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**Changes in Wellness Practices and Health Care Utilization after an
Educational Intervention for Perimenopausal Women**

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Running Head: OUTCOMES OF AN EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

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ABSTRACT

Context During the perimenopause there is a mismatch between women's needs for information and decisional support and the ability of outpatient care to meet these needs. Group educational programs are one possible solution, but little is known about the effectiveness of such programs.

Objective To evaluate the effectiveness of a multimedia educational program specifically designed for perimenopausal women.

Design, Setting, and Participants Women attending the program at 6 locations in the East and Midwest between Fall, 1998, and Spring, 2000 were surveyed 2 weeks and 3 months after attending the program. The program included current health information, women's values and wisdom about menopause, and peer-interactive discussions in a multimedia format. The goal of the program was to assist each participant to take an informed, proactive role in choosing menopause management options and to develop a personalized midlife wellness plan.

Main Outcome Measures The surveys measured 11 specific wellness practices and 4 health care utilization behaviors discussed in the program and asked respondents if they had changed their health care provider for menopause after attending the program.

Results The women ($N = 174$) ranged in age from 28 to 79 years ($M = 49.07$, $SD = 6.63$). Most were married/partnered (79.5%), of Caucasian ancestry (93.6%), and had a college or postgraduate education (61%) and private (51.5%) or HMO (32.8%) health insurance. They were premenopausal (31.7%), perimenopausal (38.4%), or postmenopausal (29.9%), and most were having menopausal symptoms sometimes (57.7%) or often (31.3%).

Women changed their wellness practices after attending the program ($t = 2.509$, $df 171$, $p = .013$). For health care utilization, 56% of the women had talked with their health care provider about menopause by 3 months, the largest effect size obtained for all items. They did not change their health care provider for menopause ($t = .317$, $df 150$, NS). Women who were having more symptoms of menopause were more likely to make changes in wellness practices ($F = 3.87$, $df 2$, $p = .05$). Women who were perimenopausal were more likely to talk with their health care providers ($F = 3.91$, $df 2$, $p = .05$), especially if they were having symptoms of menopause ($F = 5.98$, $df 2$, $p = .003$).

Conclusion A group educational intervention that addresses the concerns and values of perimenopausal women may be effective in changing wellness practices and supporting improved communication with health care providers.

The perimenopause is a time when women seek health care, not only to assist with the symptoms they may be having, but also to help them answer the questions they have, such as whether to start or continue hormone replacement therapy (HRT), whether alternative therapies are effective or useful, and whether lifestyle changes are advisable (Cobb, 1998; Lemaire & Lenz, 1995). At the same time, many women today are rejecting what they perceive as prescriptive care and instead seeking care they feel takes their personal values and preferences into account (Hunter et al., 1997). In today's health care environment, physician time to engage in thoughtful dialogue and provide the information and counseling women want is constrained (Kroll et al., 2000). There is a mismatch between women's needs and the ability of everyday outpatient care to meet their needs (Clinkingbeard et al., 1999; Commonwealth Fund, 2000, Randall, 1993).

To address these problems, hospital systems are offering educational programs for perimenopausal women. Only limited evidence is available, however, about the effectiveness of such programs (Wilson, 1998). The purpose of this study was to evaluate the outcomes of a nationally presented, physician-led group education program specifically designed for perimenopausal women. It was hypothesized that a program that included women's own viewpoints, addressed their values, and modeled an optimal patient-provider relationship might be particularly effective in helping perimenopausal women to understand the implications of current research for their health, make positive lifestyle changes, and engage in a more satisfying decision-making process with their physicians.

BACKGROUND

Patient education can provide the information women want and can decrease their uncertainty about menopause (LeMaire & Lenz, 1995). A variety of formats have been used, including written materials for self-education, lectures, and small group discussions.

Self-education programs. A "women's health exchange" sponsored by a pharmaceutical company used a mailed handbook and newsletters to provide education about HRT and menopause. Most information concerned topics other than HRT such as nutrition, osteoporosis, and breast cancer. Women enrolled in the exchange were more likely to continue HRT than women who were not (Motheral & Fairman, 1998). In another self-education program, an audiotope was used with an illustrated booklet about HRT to guide decision making. The booklet was designed to help women clarify their personal values about the relative importance of benefits versus risks of HRT before making a decision. The

intervention increased knowledge, decreased uncertainty, and helped women feel more supported (O'Connor et al., 1998).

Another self-education program developed a workbook that was mailed to women to aid them in discussing HRT with their health care provider. The workbook covered menopause, HRT, and risks, detection, and prevention of osteoporosis, heart disease, and breast cancer. Self-assessment inventories were provided for each topic, and case studies of women and how they made their decisions about HRT were included. From 52% to 58% of the women receiving the workbook completed one or more of the self-assessments, and 10% made appointments to discuss HRT with their health care provider. The workbook is available online at <http://www.cdc.gov/nccdphp/hrt.htm> (Newton et al., 2001).

Group educational programs. A program taught by a team of physicians and a nurse provided information about menopause and the pros and cons of HRT and discussed breast cancer, osteoporosis, and urinary incontinence. A lecture format was used, followed by questions and answers. Women attending the program had less uncertainty and more knowledge about menopause after attending the program (LeMaire & Lenz, 1995). Another group program on menopause was designed for small groups of midlife women that met over two sessions. Women who attended the program had more knowledge and fewer negative beliefs about menopause 3 and 15 months after the program than controls who did not attend the program (Liao & Hunter, 1998).

Rothert et al. (1997) compared a brochure, a lecture/demonstration series meeting over 3 sessions, and an interactive decision support series meeting over 3 sessions. The content in all formats addressed the hormonal changes of menopause, self-care strategies, HRT decision making, and how to communicate with one's health care provider. Participants learned more with either of the face-to-face series than they did reading the brochure. There were no differences between the brochure and either of the group series on decisional conflict, which decreased after the program. Satisfaction with decisions and with interactions with health care providers both increased after the program, regardless of the format. Adherence was high to exercise changes (59%), getting adequate calcium (76%), and to one's personal HRT decision (89%) after the program, regardless of the format.

Additional analyses (Kroll et al., 2000) showed that participation in the program (Rothert et al., 1997) increased self-efficacy to actively participate in health care encounters. Also, having increased self-efficacy predicted self-report of active participation in the next health care encounter as well as

satisfaction with the decision made regarding HRT (Kroll et al., 2000). Decision analytic models of the program outcomes were developed by Holmes-Rovner et al. (1999). Findings suggested that women's decisions become more consistent with decision analytic models when they can understand risks and benefits as they relate to them personally and can more accurately estimate the likelihood of alternative outcomes for themselves. Appendices following the Holmes-Rovner article provide more detail about the brochure, lecture/discussion, and decision support formats of the program.

Most of the programs reviewed focus on decision making for HRT. While these programs provide information about other health concerns at midlife, such as nutrition and exercise, few evaluations reported outcomes in these areas. Health promotion includes a broad array of activities beyond making a decision about HRT, and it is important to know if health education programs can effectively promote these activities. Additionally, despite the widespread dissatisfaction with health care that menopausal women have (Clinkingbeard et al., 1999; Commonwealth Fund, 2000, Randall, 1993), their health care utilization and specifically whether they change their health care provider as a result of these concerns has not been examined.

METHODS

Program Development

The program was developed through collaboration between a family practice physician, a health educator, and midlife community women with an interest in issues of menopause and who were willing to volunteer their time. As the initial step, focus groups of the women were held to elicit their ideas and insights. The most important finding was that the women wanted to hear women's own stories about menopause as an integral part of a program about menopause. They saw women who had been through menopause as the best source of information and understanding. Also, they said they could not figure out how to make a decision about whether to use hormone replacement therapy. They did not understand how hormone replacement could affect their future heart and bone health, even though they were hearing about it frequently in the media as being significant for their preventive care. They were concerned about the risks of breast cancer if they did use hormone replacement, but they couldn't find answers about what the risks might be for them personally. Adding to their frustrations, these women said they did not know how to approach their physicians and what questions to ask in order to resolve these concerns. These findings

OUTCOMES OF A COMMUNITY-BASED EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

were consistent with other reports of women's concerns about menopause (Griffiths, 1999; Marmmoreo et al., 1998; McVeigh, 1995).

The educational intervention resulting from this collaboration was a 3-hour multimedia program that incorporated current health information, women's stories about menopause, and peer-interactive discussions between the presenters and the audience. The program presented menopause as a natural, manageable, and potentially positive and self-renewing time.

Setting the tone for this approach, the program began with videotaped interviews of women from a variety of cultural backgrounds describing their experiences and sharing their wisdom about menopause. As the program continued, additional video vignettes of these women speaking were woven in with the other materials being presented. This established the women as the "wisdom keepers" about menopause rather than the presenters, with the information being provided by the presenters serving to amplify and explain what the women wanted to know.

Approaching the participants as adult learners and decision-makers, the presenters role played patient-provider relationships for collaborative decision making and the development of equal partnerships. The goal throughout was to create a relational environment to help women to take an informed, proactive role in choosing, using, and evaluating management options for themselves. The presenters, both of whom had experienced menopause themselves, also related their own experiences, thus further identifying the shared personal commonalties among attendees and presenters.

During the first half of the program, video and audio multimedia were used to review how menopause occurs, what symptoms women may experience, and what preventive health choices women can make during midlife. Slides were used to present research on menopause and aging and make it accessible and understandable. The slides were revised if needed between presentations of the program to provide the most current information, so that each presentation would be up to date.

The intervention content consisted of eight specific elements that were framed within the context of each woman's personal characteristics and her motivation, self-appraisal, and emotional response. These elements focused on the images and symptoms of peri/menopause, the role of hormones and hormone replacement options in overall health, diet and exercise for women's health, and complicating health problems affecting women, such as osteoporosis, heart disease, and breast cancer. The presenters also focused on communicating and working with health providers specifically to help women obtain

options not previously available to them. As natural progesterone is one hormone replacement that can significantly increase a woman's compliance because side effects are decreased, this hormone was explained in greater detail.

To explain the complexities of hormonal cycles, a woman composer was commissioned to create musical interpretations, with each hormone having its own tonal pattern. The musical interpretations of pre-, peri-, and postmenopausal hormonal patterns were then set to videos, with each hormone also having its own color. In this way, women could see and hear the harmonious regularity of premenopause, the fluctuating disruptions and changes of perimenopause, and the stable, ongoing pattern of postmenopause.

During the second half of the program, the presenters interactively with the participants outlined how to develop an individualized, self-directed, flexible wellness plan based on each woman's personal appraisal of risks versus benefits using the detailed wellness workbook provided to attendees. This plan could include midlife screening activities, development of support systems, modification of diet and exercise patterns, and decisions about whether to use hormone replacement, natural hormones, and/or alternative therapies. The pros and cons of choices were explored, with questions from the audience guiding the time spent on the topics covered. Women were also invited to stay after the program to further discuss their concerns.

Each participant received the wellness booklet to take home summarizing the program and was encouraged to follow up with her own health care provider. At each of the sites where the program was presented, a separate informational session was provided for physicians and other interested health care professionals. The physician and health educator presented the program at all sites, and all presentations were sponsored by hospitals as part of their community outreach and marketing programs.

Program Evaluation

With institutional review board approval, women attending the program at presentations in New Berlin and Milwaukee, WI; Troy, NY; Anderson, SC; Melrose, MA; and Chicago, IL between Fall, 1998, and Spring, 2000, were invited to participate in an evaluation of the program. No fees were charged by the hospitals sponsoring the program. The evaluation surveyed volunteers 2 weeks and 3 months after the program in order to track changes over time in knowledge, self-directed wellness practices, decision making, and health care utilization.

The questionnaires measured specific wellness practices (11 items; alpha reliability, .89 at 2 weeks and .76 at 3 months) and health care utilization (4 items; alpha reliability, .79 at 2 weeks and .61 at 3 months) discussed in the program. Women were also asked if they had changed their health care provider for menopause. Possible responses for all items ranged from 1 (No, don't plan to) to 4 (Yes). Data were analyzed using descriptive statistics, paired t-tests, general linear models procedures, and repeated measures analysis of variance.

RESULTS

Across the six locations, 433 of approximately 1200 women attending program presentations agreed to participate in the evaluation. Of these, 292 returned the first survey and 174 completed the study by returning both surveys. The women ranged in age from 28 to 79 years ($M = 49.07$, $SD = 6.63$), with 61% having a college or postgraduate education. The majority were married/partnered (79.5%) and of Caucasian ancestry (93.6%). Most had private health insurance (51.5%) or belonged to an HMO (32.8%) and had middle to upper total family incomes ($Mdn = \$70,000$ - $\$99,999$). Their health care providers for menopause were physicians in obstetrics/gynecology (64.7%) or family practice (25.1%). Most (79.2%) had never attended an educational program about menopause. In terms of menstrual status, 31.7% of participants were premenopausal (regular menses), 38.4% were perimenopausal (irregular menses), and 29.9% were postmenopausal (no menses for the past 12 months). Almost 90% said they were having symptoms of menopause sometimes (57.7%) or often (31.3%). There were no differences between those who only returned the first survey and those who returned both surveys in terms of education, marital status, ethnicity, type of health insurance, income, menstrual status, or menopausal symptoms.

The means and percentages of women reporting they had made changes in wellness practices such as nutrition and exercise and utilization of health care after attending the program are presented in the Table. The percentages increased over time for all items tested except for changing alternative therapies, which declined. Mean scores increased for all items except for those pertaining to alternative therapies and changing to a new health care provider for menopause, which declined.

Overall, women changed their wellness practices after attending the program ($t = 2.509$, $df 171$, $p = .013$). Their health care utilization did not change ($t = .962$, $df 156$, NS), but this was because most did not discuss natural or alternative therapies with their health care providers, which accounted for half the items measuring utilization. Indeed, 56% of the women had talked with their health care provider about

OUTCOMES OF A COMMUNITY-BASED EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

menopause by 3 months, which was the largest effect size obtained for all items surveyed. Women did not change their health care provider for menopause after attending the program ($t = .317, df 150, NS$).

The frequency of menopausal symptoms predicted adopting a new wellness practice after the program ($F = 3.87, df 2, p = .05$). Women who were having more symptoms were more likely to make changes in wellness practices. Both menopausal status ($F = 3.91, df 2, p = .05$) and menopausal symptoms ($F = 5.98, df 2, p = .003$) were predictors of health care utilization after the program. Women who were perimenopausal were more likely to talk with their physicians, especially if they were having symptoms.

DISCUSSION

The perimenopause is a time when women are actively seeking health information, particularly if they are experiencing menopausal symptoms. When such information is framed in terms of supporting women to take informed, proactive role in choosing, using, and evaluating management options for themselves, they appear to be open to making lifestyle changes and adhering to them, as others have also found (Rothert et al., 1997). The intervention promotes values emerging in women's health today, including wellness, the totality of the woman's experience, the woman as an adult learner and decision maker, and the collaborative relationship between the woman and her health care provider (Cohen, 1998; McBride & McBride, 1981; Rodriguez-Trias, 1992; Woods, 1985).

A contribution of this study is its analysis of specific practices and behaviors as outcomes of the educational intervention. Most notably, the program clearly encouraged women to talk with their physicians about menopause (56%) and hormone replacement therapy (47%) rather than change their health care provider for menopause (9%). We believe these outcomes in part reflect the program, which coached women in developing partnering, collaborative relationships for menopause management with their physicians and provided the same for physicians in separate informational sessions.

After attending the program, women made changes in diet (41%) and vitamins and/or minerals (49%), a finding consistent with other research (Rothert et al., 1997). These may be easier changes to make than some other wellness practices discussed in the program. To a lesser extent, the women did change exercise practices (34%), made 1 or more decisions about HRT (21-38%), and/or started a "noticing calendar" (25%). Of interest were the declining mean values over the three months of follow-up in starting or changing alternative therapies or in discussing these therapies with health care providers. Despite attention to alternative therapies prevalent in the media at the time, the study participants may have decided not to use them.

Limitations of this study include the reliance on volunteers, who may have been more interested in changing their health behaviors than those who did not volunteer. Also, the increases in percentages of women reporting new wellness practices between 2 weeks and 3 months after the program may indicate that adopting new health behaviors takes time. However, women who did adopt new practices may have been more likely to answer the second questionnaire 3 months after the program.

Although the content of the program and the women who shared their stories on videotape were multicultural, the audiences were not. The sample was homogeneous, predominately consisting of well-educated, middle class Caucasian women targeted by hospital marketing campaigns. Programs of this type need to be available for other populations of midlife women. In addition to hospital-sponsored presentations, the program has been presented in inner-city Milwaukee churches and community centers for some time and does attract minority and low-income women who might not be reached otherwise. An in-depth multimedia program about menopause is appropriate for all women during midlife.

Involving women in decision-making, clearly explaining risks and benefits, and helping women to develop a personalized regimen as this program did is consistent with the recommendations of the North American Menopause Society (1998). Group education provided in an appealing multimedia format in the setting of a relational, supportive environment may be an appropriate and cost-effective way to begin this process. A multimedia approach enables many kinds of learners and reaches multiple intelligences (Kornhaber & Gardner, 1991). While delivering group education may be a new role for physicians, it represents an opportunity for health leadership and enhanced visibility in a new paradigm of providing care.

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Program Information: For more information about the educational program "Setting the Course: Passages through Menopause" contact Healthhavens@wi.rr.com or www.healthhavens.com

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OUTCOMES OF A COMMUNITY-BASED EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

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OUTCOMES OF A COMMUNITY-BASED EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

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OUTCOMES OF A COMMUNITY-BASED EDUCATIONAL PROGRAM FOR PERIMENOPAUSAL WOMEN

TABLE. Means* and Percentages \perp for Adoption of New Wellness Practices and Changes in Health Care Utilization in 174 Women after Attending a Community-Based Educational Program about Menopause

	2 Weeks M (%)	3 Months M (%)
New wellness practices		
Started a "noticing calendar"	2.27 (10.3)	2.46 (25.3)
Changed diet	2.77 (26.2)	2.88 (40.6)
Changed vitamins and/or minerals	2.71 (27.1)	2.82 (48.9)
Changed kind of exercise	2.55 (16.5)	2.69 (34.1)
Changed amount of exercise	2.64 (18.0)	2.83 (34.1)
Started alternative therapies	1.90 (8.1)	1.80 (12.5)
Changed alternative therapies	1.73 (3.9)	1.44 (3.4)
Decided about starting hormones	2.15 (10.4)	2.25 (22.6)
Decided about continuing hormones	2.16 (13.4)	2.27 (27.6)
Paid attention to hormone side effects	2.47 (23.9)	2.60 (38.5)
Had hormone levels checked	2.40 (9.2)	2.48 (21.3)
Health care utilization behaviors		
Discussed menopause with provider	3.10 (26.0)	3.47 (56.1)
Discussed hormone therapy with provider	2.88 (23.1)	3.18 (46.9)
Discussed natural hormones with provider	2.68 (12.7)	2.55 (19.8)
Discussed alternative therapies with provider	2.61 (13.1)	2.35 (17.1)
Changed to a new health care provider	1.52 (4.9)	1.49 (8.8)

* Possible range of scores: 1 (No, don't plan to) to 4 (Yes). Women also had the option of recording "No, Was Already Doing," in which case the response was not counted as a change occurring after attending the program.

\perp Percentage reporting that they had made the change.