.2%	23.4%	**34.9%**[2]

[1]The communication method most often ranked a "1" (most preferred).
[2]The communication method most often ranked a "5" (least preferred).

Pregnancy Goals

Close to 90% of respondents reported they were currently "not trying get pregnant now." The differences by age group were very small (Figure 23), and pregnancy goals were very similar whether the individual completed the survey in English or Spanish. There were no differences between women and men who answered the question.

Figure 23. Current Pregnancy Goals



Respondents whose pregnancy goal was "not get pregnant now" were asked whether they were using a birth control method and, if not, why. As Figure 24 shows, between about 40% and 88% of the individuals with this goal—in ascending order of age—reported *not* currently using birth control. Table 14 below sheds light on some of the reasons provided by those (47 of 137) who provided a valid reason.*

Figure 24. Percent of Respondents not wanting to get Pregnant, not Currently Using Birth Control (n=137)

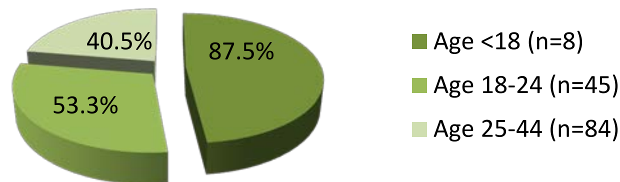


Table 14. Reasons for not Using Birth Control among Respondents whose Pregnancy Goal was "Not Get Pregnant Now" (n=47)

Reason	Age <18 (n=7) *n*	Age 18-24 (n=16) *n*	Age 25-44 (n=24) *n*
Have male/female sterilization	0	0	12
Not sexually active (now/ever)	4	12	7
Fear of/didn't like side effects	1	4	5
Fear of parents finding out	2	0	0

* Examples of "invalid" reasons excluded from the analysis included "currently pregnant" and "using condoms."

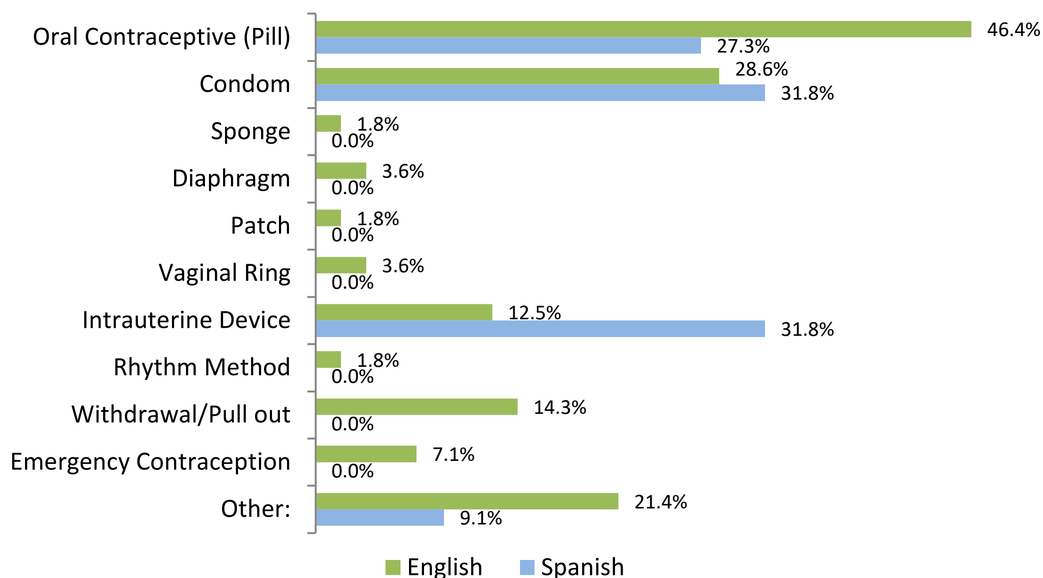
A certain amount of ambivalence, incongruity, misinformation or procrastination are evident from the comments below respondents offered for not using birth control when they claimed their goal was to not get pregnant. None of these individuals described not having knowledge or resources to act in accordance with their no-pregnancy goals.

- *"I personally don't see why I should need to use any type of birth control if it's going to mess with my body and hormones. "*
- *"Not planning for pregnancy right now but I wouldn't be against it if it happened."*
- *"I'm thinking about getting on it [making an appointment]."*
- *"At the moment I am not having any kind of relationships physically or mentally."*
- *"I can live with it" [if I get pregnant]."*
- *"Don't need it, I'm almost 45 years old [and can't get pregnant]."*
- *"I'm a male [so not applicable?]."*

Method of Birth Control

Respondents who answered their pregnancy goal was "not get pregnant now," and who said they were using a birth control method, were asked what method they were using. Similar to the most recent national data for women of childbearing age,[87] oral contraceptives were the most commonly used method, reported by 46.4% of Tulare County respondents who took the survey in English; 27.3% of those who took it in Spanish favored the pill (Figure 25). The IUD and condoms, equally at 31.8%, were most favored by individuals who completed the survey in Spanish.

Figure 25. Birth Control Method, by Survey Language Type (n=78)



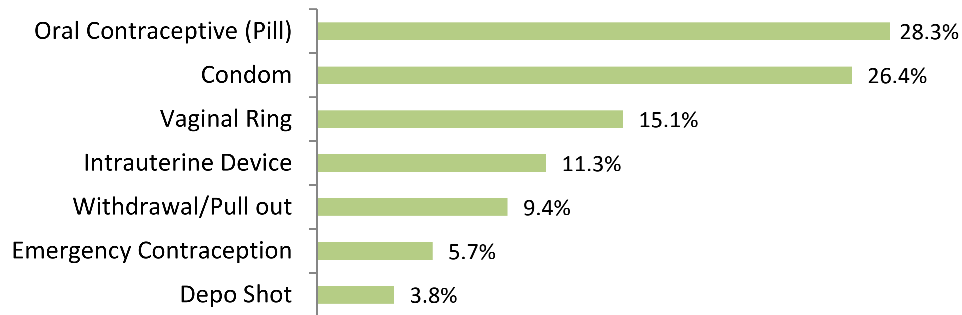
Note: Age group 45+ excluded from analysis due to small sample size

[87] Contraceptive Use in the United States. Fact Sheet. September April 2020.. Guttmacher Institute. https://www.guttmacher.org/sites/default/files/factsheet/fb_contr_use_0.pdf

The “Other” birth control methods the survey respondents reported, in order of mention, included male/female sterilization, Implant, and Depo shot.

Looking at birth control use by age group, none of those ages 18 and under reported using a method, and nearly all of the age 18-24 group relied on the pill. The breakout of the age group 25-44 (Figure 26) is varied and shows birth control methods in order of reported use.

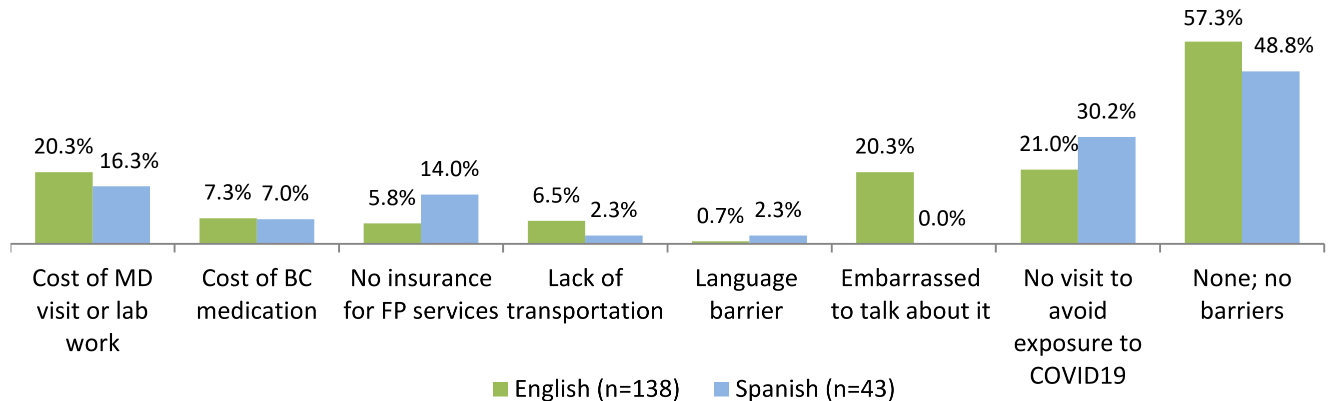
Figure 26. Birth Control Methods, by Age Group 25-44 only (n=53



Barriers

While about half (48.8%) of the Spanish language and 57.3% of the English language respondents reported not encountering any barriers when trying to access family planning services, financial considerations—the cost of visits/lab work/birth control medication/no insurance coverage—posed a hardship for one-third of both groups (Figure 27). Wanting to reduce risk to COVID kept 21.0% of English and 30.2% of Spanish language respondents from seeking family planning services during the COVID epidemic. While none of the individuals completing the survey in Spanish reported being embarrassed to talk about family planning with anyone, for 20.3% of the English respondents embarrassment was identified as a barrier. The barrier of embarrassment was most commonly reported among the youngest age group (33% age <18; 26.9% age 18-24; 7.6% age 25-44; 4.3% age 45+).

Figure 27. Barriers When Trying to Access Family Planning Services (n=181)



Note: Survey respondents could identify more than one barrier.

The Relative Importance of Family Planning-Related Concerns

The survey described five family planning-related concerns and asked respondents to rate the relative importance to themselves on a scale of 1-5. Their responses are shown by survey language type in Figures 28 (English) and 29 (Spanish). The footnote to these two bar graphs shows that some response choices may not have been applicable to all participants.

Consistent with their earlier responses, the level of concern about not getting pregnant was viewed by both groups as "very important" (56.0%/52.4%, English/Spanish, respectively)—regardless of their birth control use decisions. When it came to the importance of not getting an STD/HIV, the greatest majority (82.4% and 86.1%, English/Spanish, respectively) considered the concern "very important." About the same proportion of both language respondents, 4.5% on average, considered the STD/HIV issue as "not very important."

As a group, a higher proportion of respondents who completed the survey in Spanish and answered questions about "learning how to talk to…." viewed these issues as more important. For example, learning how to talk to their son/daughter about sex education was rated as "very important" by 88.4% of Spanish language parents but by 54.1% of the English language parents. Similarly, a higher proportion of the younger Spanish than English respondents thought learning how to talk to their parents about health relationships and sexual choices was "very important" (46.5% vs. 29.6%).

Figure 28. The Relative Importance of Family Planning-Related Concerns, English Survey (n=142)

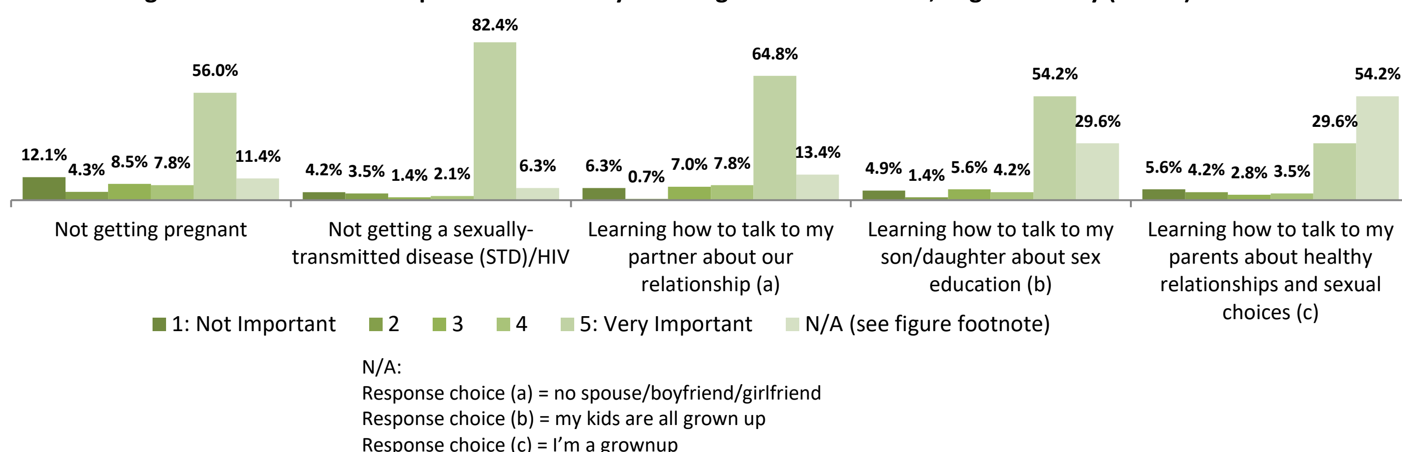
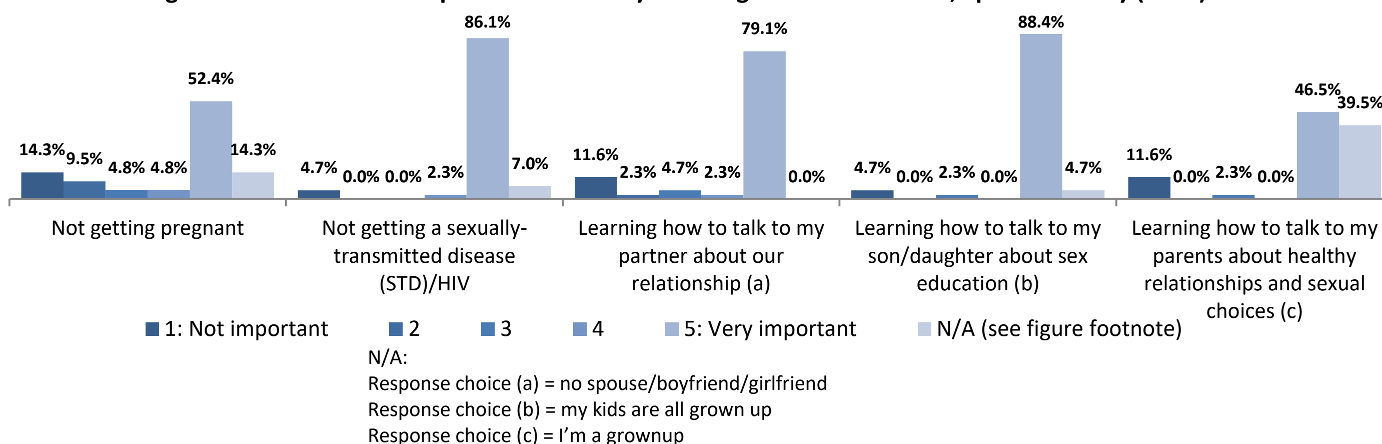


Figure 29. The Relative Importance of Family Planning-Related Concerns, Spanish Survey (n=43)



Additional Input

Just over 40% of the survey respondents wrote in comments to offer "suggestions for improving family planning services in your area." (Note: most people offered only one suggestion but a few wrote in two or more.) Their input is summarized by frequency count in Table 15 below. While the types of comments between the English- and Spanish-language surveys do not appear to be substantively different, we separated them by language type in case this information or the quantity of it may be meaningful to ALTURA and its Title X partner organizations. We deliberately included "Increase community/school education about STDs" (the last row of the table in gray text) to show that whereas this recommendation was made by six individuals in the previous needs assessment survey, no one mentioned it this time.

Table 15. Summary of Survey Respondents' Suggestions for Improving Family Planning Services in Their Area[1]

Comment	English Frequency (n=79)	Spanish Frequency (n=18)	Total (n=97)
Nothing needs to be improved/changed	11	5	16
Provide more/better/earlier sex education in schools	11	1	12
Increase awareness about where FP services are available	8	0	8
More information at public events/through flyers	8	0	8
Get MDs to ask FP-related questions; better communication skills (all staff)	6	1	7
Use more social media/TV ads/create a hotline	4	2	6
More, earlier information about FP responsibility/sexuality in general	5	1	6
Increase communication w/in families; between partners	6	0	6
Give out free condoms in multiples places	4	1	5
More access to earlier/quicker FP clinic appointments	3	1	4
Promote more male responsibility	2	1	3
Provide more information about FP in Spanish/provide interpreters	2	1	3
Create more privacy/lowered voices/discreet packaging in clinics	3	0	3
Provide more activities for teens to counteract negative influences	1	1	2
Include sex education classes in the workplace; in churches	1	1	2
Promote abstinence education more	1	1	2
Easier enrollment in insurance plans/provider choice	1	1	2
Make it clearer FP is a personal choice; let patients decide for self	2	0	2
Increase community/school education about STDs[2]	0	0	0

[1]Some respondents offered more than one suggestion.
[1]Recommendation not made by any respondents in the current survey.

The following verbatim observations and recommendations below (in some cases edited for brevity or clarity) were included to supplement the summarized comments above and offer additional insight into the community's views. While some comments appear to be directed more at the individual client level, all of them have implications for the family planning delivery system as a whole.

- *"Allow women to elect tube tying when they want without push back. If she's 'one and done' at age 20—let her be!"*
- *"We have to educate the youth on birth control; when I was younger I thought you had to be 18 or older to be on birth control so I had a child at 16."*

- *“Don’t keep patients waiting an hour in the exam room to see the doctor in a paper gown while the rooms are cold and the doctors are outside your room talking about their day.”*
- *“We need non biased doctors and staff—no racism, homophobia, transphobia, or ableism.”*
- *“Don’t judge the patient. I’ve gotten judged because I want a kid at age 18/19 so it made me not want to go see them [the provider] again.”*
- *“The cost of oral contraception is high if you are on private insurance or private pay. Having assistance other than Medi-Cal would be helpful.”*
- *“Too many agencies routinely dispatch clients to navigate or initiate securing services on their own; people need help who can’t figure it out on their own.”*
- *“Improve family planning marketing and advertising of services, variety of services offered, eligibility to all peoples, inclusive to variety of gender identities and sexualities.”*
- *“Find ways to have parents more involved to make them aware of the importance of open communication.”*
- *“Use outside instructors/experts to teach at school; teach parents about the realities of modern sexual patterns.”*
- *“Have meetings monthly during this pandemic, I feel a lot of people are becoming pregnant and getting more sexual diseases.”*
- *“Link up with different community service programs, to develop workshops and community events on this topic.”*
- *“Better advertisement of services provided to help reduce the stigma around sexual health and family planning; build better rapport with the community.”*
- *We need to be realistic with girls in Tulare County. Abortion and Plan B are not birth control and welfare is not a plan. Life happens but we shouldn't depend on these things and girls need to understand that.*
- *Improve communication with patient and provide education to me without me having to ask or request it.*
- *Train influential leaders in the community to effectively impact youth through education, peer-to-peer counselling, community programs, etc.*
- *“Get more agencies working together to prevent overserving and duplicating services.”*

Focus Groups

Characteristics of the Sample

A total of 56 mostly younger adults from Tulare County who were invited by CSET attended 4 virtual focus groups. CSET Youth Department staff also attended and helped field questions to ensure anyone who wanted to speak would have the opportunity to do so. While no one group was expected to be representative of Tulare County residents, or even necessarily the geographical areas served by ALTURA, *in the aggregate* the groups generally reflected similar characteristics of youth with family planning-related needs. Overall, as Table 16 shows, the participants were primarily Hispanic, 20-30-ish years of age, and women a little more represented than men.

Table 16. CSET Focus Group Characteristics

Primary Community	Main Characteristics	Participants
Tulare/Visalia	Most were ages 18-20; primarily Hispanic; 2 men, 2 women).	4
North County	Most were ages 20-35; primarily Hispanic; a couple were parents; a mix of staff and youth clients; 6 men, 9 women.	15
Visalia	Most were ages 20-30, with a couple 30-50; mixed ethnicity; 5 men, 11 women.	16
Tulare	Mix of ages 25-55; mixed ethnicity; 4 men, 17 women; a couple of participants invited from other organizations.	21
Total		56

The focus group participants were refreshingly candid during the discussions and many of them actively participated; several individuals asked many questions and most appeared to be comfortable verbally sharing personal stories and experiences (with some posing questions and offering comments via the chat box function).

Communication about Sexual Issues

One of the main topics discussed during the focus groups was where individuals get their information about sexual development, sex behavior, dating, and birth control. While some of the participants received the information (such that it was) from parents – mothers, predominantly – most said it was from social media and friends, and was not early enough. Despite later finding that some of the information they received was inaccurate ("full of misconceptions; anyone can post anything") others said it was "comfortable because it's private." "The talk" with parents was usually superficial (the common example was the admonition, especially in Hispanic/Catholic homes, "Don't have sex, don't come home pregnant"), and was sometimes uncomfortable whether the participant or their parent initiated it.

On the other hand, some of the participants who were parents – their children ranged in age from late adolescence to late 30s– stated they were "very open talking about these issues" while others were a little uncomfortable knowing at what age to start and what to say, though it was very clear they *wanted* to learn these skills to *become* more comfortable.

The best sex education some of the focus group members said they had came from school – primarily those who had taken a course in college, but a few in high school. They explained how important it was that the course had been offered over several months and "not just a guest speaker for a week," and stressed relationships in addition to traditional reproductive health information ("talk about the emotional not just the physical").

Further input from the participants that reflects important issues for ALTURA and other Title X providers to consider when offering community- and school-based sex education includes:

- *"Start offering sex education in middle school; don't worry about the [minority of] parents who might be opposed to it."*
- *"Offer more parents the opportunity to learn how/when to talk to their kids about sex; start with classes for parents of young kids."*
- *"Be honest about issues like gender identify/fluidity; it exists and everyone needs to feel comfortable about it."*
- *"Stress to parents that they need to create a safe environment for their kids to be able to ask questions—so they won't feel reluctant or shy about it."*
- *"Boys get left out [of sex education] sometimes and they are the ones that really need to understand that 'it takes two.'"*
- *"You grow up with the stigma that 'you don't talk about these things;' it leads to promiscuity."*

Barriers to the Use of Family Planning Services

While most of the focus group participants believe people they know are aware of where family planning services are offered in Tulare County, they still thought it would be helpful for the clinics, especially, to make it plainer they are an available, confidential and free resource. Even when aware, important barriers – both personal and structural – such as the following they mentioned limit young people and others' use of services that have implications for the provision of services:

- Being embarrassed or scared the doctor will tell parents if you ask for birth control.
- Experiencing discomfort when examined ("*my first exam was very uncomfortable, impersonal, for a teenager, and the communication from the doctor and how he was verbalizing everything made me extremely uncomfortable and fearful to return for services*").
- Being conflicted about being sexually active before marriage (especially in very religious homes).
- Not having a driver's license or a friend with a car who can take you to a clinic.
- Thinking parental consent is required for birth control or STD/HIV-related services.
- Not thinking you could get pregnant by relying on misinformation.
- Worrying about potential side effects of some family planning methods and not using them.
- Being afraid to ask for help.
- *Wanting* to get pregnant as a "way out" of living in your home.
- Worrying about exposure of being undocumented by receiving services.

Concerns about Sexual Health and STDs/HIV

Unlike the focus groups we met with during the previous needs assessment, the current participants, despite their relatively younger ages, did not seem overly concerned about the issue of STDs and HIV. Although they seemed well aware of the importance of "staying safe" by using condoms, the topic received minimal attention during each of the discussions even when specifically talking about areas of male/female responsibility.

Goal Orientation

Avoiding early, unintentional pregnancy by setting and working toward achieving personal life goals—for which unintended pregnancy and childbearing can be a derailment—was acknowledged as something missing in the life of numerous young people in Tulare County. Many of the participants agreed that life goals for some young people they knew, including their older sisters who'd gotten pregnant while still in high school, did not go much beyond parenthood. Cultural reasons seemed to be an important influence when homes were described as "traditional." Some of the parents in the groups, particularly those who described themselves as "being an open parent," made it clear, however, that their children's educational achievement and becoming responsible, self-sufficient adults were values *they* promoted in their homes.

Focus Groups' Recommendations for Improvement

The focus group participants offered the recommendations below for ALTURA and its Title X partners to improve family planning-related information and increase access to services in Tulare County. Although some of these suggestions have been implemented to some extent by various providers they are offered as important ways to promote improvement.

- Create a confidential texting option and ensure students and others throughout Tulare County know about it.
- Make it clear that family planning services are free and that parent consent is not required to receive services.
- Make it clear that it is safe to seek family planning services regardless of documentation status.
- Get middle schools on board with the importance of offering sex education and help them with age-appropriate materials and speakers.
- Offer or arrange to offer classes to help parents communicate more effectively with their children about sexual matters, tailoring the classes to a conservative community.
- Increase the use of mobile and school-based family planning clinics.
- Increase collaboration among agencies in Tulare County to promote awareness and consistency in delivering services.
- Provide clinic professionals and medical personnel sensitivity and communication skills trainings as it applies across diverse age groups.

Key Informant Interviews

Seventeen of the 20 key informants identified by ALTURA Centers for Health responded to an email invitation to participate in an interview. The interviews were conducted by telephone and generally lasted about 45 minutes. The key informants, who represented a cross-section of Tulare County as well as a focus on the cities of Tulare and Woodville, included health and human service professionals, community- and faith-based organization representatives, school personnel, and other individuals with an informed perspective about the Tulare County population and its needs related to reproductive health services (See Attachment 1). While most of the interviewees spoke to the issues they knew best from their professional roles, many also shared personal experiences, speaking from that perspective as well.

It is of interest to note that while none of the key informants from our previous family planning needs assessment was re-interviewed, the views, experiences and recommendations of the current key informants was totally consistent with the perspectives of the previous group of individuals. The consistency helps emphasize the value and continuing importance of the following input.

Highest Unmet Need

The need for more preventive education—timely, age-appropriate, accurate and *realistic*—was by far the most commonly identified unmet need in the county relative to family planning (Table 17). The key informants' numerous comments about the importance of this issue were primarily directed to middle- and high-school-age students because of Tulare County's high teen pregnancy rate (which virtually all interviewees said they were aware of ("everyone knows this"). While everyone agreed "schools should be doing a better job of providing this," over half of the individuals remarked that the lack of parent responsibility for talking to their children about sexual matters was because of discomfort with the subject or denial that their child could be sexually active. The majority of the individuals—especially those who worked with teen mothers—believed that "families put too much emphasis on abstinence ('*just don't have sex*') and this is unrealistic." (These opinions were corroborated by the youth during their focus groups.)

Table 17. Five Highest Unmet Needs for Family Planning Identified by Key Informants, Rank Order (n=17)

Need	Frequency of Mention
Preventive sex education for adolescents/pre-teens	16
Education/support for parents (as their child's first teacher)	11
Greater access to services (both urban and rural)	5
Someone in Tulare County to take this [teen pregnancy] on as an issue	4
More Medi-Cal providers/more continuity of providers at the health centers	4

For those who had the most direct knowledge about school-based sex education curricula and programing, opinions were mixed about the quality and quantity. Two or three of the 17 interviewees thought the efforts were "acceptable," while the others were either unsure or felt the programs were "inadequate." The latter group offered as examples a contracted nurse coming in to do sex education classes one week a year; a boys' coach talking to the boys and a girls' coach/PE teacher talking to the girls (regardless of the coach's comfort level or preparation); and using primarily films in place of discussion groups.

It was apparent in these conversations that some key informants felt "teen pregnancy is always going to remain a big problem in Tulare County," as if they were resigned to this. Their reasons ranged from "because it's just part of the culture" to "the burden continues to rest mostly on the female," to "no one [among professionals] is willing to step up, say 'enough is enough' and take a leadership role."

Additional comments that reflect these and other perspectives about family planning needs include the following:

- "*Sometimes it just takes one adult who believes in a kid to make a positive impact in their life."*
- *"Schools focus so much on benchmarks and quotas they sometimes forget about relationships with students and helping them to learn how to develop as a person."*
- "*Girls, it seems, have so few life goals, aren't long-range in their thinking, have few women role models/mentors in their lives to support a different path from even their own mothers and grandmothers."*
- *"We* tell *students about condoms, but we don't always* demonstrate *it to them but just assume they will know how [to use it]; even the clinic education about this isn't always consistent."*
- *"Honest conversations are missing; no one is willing to talk to the kids."*

Awareness of Family Planning Services

While about two-thirds of the key informants agreed that "most people know where they can go to get family planning services," others commented that provider websites were sometimes confusing and didn't make clear that family planning was an offered service (similar to what we concluded). Several people remarked that lack of transportation was the main reason people didn't seek the services or use them consistently. A couple of people thought "living in survival mode" prevented some couples from thinking in the longer-term when trying to avoid a pregnancy. One individual said client motivation and poor follow-up was part of the issue—some teens saying, "I was going to go but I just didn't get around to it"—some of whom returned to the program with a repeat unintended pregnancy. Expanded clinic sites, including mobile and school-based services, more weekend hours and increased, targeted messaging, in urban as well as rural communities, were said to be needed to increase awareness and expand access.

Male Involvement

Many of the key informants volunteered the opinion that more messaging, education and other resources were needed for young men, and needed early on. The lack of positive male role models (or any male figures in the home) was acknowledged to be part of the problem of "guys not stepping up and getting on board with these issues." The following observations with implications for serving teen fathers were shared by two direct service providers:

- *"Some teen dads say, 'I didn't have a father so I want to be a father to my baby. Once the baby is born, though, reality sets in and they split because it's too hard. Some even say, 'she's [the girl] better off without me. We've got to do a better job offering fatherhood classes/support."*
- *"So many men are raising other people's children [blended families] and some of these dads aren't even stepping up to talk to their own kids, especially their sons."*

Identified Barriers and Other Challenges

Structural barriers like delivery system issues, individual barriers like personal beliefs, and the influence of cultural norms were cited as the main challenges for successful family planning. The majority of the key informants attributed most problems as related to "the conservative nature of Tulare County." This was described as "schools not wanting to offend parents" to "providers not wanting to rock the boat" to "families not wanting to go against the church." Table 18 explains these comments more fully.

Table 18. Main Barriers Related to Family Planning Identified by Key Informants*

Influence	Perspective
Cultural/Peer	▪ Lack of belief that unintended/teen pregnancy is "a bad thing" ("*not that many negative consequences anymore*"). ▪ Cultural tolerance or acceptability of early/unintended pregnancy in the Hispanic culture; though more conservative, may be less "distressful" to these families. ▪ Multigenerational problem: teen pregnancy "*not such a big deal*" because mom or older sister also bore children when teenaged/when unmarried. ▪ Some families don't have high educational expectations for their daughters ("*They expect them to become wives and mothers and stay home*"). ▪ Teens' own values and expectations: some wanting a baby ("*I want to give my baby the love my mother/father didn't give me;" "All my friends have babies, I'm the only one who doesn't;" "It's OK because I can get money once I have a baby and can take care of myself")*. ▪ The attitude of *"That's just their culture. Who am I to put my cultural beliefs on them?"*
Political/System	▪ *"Are people willing to take this [teen birth rate] on as an issue? I don't think so. People are too complacent."* ▪ *"Public Health is the core place from which policy change needs to occur if we really want to tackle the teen birth problem; they can bring people to the table."* ▪ *"Sometimes, even when the kid has an STD and you're trying to reach them at school the school will not make it easy or put 'bureaucracy' in the way; you've just got to be persistent."* ▪ "*Some school administrators listen to the vocal minority of parents/ community and are too cautious to do a good job of providing it [comprehensive sex education]—but don't want anyone else coming in to offer it either."* ▪ "*We make pregnancy the way out for the teen who is sick of school and wants to drop out or wants independence from their family—that's when benefits become available. What if it was the other way around*?"

	- *"Doctors don't ever talk about family planning unless you ask."* - *"More workers of color/better gender and ethnic representation make people more comfortable in seeking services."*
Religion	- "*Many Hispanic and Southeast Asian families are Catholic but this doesn't mean their kids don't engage in early sexual behavior—though they may think it will keep them from doing so*." - *"In some families religion is mostly a cultural thing, not really in practice, but it's still there [as an influence].*
Family and Other	- Many parents don't feel "properly educated" to approach the subject so avoid it altogether. - *"Some families depend on the teen mom's cash grant assistance or disability benefits [e.g., even falsely claiming that a child is born drug exposed] as part of their own financial support*." - Kids get their education from friends or "weird" websites; much is misinformation. - *"When the teen mom goes to live with the boy's parents, watch out: the 'mother-in-law' will pressure her to have a repeat pregnancy (about one-third will) so the baby won't grow up without a sibling."* - Parents working (one or more jobs) so kids are not being supervised after school. - *"Families have to be broken to be able to get [be eligible for] services; what kind of screwed up public policy is this?"*

*Italicized words or phrases in quotation marks are verbatim remarks.

Additional comments and perceptions that help shed light on areas that could be addressed by ALTURA and its partners with improvement strategies included:

- *"If you don't have a healthy regard for yourself (at any age), and aren't forward thinking, how can you make good decisions for your life? That's where the need is: self-esteem strategies to create healthy relationships."*
- *"Providers don't really take the time to talk to you about 'issues;' they just say 'what method do you want?' and that's it."*
- *"Across the board [ethnically], teens just live on a whole different dynamic than we [adults] do and that's where you need to go if you're really going to reach them.*"
- *"Some kids tell the preschool/schools that they used drugs when pregnant—or are coached by family members of other ways of suggesting disability—so their child will be eligible to receive SSDI that the whole family can use."*

- *"Sex education classes may even save a life: some adult clients have said it wasn't until that class in school that they realized they were being [sexually] abused."*
- *"Parents' own relationships are often fractured/dysfunctional, making it a problem to talk about healthy relationships.*"
- *Some of these young women [programs are working with] have never even seen anyone in their family actually get up and go to work in the morning, so it's a new concept to have to think about how to become a responsible worker."*
- *"Build a community where people feel empowered to take charge of their own lives; give them resources and knowledge and help them do things for themselves."*

Opportunities for Improvement

The key informants were asked to think about Tulare County as a whole and the communities served by ALTURA in particular, and identify recommendations for improving reproductive health and family planning services to address the issues they had identified. Their suggestions are summarized in Table 20 below. Note that some of the recommendations are not mutually exclusive and support for one could positively impact another. Some are relatively low-cost strategies that could be undertaken even with limited dollars and good coordination and effective collaboration, while other improvements could require policy change, more public/private cooperation and increased funding if, as one key informant stated, *"There is the political will to do so*."

Table 20. Priority Improvement Recommendations Offered by Key Informants (n=13)

Community Oriented
▪ "*Title X funds get lost in the clinic; need to use it for more community-based efforts*." ▪ "*ALTURA should make presentations to every school board as part of their community presentations, highlighting the importance of family planning as an issue."* ▪ Embed family planning messages in all kinds of programs that reach women, families and young people. ▪ Assign only people who are comfortable talking about reproductive health issues to provide community and school education. ▪ Include more outreach and emphasis on males ("*more programs aimed at young dads*"). ▪ Increase family planning services at school-based clinics. ▪ Expand access in *urban* areas ("*the FRCs do a good job of getting services to people in rural areas*") ▪ Use more non-traditional approaches to sex education; be frank; make it more "real" for adolescents and young adults. ▪ Some information/messaging still need to be "old school" because access to the internet is spotty in some Tulare County rural areas. ▪ Integrate human sexuality/family planning in non-traditional places, starting early such as with young parents because they tend to come to the school when they're kids are young, and parents of Head Start children because they're required to attend certain classes/meetings like this.

Policy Oriented

- In ALTURA community presentations explain how people can *get* the services, not just tell people that the organization has OB-GYN providers and what they offer.
- Identify and provide support for a "champion" to take a leadership role in the teen pregnancy issue ("*someone needs to say 'enough is enough' and take a stand*").
- Need a coordinated approach to whatever strategies are being implemented ("*all schools have to be on board*").
- Establish a multidisciplinary Coalition or Task Force with a long-term commitment to change ("*the problem [teen pregnancy] belongs to all of us; enough is enough*").
- Engage business and other community leaders from various cultures to engage in the issues ("*everyone in the community has a stake in the issues—e.g., stress the economic impact from lost opportunities associated with early childbearing*"); engage more of the faith-based community (*"as long as the messaging is realistic and not a 'just don't have sex' approach*").
- Partner with agencies like United Way for messaging to create more awareness ("*ALTURA is good at this*").
- Look for youth leadership opportunities and create ways for teens to talk to teens (e.g., peer group strategies).

*Italicized words or phrases in quotation marks are verbatim remarks.

SUMMARY

“There is a desperate need for male role models. Boys are not taught why they’re supposed to be responsible; girls are too accepting of this.“ – Key Informant Interviewee

Our recommendations, based on the following summary conclusions, are offered in recognition that Altura Centers for Health works in collaboration with local partner organizations, particularly other Title X grantees; it may wish to implement some of these suggestions individually and some collaboratively.

An understanding of how to improve the delivery of reproductive health services in Tulare County has the potential to increase consistent contraceptive use and reduce high rates of unintended pregnancy. The recommendations of the community—through surveys, focus groups and interviews presented in the previous section—that emphasized the need for more timely preventive education and support services for young people and their parents make these goals clear.

- Although teen pregnancy rates *are* declining, the gap between the local and state rate hasn’t significantly changed in the last decade. The county’s adolescent birth rate ranks second worst among California counties. Nearly everyone we interacted with was aware of this.

- In general, reducing teen pregnancy as a public health issue appears not to be a top priority in Tulare County (even before COVID-19). It is also not necessarily viewed by everyone as problematical, even among some of the professionals who were interviewed for this study. The reasons range from responsibility (“it’s a family matter/the schools should take care of it”) to cultural (“that’s not uncommon among Hispanic families”) to tolerance (“it’s just the way it is here”) to resignation (“it’s just not been anybody’s priority”).

    - *Establishing a multidisciplinary countywide coalition or task force dedicated to the issue of addressing the county’s inordinately high teen pregnancy rate is overdue, as we pointed out previously. This would be an important step for the Tulare County Title X grantees and their partners and stakeholder groups to take if this problem is going to be adequately addressed.*

- Avoiding early, unintentional pregnancy by working toward achievement of personal goals for which childbearing is a derailment seems to be a far-off concept for many young people, as validated by many of the key informants who serve teens. The idea of goal setting as a “family planning” concept is a new notion for some.

    - *We would encourage Title X grantees’ community education efforts– in addition to the school-based sex education classes that are offered – to more fully integrate this concept into curricula and other materials, i.e., impress young teens how having and trying to reach life goals beyond parenthood fit into a person’s life.*

- Most of the healthcare organizations’ websites do not make availability of family planning services clear enough, so that one has to click through multiple “pages” to infer about what is offered.

    - *Update websites to make family planning services clearer. Create or revise an existing simple family planning resource list (English and Spanish), keep it updated, and widely promote awareness through social media outlets, and particularly the high school campuses.*

- Planned Parenthood was referenced by several people during the community input sessions as a resource for clients, but when asked no one had actually tried to recently access their appointment-making; they were surprised to learn how challenging it is to actually make an appointment there now (only by phone, as required). The time on hold, when we called (twice) was at least 1.5 hours each time, though we gave up before anyone ever answered.[*]

    - *It would be helpful for someone to try to get a hold of a local PP representative (no one knew who to contact when we asked) to see if the access problem could be addressed; or, at least for local organizations to check out actual availability before making referrals so that potential clients aren't discouraged from seeking family planning services there.*

- The concept of birth spacing as part of a family planning or postpartum visit, or at least people's recollection of a discussion about it, is not occurring often enough. Fewer than half (down from two-thirds in the previous survey) of the survey respondents recalled such a discussion with a health professional.

    - *Not including the issue of birth spacing in conversations about family planning is a missed opportunity to set reproductive health in the context of good maternal health. Pregnancies that start less than 18 months after birth are associated with adverse maternal and child health outcomes,[88] as was discussed above and, as also noted above, inter-pregnancy intervals are shorter for Tulare County women than for women statewide. Provider training to ensure this concept is part of counseling seems important.*

- The 3-year case rate of chlamydia for the county was again slightly higher than the statewide rate (gonorrhea and syphilis were lower than that of chlamydia), and trend data suggest it continues to rise. Given what seemed to be little attention to STDs by focus group participants and no recommendations related to STDs by any of the community survey respondents we wonder whether the issue may need to be more highlighted in future community and client education efforts.

- Some community survey respondents who reported their pregnancy goal was "not get pregnant now" reported not using a birth control method—yet did not indicate they were sexually abstinent or depended on male/female sterilization as a method; this at-risk cohort group would be among the most important for providers (especially MDs/NPs during exams) to raise questions about contraceptive method use.

    - *Recall from the CHIS results that while at least half of the adult women said they had received birth control information or counseling from their doctor more than 90% of men and teens had not. Recall too that focus group members and Family Planning Survey respondents said the way to improve family planning services in Tulare County was "Get MDs to ask FP-related questions." Even though providers are often rushed and have limited time in the exam room, training to encourage initiating even a brief mention of family planning seems necessary.*

- Some type of financial challenge—the cost of visits/lab work/birth control medication/no insurance coverage—was reported to be a barrier for one-third of the survey respondents.

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[*] See also page 25 regarding no response from PP local clinic, parent organization, or national PP to our voice messages.

[88] DeFranco EA, Seske LM, Greenberg JM, Muglia LJ. Influence of interpregnancy interval on neonatal morbidity. *Am J Obstet Gynecol.* 2015 Mar;212(3):386.e1-9.

- *It is possible some of these individuals did not know that Family PACT/Title X services could be accessed for free. As the focus group participants recommended, ALTURA and its partners should stress this point more when making people aware of local family planning resources.*

- School connectedness, like alcohol and drug use, is a marker for sexual behavior. A number of the 9th and 11th grade respondents to the California Healthy Kids Survey in the ALTURA service area schools reported feeling not cared about or listened to.

    - *While this finding is really more of a responsibility of these schools, we encourage Title X providers who offer school-based sex education classes or community-based youth sex education efforts to take this finding into account.*

- Most of the youth focus group participants, regardless of gender or ethnicity, shared that they did not received the type of sex education they wish they'd had from parents or could not approach their parents/adult caregivers with "personal" questions like family planning. This is not of course unique to Tulare County, but makes the point that because of the particularly conservative nature of many local families, there is an additional "burden" for providers/professionals to create access to timely, accurate, community-based information.

    - *We think the suggestion by one of the youth focus group participants to create a confidential texting option – and widely advertise it – makes a lot of sense and should be considered.*

- There are several favorable findings since the earlier needs assessment to note. For example, the increase in the percentage of Tulare County women 40 years and older who reported a recent mammogram to CHIS is positive and suggests an increased awareness and use of mammogram screening services. The slightly higher postpartum birth control use among local than among statewide MIHA survey respondents is an encouraging sign of awareness of the importance of birth spacing.

ATTACHMENTS

"When you come from a Hispanic, Catholic home you don't get talked to about sexual health matters."
– Key Informant Interviewee (from personal experience)

Attachment 1

List of Key Informants

(In Alphabetical Order by First Name)

Name	Organization/Affiliation
Amanda Rentaria	Principal, Woodville Union School District
Andrea Kelly	Executive Director, Food Link
Brittni Ellis	Pro-Youth Heart (Woodville School)
Christina Sauceda	Senior Program Officer, First 5 Tulare
Dennis Mederos	Mayor, City of Tulare
Donnette Silva Carter	CEO, Tulare Chamber of Commerce
Dorinne Henken	Executive Director, Love in the Name of Christ
Joan Daniels	Health Center Director, College of the Sequoias
Karen Cardoza	Director, Regional YoungLives
Karen Pringle	Perinatal Services Coordinator, Tulare County Public Health
Marie Pinto	Executive Director, Pro-Youth Heart (Woodville School)
Mary Alice Escarsega-Fechner	Executive Director, CSET
Michele Eaton	Executive Director, First 5 Tulare
Mimi Shirey	School Nurse, Tulare Joint Union High School District
Stephenie Espinoza	Health Manager, Tulare County Office of Education
Teresa Spicer	Program Supervisor, Cal Fresh Healthy Living
Tricia Leslie	Director of Health Services, Tulare City School District

2021 FAMILY PLANNING COMMUNITY SURVEY

We invite you to complete this brief 6-8 minute family planning and reproductive health survey. Please also encourage your friends and acquaintances to participate. Your opinions and experiences will help us learn how we can provide better services. The survey will end on February 28, 2020. Thank you!

These 5 questions ask you to tell us about yourself:

1. What is your age group? ___ 17 and under ___ 18 – 24 ___ 25-44 ___ 45 and older
2. What is your gender? ___ Female ___ Male ___ Other
3. Are you of Hispanic/Latino(a) origin? __ Yes ____ No
4. What city/town do you live in? ____
5. What kind of health insurance do you have? ___ Medi-Cal ___ Private ___ Uninsured/self-pay ___ Other

The next set of questions asks you about your health and family planning experience:

6. Where did you go the last time you had a regular health check-up? ______________________________
7. Thinking back to just before you/your partner got pregnant with your new baby, how did you feel about becoming pregnant? [✓*ONLY 1]*

    ____ Neither I nor my partner has had a baby
    ____ I/we wanted to be pregnant at that time
    ____ I/we wanted to be pregnant sooner
    ____ I/we wanted to become pregnant later
    ____ I/we didn't want to be pregnant then or at any time in the future
    ____ I/we weren't sure what I/we wanted

8. Do you know where you can get family planning services in your area? (Such as birth control, pelvic exams and Pap smears, testing or treatment for sexually-transmitted diseases) ___ Yes ___ No
9. Where do you go for family planning services? [✓*ONLY 1]*

    ___ Private doctor
    ___ Clinic (Which one? ____)
    ___ Drug store
    ___ I don't use family planning services but I know where I could go if I wanted to
    ___ I don't use family planning services because I DON'T know where to go

10. Has a doctor or nurse ever talked with you about:

	Yes	*No*
Family planning	___	___
Spacing births	___	___
How to avoid getting pregnant	___	___
HIV or STD testing	___	___

[NOTE: Qs 11 and 12 were formatted in a skip pattern]

11. What are your pregnancy goals now? ___ Not get pregnant now ___Trying to get pregnant now [This response was skipped to Q 13]

12. If you answered "Not get pregnant now,"

    a. Are you currently using a birth control method? Yes/No

    If "No", why not?____

If "Yes," what method of birth control are you using? [*Circle all that apply*] Oral Contraceptive (Pill) Condom Sponge Diaphragm Patch Vaginal Ring Intrauterine Device Rhythm Method Withdrawl/pull out Emergency Contraception Other:___________________________

The next 3 questions ask you about any family planning concerns:

13. How important are the following concerns for you? [*On a scale of 1 – 5, circle the best number in the box below or circle N/A if the concern is not applicable*]

1 ⟵⟶ *5*

Not Important *Very Important*

						Not Applicable
a) Not getting pregnant	1	2	3	4	5	
b) Not getting a sexually-transmitted disease (STD)/HIV	1	2	3	4	5	
c) Learning how to talk to my partner about our relationship (N/A = no spouse/boyfriend/girlfriend)	1	2	3	4	5	N/A
c) Learning how to talk to my son/daughter about sex education (N/A = my kids are all grown up)	1	2	3	4	5	N/A
d) Learning how to talk to my parents about healthy relationships and sexual choices (N/A = I'm a grown up)	1	2	3	4	5	N/A

14. What barriers have you encountered when trying to access family planning services? Circle all that apply:

    a. Cost of doctor's visit or lab work
    b. Cost of contraceptive medication
    c. I don't have insurance that covers family planning services
    d. Lack of transportation

e. Language barrier (a health provider who can speak my language)
f. I'm embarrassed to talk about it with anyone
g. During the COVID19 pandemic, I don't want to go to a doctor's office, to avoid exposure to COVID19.
h. None; I don't experience any barriers when I seek family planning services.

15. In general, what is your preferred way of receiving information about family planning? *[For the 5 choices below, put them in order of preference. Write a "1" for the "Least preferred" method, a "2" for the next lowest one, all the way to a "5" for the "Most Preferred"]*

a. _____ Through a face-to-face meeting with a health provider
b. _____ Having a virtual (telephone/video) visit with my health provider
c. _____ Using an app on a smart phone
d. _____ Using my computer/finding information on my own on the Internet
e. _____ Receiving printed information at a community event …

16. Please write 1 or 2 suggestions for improving family planning services in your area:

____

____

This last section of the survey offers you a way of providing us with additional information – and our way of saying thank you for participating in this survey.

As a thank-you for participating in our survey, we are offering 5 people the chance to win $100 Amazon Gift cards! If you would like to be included in the drawing, please provide BOTH your name and best daytime contact information below. We will notify the 5 winners the week after the survey ends (the week of March 1). Winners must claim their gift card by March 12, 2020.

Name ____

Best daytime phone number ______________________________

Email ____