

One Tiny Reason to Quit

An Innovation Station Best Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	Virginia	Title V/MCH Block Grant Measures Addressed NPM # 14.1: Percent of women who smoke during pregnancy
Category:	Best	
Date Submitted:	5/2019	

Practice Description

One Tiny Reason to Quit (OTRTQ) is a social marketing campaign designed to prompt pregnant African American smokers to call 1-800-QUITNOW, a free, evidence-based smoking cessation counseling line. OTRTQ (a) was mounted twice in Richmond, VA (in 2009 and 2011), (b) significantly increased quitline calls from the target audience both times, and (c) was replicated in 2018 in Louisiana where other racial/ethnic groups and media channels were added.

Purpose

Infant mortality (IM) in the U.S. IM is a critical indicator of the overall health status of a community. Despite advances in research and healthcare, the United States ranks 26th in IM among developed nations (CDC, 2014), with a national IM rate of 5.8 per 1,000 live births (CDC, 2017). Even more striking is the fact that the national IM rate among African American women is more than double that of whites.

Negative birth outcomes associated with smoking. Smoking during pregnancy is the most significant cause of low birthweight that a pregnant woman can control, and low birthweight is the 2nd leading cause of IM. Smoking during pregnancy is also related to other causes of IM, including increased risk for premature rupture of membranes, placenta previa, and preterm delivery (Andres RL & Day MC, 2000). Finally, the risk of Sudden Infant Death Syndrome (SIDS) is higher for babies of women who smoke during pregnancy (Anderson TM et al., 2019). An

estimated 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions could be achieved by eliminating maternal smoking (2001 Surgeon General's Report).

Quitlines and smoking cessation. One evidence-based smoking cessation service available to all pregnant women in the United States (via state, corporate or CDC funding) is the telephone smoking cessation "quitline" (e.g., 1800-QUITNOW). The *U.S. Public Health Service Clinical Practice Guidelines* and the *Guide to Community Preventive Services* both found quitlines to be effective in helping people to stop smoking. Quitline services include coaching and counseling by qualified and trained professionals, supplementary online and print information and self-help materials, referrals to community-based cessation programs and, in some cases, free medications such as nicotine replacement therapy (NAQC, accessed April 2019). Finally, quitline counselors have specific training and call protocols for pregnant women. **Unfortunately, smoking quitlines have been underutilized by high-risk populations, and there is a particular need to link pregnant smokers to this effective existing support.**

Promoting a quitline to pregnant smokers. *One Tiny Reason to Quit* was a community-based Social Marketing campaign originally conducted in Richmond, VA. Planned in collaboration with a local coalition, its goal was to increase calls from African American smokers to 1-800-QUITNOW. Pregnant African American cigarette smokers in 3 high risk zip codes were the primary target audience because the IM rate among blacks was 3-5 times as high as it was among whites in Richmond. Black female smokers with infants were a closely-related secondary audience.

Several kinds of formative audience research guided campaign planning. For example, both the campaign name and its creative copy were pre-tested with audience members prior to launch. *One Tiny Reason to Quit* campaign components included peer outreach, small media (e.g., flyers) and mass media (e.g., radio ads). The campaign was in the field for three months (wave 1, 2009), and then again for another three months two years later (wave 2, 2011).

Practice Foundation

The conceptual framework of *One Tiny Reason to Quit* was Social Marketing, a behavior change strategy that has had a variety of positive impacts on multiple audiences world-wide. For our purposes, one of the biggest advantages of a Social Marketing campaign was that it could reach individuals who were not already receiving medical care, as well as those already in care. Another advantage of Social Marketing is that it can be integrated with formal theories of behavior change. In our case, the *Theory of Reasoned Action* (summarized below) was brought to bear.

Arguably, it is unrealistic to expect a chemical dependency such as nicotine addiction to be overcome by a campaign message. However, a compelling message can motivate a relatively easy, 1-time behavior such as calling a quitline. After a pregnant woman makes that first call, quitline staff keep in touch with her proactively, and the resulting multi-session encounter has been shown to be effective in supporting smoking cessation. A Social Marketing campaign that increases calls from pregnant African Americans to quitlines could help decrease racial disparities in negative birth outcomes.

The Social Marketing Framework:

Social Marketing (Kotler & Andreasen, 1991) is more an approach than a formal theory. Social Marketers use commercial marketing techniques to change behavior in such a way as to foster health or other positive outcomes. To develop *One Tiny Reason to Quit*, we followed a series of planning steps outlined in a free, interactive tool called *CDCynergy Social Marketing Edition*, version 2, available at: www.orau.gov/cdcynergy. A similar list of Social Marketing planning steps and other planning aids is available online from the UK-based *National Social Marketing Centre* at www.thensmc.com.

All marketing shares a central concept: the *principle of exchange*. This is the idea that what one gets for what one gives (or gives up) must be (a) worth it from his or her perspective, and (b) a better deal than the one being offered by the *competition*. In our case, continuing to smoke was the competition; women who participated in our formative research explained to us that smoking offered a rare pleasurable break from an otherwise stressful life.

Social Marketing uses insights from *audience research* to inform *segmentation* of audience members into subgroups of individuals with similar health risks, motivations and media habits. Guided by audience research findings, an *offering* is crafted for each high-priority segment. This is essentially a promise that what they will get in return for a behavior change will be worthwhile. The offering is conveyed by means of a *marketing mix* of intervention elements that take the *4 P's* (product, price, place and promotion) into account.

The Theory of Reasoned Action:

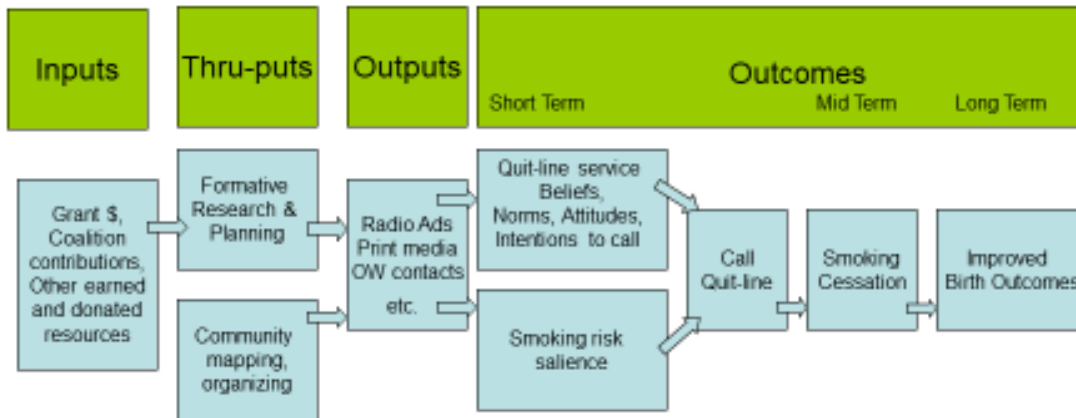
The *Theory of Reasoned Action* (Ajzen & Fishbein, 1980) guided much of our audience research. In this theory, belief-based attitudes and subjective (or injunctive) norms are the key determinants of behavioral intentions. Intentions, in turn, predict behavior.

Women from the target audience told us that "young children" and "women like me" would be the most salient normative referents (i.e., the most potentially powerful spokespersons) for an appeal to call the quitline. They also considered it pivotally important that messages assure friendly, non-judgmental help and employ a positive tone. Mass media are known to influence normative perceptions, and our audience consumed a great deal of radio, so we broadcast radio ads. They contained an appeal to quit smoking in the voice of a child, followed by the voice of a young woman who gave the quitline number and described it as a source of free, friendly help to quick smoking. Those messages were reinforced by peer outreach workers ("women like me").

Logic Model:

The schematic below shows how Social Marketing and the Theory of Reasoned Action were integrated in *One Tiny Reason to Quit*. It appears to have been a 1-way, linear process, but like strategic planning for most Social Marketing interventions, it was actually iterative. In other words, insights about the target audience or their environments that were gained as planning proceeded re-opened earlier questions and prompted reassessment of initial decisions.

One Tiny Reason to Quit Logic Model



Core Components

Core components are those essential practice elements which are observable and measurable.

To encourage pregnant smokers to call 1-800-QUITNOW, *One Tiny Reason to Quit* incorporated all six of the core components of any Social Marketing campaign (Andreasen, 2002):

1. Our goal was behavior change – not just awareness or some other precursor of behavior.
2. We conducted several kinds of audience research to (a) understand the audience, (b) pre-test messages and materials, and (c) monitor intervention components as they were rolled out.
3. We segmented the audience to use our scarce resources efficiently and effectively, understanding that "one size does not fit all."
4. We made an attractive exchange the central element of our influence strategy.
5. We used the 4 P's to craft a marketing mix of intervention elements.
6. We identified and acknowledged the appeal of the competition.

In addition, the *One Tiny Reason to Quit* campaign itself had three core elements:

7. We collaborated with community members and stakeholders throughout our planning and implementation phases.
8. We used formal behavior change theory to guide our formative research, and its results indicated that quitline call promotions should have a positive tone, and be delivered in the "voice of a child" and "a woman like me."
9. Our interventions employed both "air cover" (mass media channels) and "ground cover" (face-to-face channels).

Practice Activities

The chart below aligns many of the activities of the original *One Tiny Reason to Quit* campaign with its core components, as well as with the core components of Social Marketing more broadly. If you replicate the original campaign faithfully, it still will be necessary to copy-test the creative materials and pilot-test the intervention procedures you plan to use because audiences vary geographically and over time. If you add target audiences and/or intervention components to the original campaign, you will have to pay attention to the other core components.

Core Component	Activities	Operational Details
Behavior change focus	Debate potential behavioral objective/target audience pairs (e.g., quitting smoking/at-risk women pre-conception)	<i>CDCynergy</i> -Social Marketing version (Phase 3, Step 2): Wizard exercise. Staff and community partners rated possible audience/behavior change pairs on risk prevalence, potential health impact, feasibility of behavior change, resource feasibility and political feasibility.
Audience research	<p>Formative:</p> <ul style="list-style-type: none"> • 2 rounds of literature review • PPOR (linked birth/death certificate data) analysis • Potential audiences listed • SWOT analysis • Possible behavioral objectives ranked by local & national scientists and community partners • Focus groups • Secret shopper study <p>Pre-testing:</p> <ul style="list-style-type: none"> • Copy-test "candidate" materials for each audience segment • Revise materials on the basis of the results of the copy-testing if necessary <p>Monitoring:</p> <ul style="list-style-type: none"> • Track exposure • Solicit feedback from partners and audience members 	<p>Details about each activity are available in a case study by Sepulveda et al. (2010) entitled: <u><i>One Tiny Reason to Quit: A coalition-based smoking cessation campaign for pregnant African-American women</i></u></p> <p>The focus group guide is in an appendix of the <u><i>Operations Manual</i></u></p> <p>See the NIH/NCI publication, <i>Making Health Communications Work</i> <u>https://www.cancer.gov/publications/health-communication/pink-book.pdf</u> for advice about copy-testing of materials and messages.</p> <ul style="list-style-type: none"> • require time-stamped photos of billboards • get regular reports of "hits" on any websites included • have outreach workers submit contact cards every week • monitor stockpiles of give-away items • check in with quitline manager to see if there have been any problems • get estimates of media impressions on a periodic basis throughout the campaign from your marketing/advertising partner

		<ul style="list-style-type: none"> do small, ad-hoc surveys (e.g., mall intercept interviews) to get feedback from the target audience in time to make mid-course corrections
Audience segmentation	<ul style="list-style-type: none"> Gather information on epidemiology, audience motivation, & audience media habits Identify audience clusters that overlap on these three dimensions 	See the Operations Manual and Case Study for details.
Exchange	<ul style="list-style-type: none"> Highlight or increase the benefits of the desired behavior Lower the barriers to the desired behavior 	<p>Benefits:</p> <ul style="list-style-type: none"> Protection of the baby's health Effective, friendly support for quitting smoking Tips about alternative ways to relieve stress A little substitute treat <p>Barriers:</p> <ul style="list-style-type: none"> Physical objects with 1-800-QUITNOW on them serve as reminders Applications for free cell-phones for Medicaid-eligible women
Marketing mix of interventions shaped by the 4 P's	<ul style="list-style-type: none"> Work with in-house or contracted marketing experts to craft a marketing mix Select new media channels, if needed Provide suggestions and retain the right of final approval, but let the "creatives" be creative Strive for a consistent look and feel across channels 	<p>Most women in our audience smoked menthol cigarettes, so our branded give-aways included mint-flavored items to enhance our <i>product</i>.</p> <p>We distributed applications for cell phones that were free for Medicaid-eligible women, thus lowering the <i>price</i> of responding to the campaign message.</p> <p>We considered <i>place</i> when we ran radio ads on hip-hop radio stations that were most popular with the audience according to Arbitron data, and when we posted print posters in community venues frequented by the women we wanted to reach.</p> <p>We <i>promoted</i> key messages in the positive, hopeful tone recommended by participants in our audience research.</p>
Competition	Explore the costs and benefits of smoking from the perspective of the target audience	<p>We conducted focus groups with pregnant African American smokers, and separate focus groups with women from similar backgrounds who do not smoke.</p> <p>Then we performed a "doer/non-doer" analysis (sometimes called a positive deviance study) of the focus group themes.</p>

<p>Community collaboration</p>	<p>Make the big campaign decisions as a group.</p>	<p>As relevant research findings came in, we assembled partners to specify the target audience, behavioral objective, benefits that would be offered in exchange for the behavior, and the strategy for lowering barriers to performing the behavior and addressing the 4 P's.</p> <p>We notified quitline management that a spike in calls was anticipated during and for some time after the campaign, in case added call volume had staffing implications.</p> <p>We held a debriefing meeting with partners after the campaign ended and final exposure figures were available.</p>
<p>Positive message tone and voices of a child and a woman like me</p>	<p>Avoid blaming the pregnant smoker for risking negative birth outcomes. Emphasize calling now and the joy of having a healthy infant.</p>	<p>Messages were:</p> <ul style="list-style-type: none"> • Even if you're already pregnant, there's still time to quit smoking and give your baby a better chance at a healthy start. • Call 1-800-QUITNOW for free, friendly, helpful support in quitting smoking. • Pass along word about the quitline (and some) to a friend who needs the information. <p>Radio ads used the voice of a child to say: "Thank you, Mom, for quitting smoking and giving me a chance at a healthy start!" and a young, African American woman to give call instructions and to reassure women that the help at 1-800-QUITNOW was friendly.</p>
<p>Use media and face-to-face channels</p>	<p>Employ the channels preferred by your target audience.</p> <p>Employ channels that will help to ensure a large number of impressions per audience member.</p> <p>Build in quality control.</p>	<p>The original <i>One Tiny Reason to Quit</i> campaign used small media (brochures, flyers and branded give-away items), as well as mass media (billboards, newspaper ads, radio spots, and media "earned" by means of a press release, a press conference, and interviews with newspaper reporters).</p> <p>Local peer outreach workers attended <i>One Tiny Reason to Quit</i> training sessions that included role-playing and feedback. After training, they carried branded reminder give-away materials and a cue card to remind them to convey the three major campaign messages.</p> <p>The Louisiana replication used social media and clinic waiting room videos for the media channels, and health and social service staff for the face-to-face channel.</p>

Evidence of Effectiveness (e.g. Evaluation Data)

Evaluation Plan:

The outcome evaluation for One Tiny Reason to Quit was guided by the following questions:

1. Were there more calls to 1-800-Quitnow from pregnant smokers during the two *One Tiny Reason to Quit* campaign waves (mounted in Richmond, VA, two years apart) than:
 - a) immediately before the campaign waves?
 - b) during the same seasons as the campaigns, but in the previous years?
2. Were African American women over-represented among any excess calls from pregnant women logged?
3. Were there unintended dips in calls from pregnant or non-pregnant white women (who were not the targets of the campaign) or among men?

Evaluation methods are detailed below:

- Participant selection process: Callership was self-selected.
- Baseline values: There were just 10 pregnant quitline callers during the 3 months prior to the first wave of the campaign, and fewer than half of them were African American.
- Outcomes: Total quitline call counts from pregnant women and comparison groups, as well as numbers of unique callers (who may have received several phone counselling sessions) from the demographic groups. Calls were tallied if they were (a) from callers who were between 18 and 45 years of age, and (b) made from counties in the local broadcast range of WBTJ-FM, the radio station that ran ads.
- Data collection method: Outcome data were drawn from quitline call records that are routinely maintained by *Free & Clear*. This organization, based in Seattle, Washington, provided quitline services to Virginia residents under contract to the Virginia State Health Department. The quitline service provider had no ties to the *One Tiny Reason to Quit* project. The call data were made available for analysis by *One Tiny Reason to Quit* evaluators through a limited use agreement endorsed by the Virginia Department of Health. *Free & Clear* also provided anonymous, caller-relevant interview data.
- Data analysis methods: We compared quitline calls from pregnant women from three target area zip codes during the 3-month campaign waves with calls during periods of the same length prior to and after the campaigns. We also compared calls during each campaign wave with calls from the same season the previous year to control for seasonal variations such as resolutions to quit smoking at the beginning of a new year. Demographic data on the women were examined descriptively to make sure that the target audience was reached.
- Biases or confounding factors: The major potential biases included incomplete quitline caller interview data, and the lack of a denominator of pregnant women exposed to the campaign. We do know that there were slightly fewer than 400 African American births per month in the 7 Richmond area health districts during the period of the campaign. About 1/3 of the pregnant African American women in a convenience sample survey conducted during the campaign in a high-risk perinatal clinic waiting room reported having smoked during their pregnancies. Of the smokers (n=22), 60% reported exposure to the campaign, 77% reported quit attempts, and 86% reported quit intentions. It is important to understand that actual quitline calls are the “tip of the outcome iceberg.” Some

individuals exposed to a quitline promotion do not call but instead quit spontaneously, seek other help, or tell others to quit. In other words, quitline call data are likely biased in the direction of underestimating campaign effects.

Results:

As detailed in Kennedy et al., 2013, whether measured by total calls or unique callers, there were statistically significant spikes in calls from pregnant women during *One Tiny Reason to Quit* campaign waves 1 and 2. The campaign appeared to be very effective in reaching its high-risk target audience; calls made during the campaign came from younger pregnant women with less education than calls made prior to the campaign, and higher proportions of pregnant callers during the campaign were African American and covered by Medicaid.

The absolute number of pregnant white callers did not drop during Wave 1 of the campaign period, but the race/ethnicity distribution of pregnant callers shifted dramatically compared to pre and post campaign periods ($\chi^2 (2) = 19.22, p < .0001$). African Americans comprised 85.6% of the 28 pregnant callers during the campaign as compared to 41% of the 10 in the season before the campaign (fractional percentages due to race non-response from some callers). The proportion of African Americans among pregnant callers dropped to 27.6% of 18 pregnant callers in the post-campaign period. There was a significant increase in the total number of calls from pregnant women during Wave 1 of OTRTQ compared to the analogous season the prior year ($\chi^2 (1) = 9.88, p < .001$). By contrast, there was no year-over-year increase in calls from all callers ($\chi^2 (1) = 1.0, p > .05$). There was an even larger increase among pregnant women when the comparison period was the season immediately before the campaign ($\chi^2 (1) = 14.6, p < .0001$).

To provide confidence in the evaluation of Wave 1, we conducted a second campaign wave two years later. Wave 2 findings followed the same general pattern. Again, although the absolute number of white callers did not drop, the race/ethnicity distribution of pregnant callers shifted. Almost all (93% of 45) of the pregnant callers during Wave 2 were African American as compared to 47.9% of 14 in the three months before the campaign and 48.8% of 49 in the post campaign comparison period ($\chi^2 (2) = 15.37, p < .001$).

During Wave 2, there was a larger increase in the number of calls from pregnant women than there had been in Wave 1; there were more than five times as many calls from pregnant women during Wave 2 than from the same season in the prior year ($\chi^2 (1) = 23.98, p < .0001$). Once again, the increase in calls from pregnant women held when the comparison period was the season just before the campaign ($\chi^2 (1) = 4.1, p < .05$), and this time the spike appeared to persist into the 3-month post-campaign period ($\chi^2 (1) = 2.1, p < .05$). However, the Wave 2 rise among pregnant callers should be viewed in light of a general secular trend; calls from all callers doubled compared with the volume during the campaign season the previous year ($\chi^2 (1) = 232.44, p < .0001$).

The demographics of all unique callers to the quitline ($N = 3,487$, inclusive of pregnant women) in the six months before and during the 2011 campaign provide context for the demographics of pregnant callers. Of all quitline callers, 57% were female, 73% were daily smokers, 26.1% had not completed high school, 30.8% had a high school degree or GED, 28.1% had some college, 15% had at least a college degree, 35% were African American, and 28.6% were uninsured.

We searched diligently for rival hypotheses that could account for our results, but found none. For example, cigarette tax increases were enacted, and might have boosted calls, but the tax was levied before the pre-wave 1 comparison period.

In interviews with a convenience sample of pregnant African Americans in a hospital-based high-risk prenatal clinic (N=30), approximately two thirds of respondents reported exposure to *One Tiny Reason to Quit*. While only a couple of the women had actually called the quitline, several reported quit attempts, and quitline promotions have been shown to prompt such attempts. These non-definitive but suggestive data, combined with outreach worker reports that the women they encountered liked the give-away items and that merchants were receptive to appeals to display posters, support the claim that the campaign was responsible for the spikes we observed.

References:

Andreasen, A. (Spring 2002). Marketing Social Marketing in the Social Change Marketplace. *Journal of Public Policy & Marketing*, 21(1), 3–13.

Kennedy, M.G., Wilson-Genderson M, Sepulveda, A.L., Garland, S, Wilson, D, Singleton, R, & Dubuque, S. (2013). Spikes in calls to a smoking Quitline: Results of the *One Tiny Reason to Quit* campaign for pregnant African-American women in urban and rural settings. *Journal of Women's Health*, 22(5), 432-438. Full text available at no cost at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3653397/>

Replication

To our knowledge, *One Tiny Reason to Quit* has been replicated three times to date:

- In Richmond. Two years after the first Richmond wave (outcomes described in detail in the section above).
- In rural Southside Virginia. The quitline call pattern shifts that we observed in this sparsely populated area mirrored the Richmond patterns, but the total numbers of pregnant callers from Southside were very small before, during and after the campaign. Because peer outreach is difficult when a population is not concentrated in a geographical area, and because statistics based on very small n's are subject to over-interpretation and instability, we cannot recommend targeting sparsely populated rural areas with our original marketing mix.
- In Louisiana. In May, 2018, the *Well-Ahead Louisiana* team partnered with Louisiana's *Bureau of Family Health* to replicate *One Tiny Reason to Quit* across the state. As required by best social marketing practice, they adapted the original campaign on the basis of their local market research (audience research plus information about the lifestyles and environments of audience members). Consistent with coalition-based social marketing principles, input from their partners changed the offering substantially.

Louisiana discovered *One Tiny Reason to Quit* on CDC's MCRC online database of evidence-based programs. The contractor that maintains the database contacted Dr. May Kennedy, lead scientist of the original campaign in Richmond, several times for advice and permission to adapt the original campaign model in specific ways. Dr. Kennedy was

assured that the core elements of *One Tiny Reason to Quit* (see above) would be retained in the replication.

The Louisiana version not only promoted Quitline resources, but also linked audience members to programs of the *Bureau of Family Health*, including WIC and maternal and reproductive health programs in each Parish Health Unit (PHU). The risk profile in their state indicated that low-income women of other races also were at high risk of smoking-related birth problems, so creative copy relevant to these women was added. In addition, to save money and reflect contemporary media usage, a mostly mobile tactic was used to reach "...the desired demographic with a female skew." The media buy consisted of Pandora, web banners, and in-app mobile ads. In addition, print education pieces were produced and placed in waiting rooms, along with video for WIC clinics and PHUs to utilize. A Brief Tobacco Intervention training was provided to clinical staff at PHUs; it promoted the support that quitline companies make available online, and it transformed clinic staff into 'fax-to-quit' providers.

Digital ads had a view rate of 604,251 impressions and over 994 clicks. Louisiana's promotional radio ads played about 144 times and reached about 25,400 residents each time. These exposure data are impressive, but the advanced statistical support necessary for meaningful outcome evaluation is beyond the scope of their resources at present.

Section II: Practice Implementation

Internal Capacity

- A faithful replication of *One Tiny Reason to Quit* will require approximately 25% effort for six months on the part of a staff member or contractor. This individual will serve as project coordinator during the planning, launch and monitoring phases of the campaign. Ideally, the project coordinator would have the equivalent of a master's degree in a field such as public health or behavioral science and at least two years of professional experience. This individual should be familiar with the target population in your community. The ability to interact with partners from churches and other community organizations, and a knowledge of financial and reporting procedures within your organization are also highly desirable.
- Unless your organization has specialized media and marketing personnel in-house, media relations and buys and graphic design services should be provided by an advertising agency or marketing firm that is hired to be part of your project team. Access to Arbitron data on local radio listeners and similar proprietary databases should be a selection criterion for the choice of firm.
- To oversee the project coordinator, and to interact with senior members of community organizations that could provide in-kind support, an individual at a faculty or managerial level should allocate 5% effort during the primary project period.

- Additional time from technical staff will be needed if you add audiences or channels, or undertake outcome evaluation. If an evaluation is planned, the data analyst should be at the table for critical meetings from the earliest stages of the project.

Collaboration/Partners

Our key community partner was the *Richmond Healthy Start Initiative* (the local grantee of a national Federal program) which was part of the City of Richmond's Department of Social Services. *Healthy Start* funded nurse home visiting and other programs for high-risk pregnant women, and had built a 300-member community consortium. *Healthy Start* was part of the *Promoting Healthy Pregnancies* (PHP) coalition, which also comprised the *Virginia Department of Health* and *Virginia Premier Insurance Company*. We worked with these entities as well.

Anonymous data on quitline callers were provided to us at no cost to us by *Free & Clear*, the company that provided quitline services to Virginia under a contract with the Virginia Department of Health. The company was subsequently acquired by *Alere* which, in turn, was acquired by *Optum*.

Our community partners were integral to campaign planning. Formative research was facilitated or provided by coalition members. After we presented the research results to them, they made all of our major strategic planning decisions. These included choosing the specific behavior change sought, the exact target audience, the campaign "promise," and the major intervention components. Then, during the development and implementation phases of the campaign, key staff from *Healthy Start* and other partners had a voice in the many small decisions we had to make, such as which campaign spokesperson and radio stations to use, which graphic copy to audience-test, and which procedures for peer outreach worker recruitment and training to employ.

Community partners also provided critical instrumental support to *One Tiny Reason to Quit*. This campaign was the community outreach component of a 5-year NIH Research Center grant (P-60, Jerome Strauss, MD, Principal Investigator). The overall aim of the Center was to reduce infant mortality rates among African Americans in the City of Richmond and elsewhere. Most of the Center's resources were dedicated to basic biomedical research, leaving only about \$12,000 per year in 2009 dollars available for our campaign expenses, not counting personnel costs. With this tight budget, the in-kind support we received from the VCU health system and our partner organizations were central to our success. For example, during campaign Wave 1, 50 peer outreach workers identified by *Healthy Start* volunteered to attend a training and to deliver 3 central campaign messages and branded give-away items to pregnant smokers face-to-face in their own neighborhoods. Fortunately, in Wave 2, we were able to afford a small gift-card incentive for outreach workers.

It should be emphasized that the Richmond-based marketing firm we hired, *Neathawk, Dubuque and Packet*, went far above and beyond what it was paid to do. The promise of pro bono contributions was one of our major selection criteria for an ad agency/marketing firm. The other criteria were having conducted campaigns in the city, the appeal of a firm's previous creative work, and the willingness of its principals to use a theory-driven social marketing approach, wherein decisions are data-based.

Conversely, in terms of community resistance, we feared but did *not* experience political challenges to this smoking cessation campaign. We had been concerned because Richmond houses the international headquarters of Altria (formerly Phillip Morris Tobacco Company), a major local employer.

Practice Cost

- The estimated \$25,000 budget below summarizes most of the major costs incurred by the Richmond, VA campaign when *One Tiny Reason to Quit* was originally mounted. If you use (and re-tag with local sponsorship information) our existing creative materials, you will have only reproduction costs, not design costs. This budget omits staff salaries, miscellaneous campaign costs (e.g., gift card incentives for outreach workers) and evaluation costs, including formative evaluation.
- The Louisiana replication was less expensive; it relied on free electronic media to a large extent. Budget guidance for that kind of campaign may be available from the Louisiana practice contact.

Note: Media costs vary greatly across markets. Radio ad time for the Richmond campaign was bought at an annual 2-for-1 sale. Billboard display space that would have been empty otherwise was donated by a billboard company; if a commercial customer had come forward to buy the space, we would have had to surrender it. Small posters on buses and stuffers in utility bill mailings were displayed for free because our lead partner was the *Richmond Healthy Start Initiative*, a city government entity.

Budget			
Activity/Item	Brief Description	Quantity	Total
Radio air-time	30-second ad	300	\$15,000
Printed materials	Design, layout and production of posters, flyers, interior bus ads, ads in local African American newspapers, & utility bill stuffers	3,000	\$5,000
	Billboards (printing & mounting only)	10	
Samples of the branded items given away by Outreach Workers	Minty lip balm	1,500	\$5,000
	Cell-phone shaped mint tints	500	
	OW tote bags	75	
	Refrigerator magnet picture frames (for ultrasound images)	500	
Approximate Total Amount (in 2009 \$):			\$25,000

Practice Timeline

Under favorable organizational circumstances, it should be possible to accomplish most of the planning and implementation tasks involved in replicating *One Tiny Reason to Quit* in about 6 months. This estimate is based on the assumption that existing ad copy is used and re-tagged by a local sponsor, and that the campaign is in the field for 3 months.

The 1-year timeline below has been extended to accommodate preliminary conversations with stakeholders that should be held well in advance of the campaign itself. This timeline omits activities entailed in obtaining internal organizational clearance of plans and materials and in evaluating campaign outcomes.

Even before the campaign year, it would be wise to investigate local history of sales of radio advertising spots; you may wish to adjust your campaign calendar to take advantage of such sales. Also, you will probably need authorization of the campaign from managers of its organizational sponsor well before you reach out to prospective community partners in the early part of the campaign year.

Local contexts differ. Consult with your marketing/ad agency early in the campaign year to benefit from their experience with media in your area.

Contact the Louisiana practice contact for timeline information about a version of the campaign that relies primarily on social media.

Practice Timeline				
Phase	Description of Activity	Date/Timeframe	# of hours needed to complete/oversee activity	Person(s) Responsible
Planning/ Pre-implementation	Approach key community partners	Month 1	5	Campaign supervisor
	Issue a call for proposals from ad agencies/marketing firms and award contract	Month 2 -	20+	Organization sponsoring the campaign
	Use infant mortality statistics to select target audience segments and zip codes, behavioral objective, major strategy components	Month 3	20-40	State or City Health Department epidemiologist, project staff, community coalition
Implementation	Secure billboard space & radio air time	Month 4	10	Ad agency media buyer
	Test ad copy with local audience members, revise as	Months 3-6	10-15/week	Project coordinator

	needed, and have materials tagged with local sponsor information and produced			
	Recruit outreach workers (OWs) and order supplies for OWs	Months 3-5	5/week	Project coordinator and Partners
	Train OWs Create and implement a program monitoring process	Month 4 - 5	10/week	Project coordinator
	Issue Press Release Launch and Monitor Campaign Maintain contact with OWs and partners Debrief stakeholders, partners and OWs, write reports	Month 6 Months 7-9 Months 3- 9 Months 10 - 12	5 hours (much more if press conference is held) 10/week 2/week 10/week	Project coordinator, Ad Agency (partner and OW time not included)
Sustainability	Bus ads and other print materials may remain in place	Months - years after the campaign	0	--
	African-American newspaper ads may still fill empty ad space	Months – years after the campaign	0	--
	Campaign materials are probably most salient to currently pregnant women	Each new cohort of pregnant women gets campaign giveaways while supplies last	¼ per client	Agency (e.g., WIC) staff in routine contact with pregnant smokers
	Word-of-mouth from previous quitline callers to newly pregnant smokers	Unknown	0	Previous quitline callers

Resources Provided

- A detailed operations manual for *One Tiny Reason to Quit* is [here](#)
- A previously published case study (no longer available online) is [here](#)
- The campaign's creative materials, including the radio ad, are available at: <https://nccd.cdc.gov/MCRC/apps/ExploreCampaignDetails.aspx?CampaignID=215>

Lessons Learned

As Social Marketing would predict, we learned lessons about conducting a *One Tiny Reason to Quit* campaign from monitoring program outputs and exposure indicators, and from feedback from partners and women from our target audience. We did make operational refinements on the basis of this information, but some of it raised as many questions as it answered.

For example, Wave 2 of the Richmond campaign had a very simple Facebook page that received few visits during the campaign. Outreach workers said that target audience members use that media channel to network with other individuals, not with organizations. Some organizations create sham "peers" to circumvent this audience tendency, but some question the ethicality of such a practice. Future replicators should base decisions about retaining media channels or adding new ones on current insight into target audience media consumption and on ethical best practice as it evolves.

There were several examples of outreach worker feedback that were straightforward enough to spur specific revisions to the 2nd wave of the campaign. We were convinced to (a) reward every 3 outreach contacts with a small incentive, (b) eliminate heavy refrigerator magnets as give-away items, and (c) provide branded give-aways to staff in health department perinatal clinics for distribution to their pregnant clients.

Luckily, outreach workers also pointed out (just before print materials went to press) that "1-800-QUITNOW" could create confusion. It is a "phone name" that assumes a traditional rotary phone array (e.g., 2 = a, b, or c; 3 = d, e, or f, and so forth). Most smart phones now have that kind of configuration, but many cell phones of the time had qwerty keyboards on which each number had its own button. This made the phone name undecipherable, so we added the phone number to the print materials.

The calendar, quitline call center record, and radio spot sales months did not coincide. Plan to maximize overlap, and time your campaign accordingly, especially if you are undertaking outcome evaluation.

Finally, some lessons we thought we had learned may now be inapplicable or invalid. For example, *One Tiny Reason to Quit* seemed to work best in densely populated urban communities -- settings where many people would be exposed to campaign billboards and outreach workers could concentrate on specific high-risk neighborhoods. Now, however, with the advent of mobile and electronic channels that can micro-target population members, the campaign could be effective and affordable in sparsely populated areas. Evaluating the 2018 statewide Louisiana OTRTQ replication would help to reassess the suitability of OTRTQ for rural areas.

Next Steps

Replications of *One Tiny Reason to Quit* are encouraged. Studies of the effects of marketing mixes that include social media and other new channels are needed to facilitate future campaign planning.

Practice Contact Information

For more information about this practice, please contact:

- **May G. Kennedy, Ph.D., M.P.H.**
404-931-9936
mgkennedy@vcu.edu
- **Susan Dubuque**
804-783-8140
sdubuque@ndp-agency.com
- **Hillary Sutton, MAC**
225-342-9291
Hillary.Sutton@la.gov