

**ONE** tiny reason to quit.

CALL 1.800.QUIT NOW  TOBACCO USER QUITLINE

Operations Manual

# One Tiny Reason to Quit Operations Manual

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# ***One Tiny Reason to Quit Operations Manual***

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## INTRODUCTION

This manual describes the contents, background and logistics of a social marketing campaign mounted to promote smoking cessation among pregnant African American women in Richmond, VA. The purpose of this manual is to help public health professionals and other service organizations replicate the *One Tiny Reason to Quit (OTRTQ)* campaign in their communities. The manual lists the core elements that we consider essential to the success of such a campaign. Additional resources (e.g., a link to an article describing the campaign's formative research in detail), sample campaign materials, and suggested action steps are provided as well.

### Acknowledgements

Both the *One Tiny Reason to Quit* campaign and its evaluation were funded primarily by Center grant #1P60MD002256-01 from the National Center on Minority Health and Health Disparities, National Institutes of Health to Dr. Jerome Strauss, Dean of the VCU School of Medicine.

The *One Tiny Reason to Quit* campaign would not have been possible without the support of a number of partner organizations. Their names and primary contributions were:

- Richmond Healthy Start Initiative  
Helped plan and execute the campaign and contributed community outreach time from staff, Community Advisory Board members, and home visiting grantees (Children's Health Involving Parents, Healthy Families, and Resource Mothers).
- Neathawk Dubuque & Packett  
Made in-kind contributions of campaign strategy consultation and creative materials design.
- Virginia Department of Health  
Contributed 1-800-QUIT-NOW business cards and authorized its cessation counseling contractor, *Free & Clear, Inc.*, to make de-identified call data available for campaign outcome evaluation.
- Richmond City Health District  
Contributed campaign consultation, staff time for outreach, and prominently displayed campaign materials in high traffic clinic waiting areas.
- Virginia Premier Health Plan  
Contributed campaign consultation and staff time for outreach.
- Lamar Advertising Company

Billboard space was donated by the Richmond office.

- GRTC Transit System  
Interior advertising space was donated on all city buses.
- VCU Tompkins-McCaw Library  
Donated project planning meeting space, literature search services of a staff medical librarian, and the time of an outreach librarian for various campaign planning activities.
- VCU Health System  
Donated newspaper and radio advertisement.
- The Richmond Free Press, The Richmond Voice, and The Richmond Times-Dispatch  
Helped get out the campaign message by writing news stories and donating ad space.

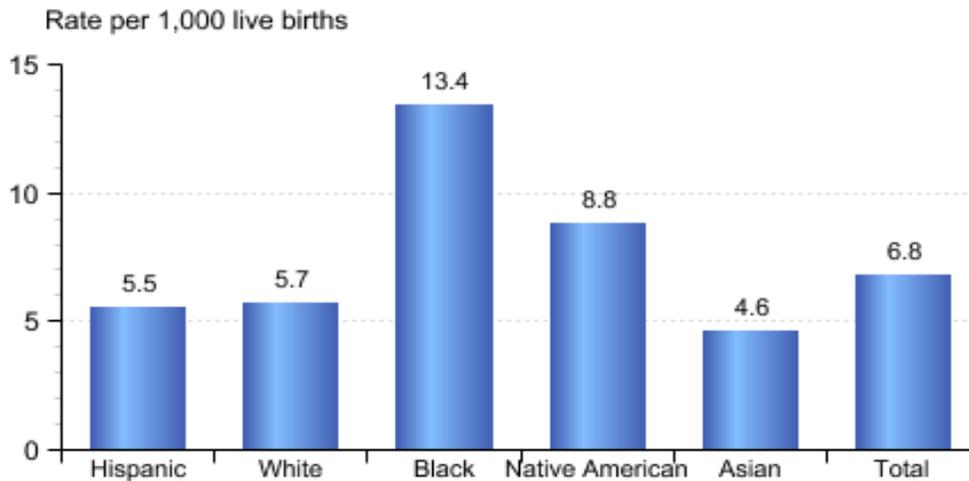
Action Step: Assemble a list of similar organizations in your community and contact them early in your planning process to ask for their help in planning and implementing a *One Tiny Reason to Quit campaign*.

## THE NEED FOR SMOKING CESSATION FOR INFANT MORTALITY PREVENTION

Infant mortality (IM) is a very serious problem in the United States. Despite scientific advances in medical treatment, the United States ranks 29<sup>th</sup> in IM among developed nations, with a national rate of 6.75 per 1,000 live births.<sup>1</sup>

Severe racial disparities compound the problem of infant mortality. During 2005-2007 (average), the infant mortality rate (per 1,000 live births) in the United States was highest for black infants (13.4), followed by Native Americans (8.8), whites (5.7), Hispanics (5.5) and Asians (4.6). Black infants (13.4) were about 3 times as likely as Asian infants (4.6) to die during the first year of life during 2005-2007.<sup>2</sup>

**Infant mortality rates by race/ethnicity: US, 2005-2007 Average**



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Leading causes of IM include congenital malformations, prematurity, low birth-weight, and Sudden Infant Death Syndrome.<sup>3</sup> *Smoking during pregnancy* has been linked to all of these conditions. Risk of SIDS is also higher for babies of women who smoke during pregnancy. It is estimated that eliminating maternal smoking could lead to a 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions.<sup>4</sup>

Action Step: To get statistics on infant mortality, smoking, and pregnancy in your community, we suggest visiting the web sites in the references above and the following web sites:

The Pregnancy Risk Assessment Monitoring System (PRAMS) [www.cdc.gov/prams/](http://www.cdc.gov/prams/)

PeriStats [www.marchofdimes.com/peristats/](http://www.marchofdimes.com/peristats/)

Community Health Status Indicators (CHSI) [www.communityhealth.hhs.gov/](http://www.communityhealth.hhs.gov/)

CDC's Behavioral Risk Factor Surveillance System (BRFSS) [www.cdc.gov/BRFSS/](http://www.cdc.gov/BRFSS/)

*\*Note:* Your state or local Department of Health may have additional relevant statistics, as well as experts in their interpretation.

## OUR SOCIAL MARKETING RESPONSE

Calling 1-800-QUIT-NOW links a smoker to smoking cessation counseling services provided by telephone (so-called “quitline” counseling). Quitline counseling follows a standard protocol and has been shown to be effective in helping people stop smoking -- as part of a multicomponent intervention, this kind of telephone support has been recommended by both the U.S. Public Health Service *Clinical Practice Guidelines*<sup>5</sup> and the *Guide to Community Preventive Services*.<sup>6</sup>

All women who call 1-800-QUIT-NOW are asked if they are pregnant. Quitline counseling for pregnant women is guided by a special protocol. Trained professional counselors continue to call the woman back after her first counseling session, mail her information and self-help materials, and refer her to community-based cessation programs if they are available.<sup>7</sup> In Virginia, quitline counseling was free for uninsured pregnant women during the period described in this manual.

When we spoke to pregnant African American women in Richmond, VA in 2008, we learned that few if any knew about 1-800-QUIT-NOW. Because quitline promotion campaigns that are positive in tone have boosted call rates among pregnant smokers,<sup>8,9</sup> we responded to the problem of smoking among pregnant women by promoting calls to 1-800-QUIT-NOW.

### Action Steps:

If the person managing the smoking quitline for your State Health Department is not already part of your planning group, be sure to call the quitline manager before you make plans to replicate OTRTQ.

You'll need to find out whether free quitline counseling is available in your state, and if so, who is eligible for it.

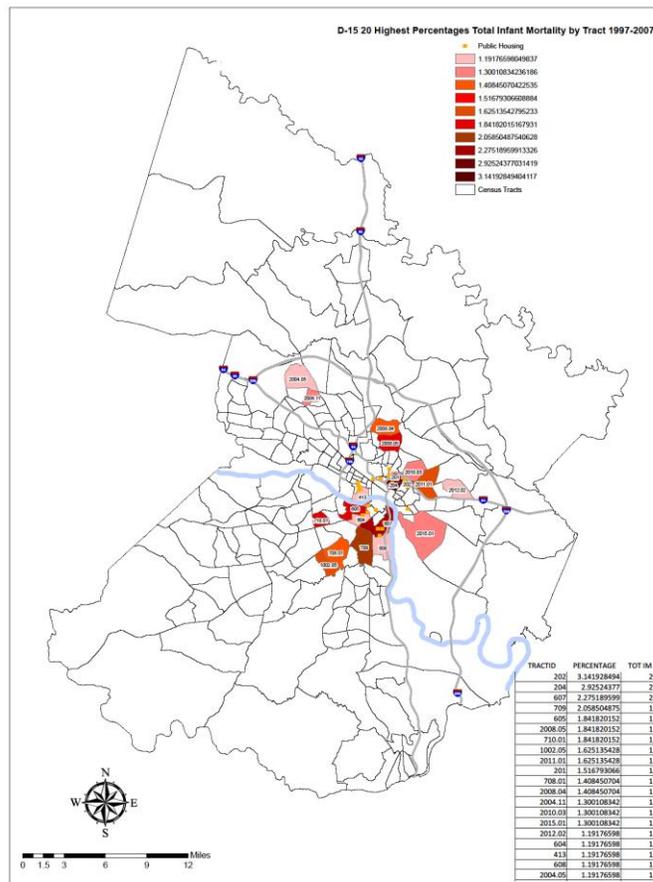
The manager can also tell you if there is sufficient counseling service *supply* to handle any increase in *demands* for the counseling brought about by your campaign.

You'll also need to know if any other quitline promotions are occurring or planned.

## INTENDED AUDIENCE

The primary intended audience for the *One Tiny Reason to Quit* campaign was pregnant, African-American women who smoke. Secondary audiences were other pregnant smokers and female African-American smokers with babies under the age of 1 year.

In Richmond, GIS data<sup>10</sup> (see map below) showed us that the cases of infant mortality over the last few years had been concentrated in specific zip codes. These geographic areas also had high concentrations of African Americans and low-income individuals. We invested most of our campaign resources in these zip codes.



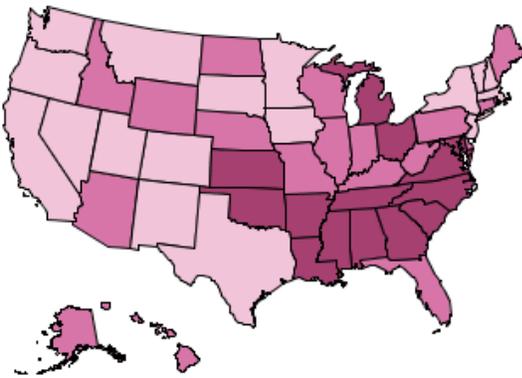
**Action Step:** Use vital statistics data to map the high risk areas in your community.

## SUITABLE SETTINGS

The most suitable settings for this campaign are communities with large African American populations and high rates of infant mortality. The campaign has also been tested and found effective in rural, sparsely populated counties. However, the ratio of dollars spent to quitline calls prompted probably declines with total population.

The purple maps below<sup>11</sup> use the most recent available data to show that rates of infant mortality and maternal smoking are higher in the eastern part of the United States. There is considerable overlap between the darkly shaded areas on these maps and the areas on the yellow map (see next page) that indicate concentrations of African Americans in the United States.

**Infant mortality rates: US, 2007**

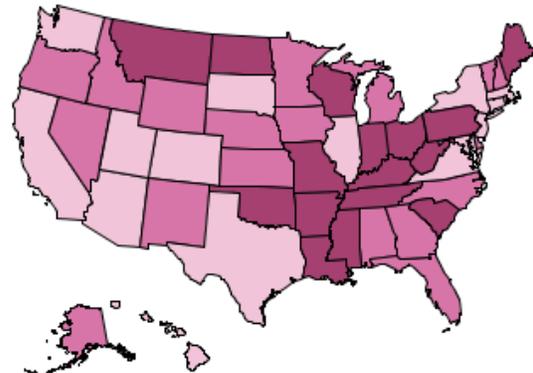


**Rate per 1,000 live births**



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**Smoking among women of childbearing age: US, 2010**



**Percent of women ages 18-44**

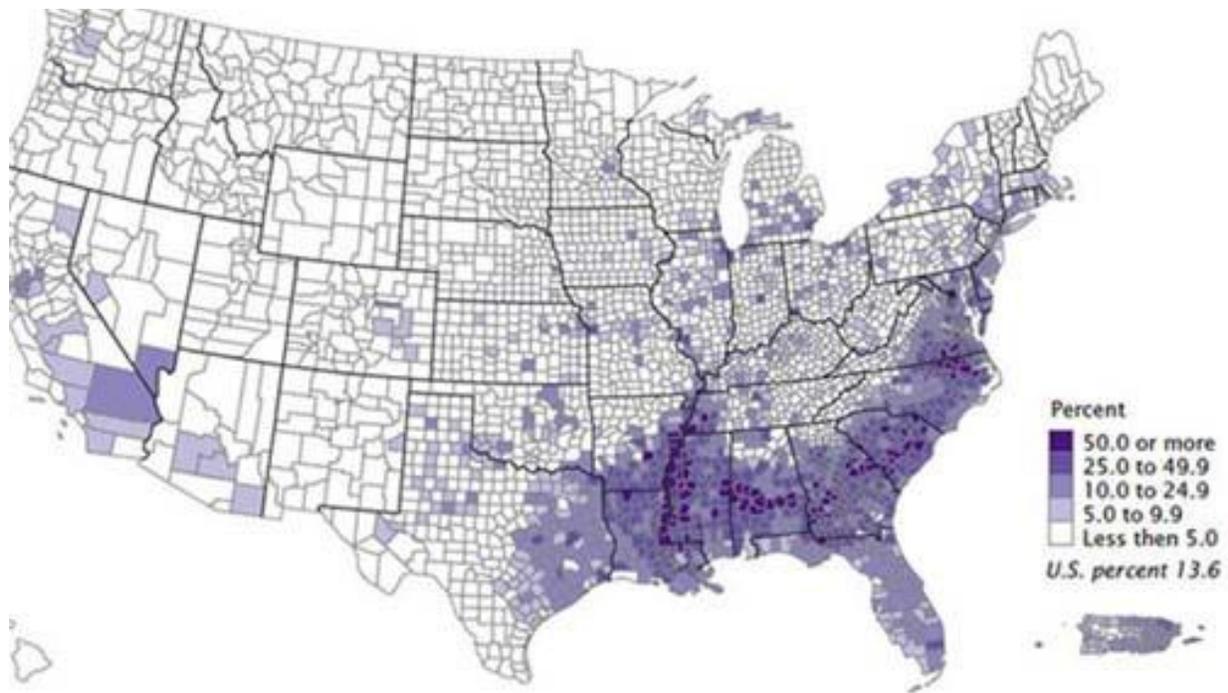


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African Americans comprise the largest racial minority in the United States, accounting for 13.6 percent of the total population in 2010. This population is concentrated largely in the southern states and urban areas.<sup>12</sup>

## United States

### AFRICAN-AMERICAN POPULATION, 2010



## OUR PROGRAM

### Program Planning History

Our program planning team averaged eight members over the project period. It included university researchers, community service providers and marketing experts. This team made day-to-day decisions about the work involved in designing, pre-testing, implementing and evaluating *One Tiny Reason to Quit*, following the steps in the *Social Marketing edition of CDCynergy*. This interactive planning tool is available for free online at: [www.orau.gov/cdcynergy/demo/](http://www.orau.gov/cdcynergy/demo/).

We involved a community advisory group when we made major strategic planning decisions. The advisory group joined a large, pre-existing infant mortality prevention coalition in supporting the project in a variety of ways. In short, our community-engaged approach was invaluable logistically, in addition to being consistent with many Community-Based Participatory Research principles.<sup>13</sup>

### Formative Research

As social marketers recommend, early planning decisions were based on formative research on the audience and its environment. Our research was guided by the Theory of Reasoned Action (see *Appendix A for a description of social marketing and Appendix B for a description of the Theory of Reasoned Action*).

It was necessary to gather several kinds of formative data (see the list below) to narrow down the campaign objective from its original infant mortality prevention charge to a specific behavior performed by a particular target audience. Eventually we arrived at calls to 1-800-QUIT-NOW from pregnant, African American women who smoke, and we were able to specify a program logic model (see *Logic Model figure, page 12*).

**We are not recommending duplication of the formative research studies** described below. Rather, the multiple data-gathering steps we took are listed to show the kinds of data we collected or obtained to inform planning decisions made over a two year period.

The types of formative research that guided our planning included the following:

- Literature Review
  - Reviewed publications on health behaviors related to infant mortality risk
- Linked birth-death certificate data
  - Examined a Perinatal Periods of Risk (PPOR) analysis of local fetal-infant deaths<sup>14</sup>
- Key Informant/Community partner surveys
  - Rank ordered nine behavioral campaign focus alternatives

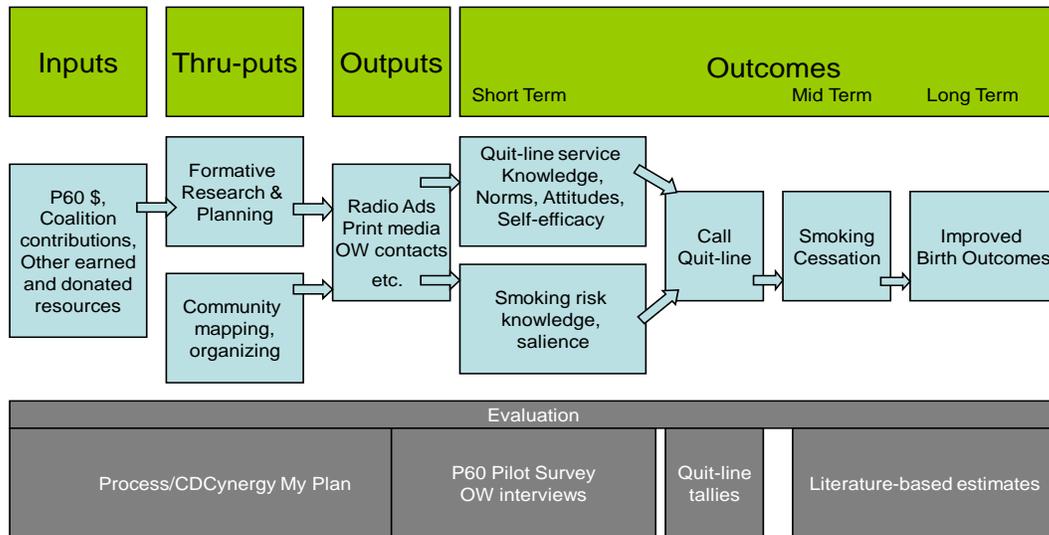
- Local smoking rates survey data  
Accessed previously collected local data to confirm the need for smoking cessation services among pregnant women
- Telephone interviews with national experts  
Interviewed smoking prevention and cessation experts to gain insight on promising interventions
- Focus groups  
Conducted focus groups with target audience members to inform development and selection of campaign elements (*see Appendix C for focus group moderator guide*)
- Secret Shopper  
A project intern posed as a pregnant woman and attempted to access all known available smoking cessation resources (both locally and the toll free quitline) to assess availability and accessibility
- Concept test surveys  
Target audience members were surveyed and asked to rate message concepts (*see Appendix D for survey*)

**For additional details on the formative research, please visit**

**[www.casesjournal.org/volume4summer](http://www.casesjournal.org/volume4summer)**

Action Step: Conduct your own local copy testing in your community to make sure the messages and ads resonate with your target audience.

# Logic Model



Draft 11/05/08

Planning decisions made after this model was developed pertained to the campaign’s tone, marketing mix, and creative copy.

## Program Structure

### Core Elements

Ultimately we took a *multi-channel* approach, in which program components reinforced each other. Your formative research and situation may lead you to decide to add or subtract one or more program components. However, from our perspective, the 3 core program elements – the things that define OTRTQ campaigns – are:

Core Element #1: Consistency with the original, theory-based formative research

- Messages maintain a positive tone (e.g., good help is available, it’s not too late to quit)<sup>1</sup>
- Spokespersons are the “voice of a child” or a “woman like me”<sup>2</sup>

<sup>1</sup> To engender positive attitudes towards quitline counseling because attitudes are a key predictor of health behaviors according to the Theory of Reasoned Action

<sup>2</sup> To employ the messengers (or “salient referents”) that would attract the woman’s attention and influence her, because use of such messengers to influence norms is consistent with the Theory of Reasoned Action

#### Core Element #2: Multiple channel approach

- Combination of media and face-to-face outreach efforts, to include radio, print and trained outreach workers channels

#### Core Element #3: Cultural Targeting

- Reaching out to women in high risk geographies
- Utilizing outreach workers who are familiar with (or part of) the community
- Pre-testing any new materials developed with members of the target audience for clarity, salience and appeal

In addition, lowering barriers like we did in providing SafeLink applications (see Barriers, page 20), are a core element of social marketing.

#### Media

- Radio ads
  - Aired on a contemporary, urban station that Arbitron data showed most popular with the target audience. The local advertising firm we worked with had access to these data.
  - The copyrighted ad is available for specific public health uses without royalty fees (*see Appendix E for the radio ad script*).
- Print materials (*see Appendix F for examples*)
  - Billboards
    - placed in areas of high visibility for the target audience
  - Posters
    - distributed by outreach workers and through a mass mailing
    - displayed in venues the target audience was likely to frequent (e.g., Laundromats, housing developments, community centers, grocery and corner stores, hair and nail salons, etc.)
  - Bus ads
    - interior placard advertisements placed inside every city bus
  - Give-away items or “small media”
    - distributed by outreach workers as a tangible reminder of the campaign
  - Brochure
    - “10 Best Reasons not to Smoke while You’re Pregnant” available for purchase from Journeyworks publishing:  
<http://www.journeyworks.com/Ten-Best-Reasons-Not-to-Smoke-While-Youre-Pregnant/productinfo/5069/>
    - distributed by outreach workers

Action Step: For purposes of replicating the *One Tiny Reason to Quit* campaign, PDFs of existing print materials and the audio file of the produced radio spot are available from Neathawk Dubuque & Packett (ND&P) Advertising Agency. There will be no charge for e-mailing these files electronically in their original formats. ND&P is able to make size adjustments and other modifications of the existing artwork (e.g., local sponsor tagging). The labor entailed in any such modification will be billed at cost.

To obtain these materials and/or to commission modifications, please contact Susan Dubuque at [sdubuque@ndp-agency.com](mailto:sdubuque@ndp-agency.com))

## Face-to-Face Outreach

### *Sources and background*

We found it most effective to partner with existing organizations already working with the target audience when recruiting Outreach Workers (OWs) for the campaign. For example:

- local Healthy Start organization and/or Healthy Start funded programs,
- community organizations serving pregnant AA women such as the Special Supplemental Program for Women, Infants, and Children (WIC) or social services,
- local health department staff,
- community volunteers,
- professional outreach workers,
- health educators,
- local service providers and physician offices serving pregnant women and children

### *Training*

- Once the OWs have been identified, a training session will be necessary. At the training, a description of the program and its goals is given, and the role of the OW is explained (*see Appendix G for training session outline and materials*). There are three main messages that the OWs are asked to communicate:
  1. It's not too late to quit smoking and give your baby the best chance at a healthy start.
  2. Free, effective help is available to you. (Give info for quitline)
  3. Tell a friend.

### *Incentives*

- If budgets allow, it can be reinforcing to offer an incentive program for the OWs. Some ideas for an incentive program might include a gift card to a local store such as Target or Wal-Mart for every [predetermined] number of contacts made.

## *Management*

- **Team Captains**

We utilized a team captain approach for communication with the OWs. For instance, one OW would volunteer to be the point of contact for a specific group of OWs. The OWs would contact their team captain when they needed to reorder supplies and the program director would then communicate directly with the team captains. Of course, all the OWs were given the program director's contact information in case any problems arose.

- **Tracking Contacts**

For monitoring and accountability purposes, it is important to track the number of members of the target audience contacted by OWs. It is better to get regular updates than just the total number of OW contacts at the end of the project. With timely feedback, the program director can take steps to solve any problems that come to light.

In the initial campaign, we established a tracking system (*see Appendix G for sample tracking card*) that required OWs to fill out and mail in a tracking card for every 3 contacts made. These cards were then entered into a weekly drawing for a gift card. We learned that many OWs supplied incomplete tracking data when the reporting mechanism was rigid and the reporting incentive uncertain.

For the second campaign, we simply asked the OWs to report their contacts to the program director in whichever way was most convenient (e.g., email, phone, or mail). After each periodic report, all the OWs that had made contacts were mailed gift cards in exchange for their participation. This proved more effective than the tracking card/drawing system and we would recommend this method if the budget allows.

## **Program Launch**

### Press Conference

To launch the campaign, we held a press conference in partnership with our local Healthy Start Initiative. We hand-delivered special boxed invitations to the handful of local reporters that specialize in health issues (*see Appendix H for press release, media invitations, and press conference agenda*). On the day of the press conference, we issued a traditional press release about the campaign, and remarks were made by the Dean of the VCU Medical School and PI of

the parent Center grant, the State Health Commissioner, the City Health Director, the local Healthy Start director, and key project leadership (see photo below).

To facilitate media attendance and coverage, it is helpful to be aware of press deadlines. Other guidance for press conferences is available in the NIH National Cancer Institute's "Pink Book," *Making Health Communication Programs Work*.<sup>15</sup> It is available for free at <http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/page1>.



**Photo of press conference speakers.** Pictured from left to right: Jerome Strauss, M.D., Dean, VCU School of Medicine; Rose Stith-Singleton, M.S., Project Director, Richmond Healthy Start Initiative; Donald Stern, M.D., Richmond Area Health Director; Karen Remley, M.D., Commissioner, Virginia Department of Health; Sheryl Garland, M.H.A., Vice President, Policy and Community Relations, VCU.

Action Step: Make a representative of the target audience (perhaps someone who has used the quitline successfully) available to press to tell a compelling personal story. Combined with local and broader health statistics, a personal testimonial is a very attractive news angle for the media.

## Earned Media

Earned media is free publicity gained through promotional efforts, other than paid advertising. Examples include TV or radio coverage, newspaper articles, and letters to the editor. In our case, the press conference generated a substantial amount of earned media for the campaign, including news coverage on two of the major local TV stations, a front page article in the principal local newspaper, and articles in two free African American weekly papers (*see Appendix I for articles*).

## Time Required

The following timeline is based on the assumption that additional formative research will not be conducted, and that a coalition of organizations that serve high-risk pregnant women already exists. If a coalition must be organized, add several months or more to the beginning of the timeline.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Contact coalition partners	█																							
Inquire about annual radio ad sales					█																			
Contact media buyer, if using					█																			
Secure billboard space														█										
Secure radio air time														█										
Recruit OWs													█	█	█									
Order OW supplies															█	█								
OW Training																	█							
Press Release																		█						
Launch Campaign <sup>1</sup>																		█	█	█	█			
Maintain contact with outreach workers																		█	█	█	█			
Conduct follow up interviews with OWs																					█	█		
Conduct exposure surveys <sup>2</sup>																						█	█	
<sup>1</sup> Campaign "months" may not coincide exactly with airtime "months" so a 3-month campaign may include coverage in more than 3 months.																								
<sup>2</sup> Timing for more elaborate surveys has not been included but up to 3 months should be allowed for IRB clearance if new data specifically for this project is being collected.																								

## Resource and Budget Considerations

### Staffing for the original campaign:

We suggest allocating at least 20 – 25% effort of a full-time bachelor or master’s level staff member for at least 6 months to run the campaign. Additional staff or ad agency support will probably be needed if new channels (e.g., text messaging) or material development is planned.

### Other program costs (in 2009 dollars):

Purchased air time for radio ads 316 total ads that ran for a period of 4 months, during the last 2 weeks of each month	\$14,328
Printed materials 3,205 posters of various sizes and 10 billboards (printing only, display costs pro bono)	\$5,015
Outreach worker give-away items 1,500 lip balms, 500 mint tins, 75 tote bags, 500 magnet frames	\$4,859
Total program costs	\$24,112

### Additional recommended resources:

Media Buyer – to assist with the purchase and placement of media (e.g., billboards, bus ads, securing PSA radio ads)

Local Healthy Start association – to assist with the identification of community outreach workers to deliver face-to-face messages. To find a local Healthy Start chapter, visit

[www.nationalhealthystart.org](http://www.nationalhealthystart.org)

## Barriers

One potential barrier a woman may face when she tries to call the quitline is a lack of consistent telephone access. In an attempt to lower this barrier, the OWs were provided with a brochure and application for the SafeLink Wireless program. SafeLink was a government-funded program (available in many states) that provided a cell phone and free minutes to income-eligible applicants.

Action Step: To find out more about the SafeLink program, you can visit [www.safelinkwireless.com](http://www.safelinkwireless.com) or call 1-800-977-3768

## **ABOUT THE STUDY**

We used three kinds of low-cost or easily obtained data to assess our reach and impact. Our primary measure of program outcome was the number of quitline calls from pregnant women during the campaign period. Details on that analysis are provided below. We also conducted intercept interviews with pregnant women and debriefed the OWs after the first Richmond campaign.

Like all other states and many major companies, the Virginia Department of Health (VDH) contracts with an external vendor to provide telephone smoking cessation counseling to Virginia residents. The counselors ask a standard set of questions during each caller's initial or "registration" call to 1-800-QUIT-NOW (a number that either links directly to counseling or refers to the appropriate state quitline). De-identified data on the number of callers and their answers to standard interview questions are routinely sent to VDH. With the support of VDH, the VCU evaluator entered into a limited call data use agreement with the counseling vendor. The agreement allowed us to access our state's de-identified quitline monitoring data before, during and after our campaigns for the purpose of program evaluation.

A study proposal covering both the formative research outlined in the "Our Program" section above and the outcome evaluation described below was submitted to the VCU Institutional Review Board (IRB) for review for ethical treatment of human subjects. It was approved by the IRB on June 12, 2008.

The initial 3-month campaign was launched in mid-June 2009 in Richmond and was replicated in rural Virginia that fall. In the sparsely populated rural area, the campaign was run for six months (September 2009 – March 2010, with a hiatus during December). Two years later, *OTRTQ* was repeated for three months (January –March) in Richmond.

## **Evaluation**

### Participants

All female 1-880-QUIT-NOW callers under 46 years of age who: (1) called from zip codes reached by the hip hop radio station that broadcast the *OTRTQ* spots, and (2) said they were pregnant when asked in the 1-800-QUIT-NOW registration call. Our team statistician created the sample from the standard state file.

### Design

Each campaign period was compared to periods of equal length immediately prior to and after the campaign. In addition, to rule out seasonal effects (e.g., New Year's resolution-based increases in calls) as the real source of any apparently campaign-related call spikes, year-over-year analyses of calls were also conducted. For example, summer 2009, the first Richmond campaign summer, was compared to summer 2008.

### Measures

Because successful cessation has been linked to a multi-call series of counseling sessions,<sup>16</sup> the total number of calls from pregnant women was calculated for each time period of interest. The number of unique pregnant callers was also calculated so that demographic information on callers would be meaningful. Patterns of calls from all callers were also calculated so general trends could be compared to trends among pregnant women.

### **Key findings**

Whether measured by total calls or unique callers, there was a statistically significant spike in calls from pregnant women during *One Tiny Reason to Quit*. Over the three campaigns to date, spikes in calls have represented increases ranging from 137% - 434%. After the second Richmond campaign (which included utility bill stuffers), the spike lasted for an additional three months after the campaign ended.

*OTRTQ* also 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.

Even when there were simultaneous rises in calls from the general population, the campaign-associated spikes in calls from pregnant women did not appear to be simply a reflection of a broader trend. Compare, for example, the 137% increase in calls from pregnant women during the first Richmond campaign to a 2% increase among all callers during the same period.

In the clinic interview sample (N=30), approximately two thirds of the women reported exposure to *One Tiny Reason to Quit*. While only a handful of the women had actually called the quitline, several reported quit attempts. This was not surprising; other quitline promotions have been shown to prompt such attempts.<sup>17</sup>

We debriefed the OWs at a “campaign wrap” brunch party. They reported that the women they encountered really liked the give-away items – especially the branded, cell phone-shaped tins of mints -- and that merchants were receptive to appeals to display smaller posters that took up relatively little display space. The volunteers also felt that future campaigns should expand the target audience to women with children less than one year of age.

A formal cost-effectiveness analysis was beyond the scope of our evaluation. However, using national estimates of costs for neonatal intensive care for premature infants as a point of comparison, we believe that the campaign would save health care dollars in geographic areas that have high rates of infant mortality and large African American populations.

Finally, we saw organization-level benefits of *OTRTQ*. For example, planning team and advisory board members acquired competency in social marketing, and Neathawk Dubuque & Packett, our ad agency (which can arrange for the re-sizing, tag-lining, printing and delivery of campaign materials) won multiple professional awards (see page 24).

## PUBLICATIONS

Sepulveda A; Wilson D; Garland S; Dubuque S; Singleton R; Kennedy M. One Tiny Reason to Quit: A Coalition-based Smoking Cessation Campaign for Pregnant African American Women. *Cases in Public Health Communication & Marketing*. 2010; 4: 28-56. Available from: [www.casesjournal.org/volume4summer](http://www.casesjournal.org/volume4summer)

Garland, S. (February 2011). *One Tiny Reason to Quit: A Coalition-Based Smoking Cessation Campaign for Pregnant African-American Women*. *The Safety Net Online*, a publication of the National Association of Public Hospitals and Health Systems. Available from: <http://www.naph.org/Homepage-Sections/Explore/Innovations/Heart-Health/VCU-Health-System.aspx>

### **Awards won by Neathawk Dubuque & Packett**

Healthcare Marketing Awards:

Virginia Society for Healthcare Marketing & Public Relations

- Gold Award for Community Partnership
- Merit Award for Public Relations

27<sup>th</sup> Annual Healthcare Marketing Awards

- 2 Golds, 2 Silvers, 1 Best in Show

Service Industry Advertising Awards

- Silver

Communicator Awards

- 4 Awards of Distinction for poster, newspaper ad, and integrated service

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## Appendix A: Social Marketing

Social marketing uses marketing techniques to influence the voluntary behavior of target audience members for health benefit. It is distinct from health education in that it goes beyond informing or persuading people to reinforcing behavior with incentives and other benefits. It also differs from commercial marketing because the people who gain from it are members of the target audience. Another difference is that the marketing organization defines success in terms of positive effects on society.

Social marketing is not a theory, but an approach to promoting health behavior.

Alan Andreason defines it as “the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of society.” This process creates a *voluntary exchange* between a marketing organization and members of a target audience based on mutual fulfillment of self-interest. In other words, the marketing organization exists to fulfill its mission (as defined by the organization’s leadership), and the target audience members act in their own interests.

Social marketing programs are generally “consumer-driven,” not expert-driven. They are targeted to serve a defined group of people. To avoid delineating the target market in an overly broad manner, social marketing practitioners *segment* a larger, heterogeneous target market into smaller subgroups. *Market segmentation* is the process of dividing a target audience into these more homogenous subgroups with distinct, unifying characteristics and needs. For example, factors such as regional location, ethnicity, gender, exercise habits, readiness for change, or media habits could be used to segment the larger audience of “smokers.” Social marketing seeks to identify patterns that distinguish one target group from another to effectively target marketing strategies.

The social marketing process involves identifying an effective “marketing mix” (“The four Ps”) of product, price, place, and promotion. The optimal marketing mix produces a timely exchange that heightens benefits, reduces barriers, and offers a better choice than the competition. The social marketer explores what benefits are of most interest to target market members and develops strategies and methods accordingly.

The four Ps of the marketing mix are:

- *Product* (the right kind of behavioral change) includes not only the behavior that is being promoted, but also the benefits that go along with it.
- *Price* (an exchange of benefits and costs) refers to barriers or costs involved in adopting the behavior (e.g., money, time, effort).
- *Place* (making new behaviors easy to do) is about making the “product” accessible and convenient. It means delivering benefits in the right place at the right time.
- *Promotion* (delivering the message to the audience) is how the practitioner notifies the target market of the product, as well as its benefits, reasonable cost, and convenience.

Ideally, social marketing interventions begin with *formative research* (also called audience or consumer research) to understand the target market's perceptions, needs, and wants concerning the health behavior. Formative research includes learning about consumers' current behavior, what enables it, and what reinforces it. Practitioners also conduct a second type of research, *competitive analysis* (also called environmental analysis), to learn about the environment in which members of the target market are making behavior decisions. This analysis examines competing behaviors that are being promoted to the target market. (For example, messages encouraging people to eat convenient, inexpensive fast foods compete with messages about eating 5 fruits and vegetables a day.) It also investigates how consumers' decisions are shaped by factors such as their social and physical surroundings or their economic situation.

Evaluation is a critical and ongoing component of social marketing programs. Formative research helps practitioners to develop and refine concepts, messages, products, services, pricing, and distribution channels before they are fully implemented. Marketers often use qualitative methods, such as focus groups or key informant interviews, to pre-test marketing concepts, messages, and materials in a cost-effective manner. They may also pilot-test materials with individuals who share characteristics of the target market in order to verify their effectiveness, identify diverse channels for delivering the message, and measure outcomes. Process evaluation methods are used to track program outputs and processes during implementation. Social marketers also conduct summative research, often in the form of outcomes monitoring. This analysis compares the program's program objectives with its immediate and long-term outcomes to determine what worked, what didn't, and whether the program was cost-effective.

Social marketing programs are most successful when they are implemented using a research-driven process; then consumer research can help to adjust program messages and outputs. The social marketing process includes four stages: planning and strategy development; development of pretesting concepts, messages, and materials; implementation; assessment of in-market effectiveness; and feedback to the first stage. Within each stage, there is a constant feedback loop between research and planning.

As an approach that promotes behavior change through voluntary exchange and positive reinforcement, social marketing borrows substantively from behavior change theory. Behavioral theory offers insights into the current behavior of target market members and what might influence or change that behavior. For example, a social marketer who references Social Cognitive Theory might examine how self-efficacy and expectations about the outcome of a behavior factor into certain health practices within a target market.

**Source:**

*Theory at a Glance: A Guide for Health Promotion Practice* (NIH Publication No. 97-3896), by the National Cancer Institute, 1995. Bethesda, MD. In the public domain.

Available from <http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf>

## Appendix B: Theory of Reasoned Action

The Theory of Planned Behavior (TPB) and the associated Theory of Reasoned Action (TRA) explore the relationship between behavior and beliefs, attitudes, and intentions. Both the TPB and the TRA assume *behavioral intention* is the most important determinant of behavior. According to these models, behavioral intention is influenced by a person's *attitude* toward performing a behavior, and by beliefs about whether individuals who are important to the person approve or disapprove of the behavior (*subjective norm*). The TPB and TRA assume all other factors (e.g., culture, the environment) operate through the models' constructs, and do not independently explain the likelihood that a person will behave a certain way. The TPB differs from the TRA in that it includes one additional construct, *perceived behavioral control*; this construct has to do with people's beliefs that they can control a particular behavior.

**Source:**

*Theory at a Glance: A Guide for Health Promotion Practice* (NIH Publication No. 97-3896), by the National Cancer Institute, 1995. Bethesda, MD. In the public domain.

Available from <http://www.cancer.gov/cancertopics/cancerlibrary/theory.pdf>

## Appendix C: Focus Group Moderator Guide

Pregnant Women Version

4/30/08

### Introduction

Good afternoon. My name is \_\_\_\_\_, and I'll be your focus group moderator today. Welcome, and thank you for participating.

A focus group is a small group discussion that focuses on a particular topic in depth. Today we'll be talking about pregnancy and health issues. I'm not an expert in the topics we'll be talking about, and I'm not here to give you information. I'm here to listen to your ideas and thoughts about the issues. It's also important for you to know that I don't usually work for the sponsors of this discussion – you should feel free to say whatever is on your mind.

There are no right or wrong answers in a focus group. In fact, you'll be using your imagination to answer some of the questions. All of your opinions matter, and I'd like to hear equally from everyone. Your thoughts are important because they are like what people who can't be here today think. Please speak up even if you disagree with someone else here. It's important to hear different points of view. And if you have questions about something, it's helpful to know what they are.

We have a lot of ground to cover, so I may skip ahead to the next topic from time to time, but feel free to stop me if you want to add anything. We'll take a short break about half way through the session.

We're audio-taping the discussion because we don't want to miss anything you say. Later, we'll go through all the comments and write a report, but this conversation is completely confidential. Some of your words may be used to get a point across, but no one's name will be connected with anything she says. And of course, if there are questions you would prefer not to answer, feel free not to respond.

My colleague \_\_\_\_\_ will be taking notes and working the tape-recorder so that we can concentrate on the discussion.

### **A. Warm Up**

- 1. I'd like to begin by having each of you tell us your first name (or the name you want to use in the group today) and something you like to do when you have a chance.**

2. **Some people like to cook with fresh ingredients when they have a chance, partly for health reasons. What are some other things that people do to try to get healthy or stay healthy?** (Probe: Not necessarily what you do, just people in general).

**B. Perceptions and Beliefs about Smoking.**

1. **I'm going to show you a picture.** (Show a black & white line drawing of a woman watching television. There is a package of cigarettes on the table.) **This woman isn't "showing" yet, but she knows she's pregnant. What is she doing? What's going through her mind?** [Probes: What kind of cigarettes are those and who do they belong to? What was she doing just before this? Was she eating or drinking something?] **What happens next? If she smoked a cigarette in this situation, what are some other situations she probably smokes in?** [Probes: When would she have the first cigarette? Describe the circumstances that make her want a cigarette the most.]
2. **A lot of women who get pregnant smoked before they got pregnant and some continue to smoke during the pregnancy. What makes them continue to smoke? What do they get out of it?** [Probes: Tell me some more about those pay-offs – benefits – from a woman's point of view.] **What makes it easy to keep smoking? What makes it more likely that a pregnant woman will smoke?** [Probes: How much does it matter if a woman's friends or family members smoke? If the guy she's seeing smokes?]
3. **What are some of the reasons pregnant women have for quitting smoking or trying to quit?** [Probes: Are they concerned about delivering too soon? Having a hard delivery? What could happen to the baby? The way smoking makes a pregnant woman feel?] **How much do pregnant women who smoke worry about health risks from smoking? What are some other things that a pregnant woman would worry about in terms of smoking – things that aren't necessarily health-related?** [The way cigarettes taste to a pregnant woman? How smoking affects the way a pregnant woman looks to other people, or what other people will think about her? The cost of cigarettes?] **What is the main reason they decide to quit?**
4. **When a woman gets pregnant, who are the people in her life who are going to have strong opinions about her smoking?** [Probes: Mother? Grandmother? Doctor or nurse? Husband or boyfriend? ] **How much attention will she pay to them? Whose opinion will matter the most to her?**

5. **How will (mention the influential person) approach the subject and what will they say? How would a pregnant woman describe the feelings of these influential people to a friend of hers?** [Probe: What words would she use?]

### ***C. Quitting smoking during pregnancy***

1. **Especially if you've been a heavy smoker, it can be really hard to quit smoking. How hard is it going to be for this woman to quit, and what will make it hard? What's the biggest thing in the way of quitting?** [Probe: What about giving up (tie in benefits listed for B2)]. **What are some things she might tell herself to justify putting off trying to quit? What are some things she might do to put off trying to quit?** [Probes: Not let anyone see her smoke? Try to eat right or exercise to make up for smoking? Just cut back during certain activities or in some situations?]
2. **How confident is this woman that she can quit when she tries to? What would make her more confident?**
3. **So now I'm going to tell you that this woman has decided to try to quit because [reflect reason(s) in B3]. Tell me about her plan to quit.** [Probe: Will she starting by cutting back or try to quit all at once? About how far along in the pregnancy will she be when she starts trying to quit? What steps will she take?]
4. **What will help her quit?** [Probes: social support (e.g., from boyfriend or husband), counseling, some kind of aid prescribed by a doctor, social stigma].

### ***D. Smoking Cessation Services*** [Do not ask of non-smokers if time is short.]

1. **It turns out that she was able to quit. Tell me about how that happened.** [Probes: Did she set a date? Succeed on the first try? Get any kind of help? Did she use anything (e.g., a nicotine replacement like the gum or the Patch)? Attend classes or a support group? Call a Quit-line for counseling? Take up some substitute activity (e.g., sucking on mints, chewing regular gum? Take anti-depressants?) **What sounds like a worthwhile service or product to help a pregnant woman who is trying to quit smoking be successful?**

2. **Tell me about any anti-smoking aids that a woman should avoid because she's pregnant, and what problems they might cause.** [Probes: patch, gum, antidepressants].
  
3. **Where around here could a pregnant woman go to get help in quitting smoking?** [Probes: Where can you find the (list the services and/or products they mentioned in D1)?] **What would make it easier and less hassle to use this service or product? Who could you ask about what kind of help is available?**

#### ***E. Information Channels***

1. **Most of the time, where do you get information about things that could affect your health? Tell me about who you go to, or what you listen to, or where you look things up?** [Probe: Someone you know, medical professional, Internet, TV, radio, newspaper, library, other] **Where are some places or people you would go if you wanted information about smoking and its impact on a pregnancy?**

[Ask E2 and E3 if time permits.]

2. **Imagine that you're sitting at your kitchen table, and the radio is on. What kind of station would it be? OK, so there's [reflect, e.g., "an urban contemporary radio station"] playing. An announcement or ad about a health service comes on between songs, and it really catches your attention. What would the ad be like?** [Probe: Who would be speaking?]
  
3. **Sometimes there are posters about health topics on buses and different places around town, and ads in free newspapers. If you actually stopped and read one, where would you be likely to be?** [Probes: Bus stop? Clinic? Store?] **Where else have you seen or heard some health information that really caught your attention? What made it stand out?**

***F. Close***

We've come to the end of our discussion. The sponsors of this focus group were the VCU Center for Health Disparities and its funder, the National Institutes of Health, the NIH. [If time permits] Are you familiar with NIH?

Do you have any other comments you'd like to make on anything we talked about?

On behalf of the sponsors of the discussion, I'd like to thank you for your time and openness. Your opinions will be very valuable to them in developing materials to help women deal with smoking and health. Please stop by the front desk on your way out. There are some informational brochures with information about tobacco and pregnancy and a little package that shows our appreciation of your participation this afternoon.

## Appendix D: Concept Test Survey

### Women's opinions on hearing about a Quitline: A brief survey

1. Are you pregnant? Yes  No
2. Have you had a baby in the past 24 months? Yes  No
3. How old are you? \_\_\_\_\_
4. Have you smoked cigarettes in the past 2 years? Yes  No

If you are pregnant or have had a baby in the last 24 months, have smoked cigarettes in the past 2 years and are at least 18 years old, please continue with this survey.

5. In which zip code do you live? \_\_\_\_\_
6. Thinking about the time you smoked during the last 2 years, would you consider yourself a heavy smoker or a light smoker? Heavy  Light
7. If you were listening to the radio and heard a commercial encouraging a pregnant woman to call 1-800-QUIT-NOW for help in quitting smoking, which voice would you be most likely to pay attention to?
  - a. The voice of a pregnant woman
  - b. A child's voice
  - c. The voice of a respected older female (like Grandma)
  - d. The voice of a female health provider
8. Which speaker would be most likely to make you think about calling the quitline?
  - a. The voice of a pregnant woman
  - b. A child's voice
  - c. The voice of a respected older female (like Grandma)
  - d. The voice of a female health provider
- 8a. Would you expect to have to pay for making the phone call? Yes  No
- 8b. Would you expect to have to pay for the telephone counseling? Yes  No
9. If you were having a face-to-face conversation with someone about calling a telephone counselor for help to quit smoking, who would be most likely to make you think about calling the quitline?
  - a. A woman in my age group
  - b. A child
  - c. An older respected female (like Grandma)
  - d. A female health provider

10. Now I'd like to ask you a few questions for each of the following messages about calling the Quitline:

a. Call the Quitline because: **Getting help to quit smoking is taking care of yourself. You can't take care of your children unless you take care of yourself.**

1. Is this message clear?  
Yes  No
2. Does it seem to be speaking to someone like you?  
Yes  No
3. Did you learn anything from this message?  
Yes  No
4. Would it encourage you to call the Quitline?  
Yes  No

b. Call the Quit-line because: **You're not just risking your own health, you're risking the health of your baby.**

1. Is this message clear?  
Yes  No
2. Does it seem to be speaking to someone like you?  
Yes  No
3. Did you learn anything from this message?  
Yes  No
4. Would it encourage you to call the Quitline?  
Yes  No

c. Call the Quit-line because: **Your child wants to live a long and healthy life and wants you to be around to be part of it.**

1. Is this message clear?  
Yes  No
2. Does it seem to be speaking to someone like you?  
Yes  No
3. Did you learn anything from this message?  
Yes  No
4. Would it encourage you to call the Quitline?  
Yes  No

d. Call the Quit-line because: **Getting the help you need is a good example for your child.**

1. Is this message clear?  
Yes  No
2. Does it seem to be speaking to someone like you?  
Yes  No
3. Did you learn anything from this message?  
Yes  No
4. Would it encourage you to call the Quitline?

Yes  No

11. Please put these messages in order, with the strongest reason to call the Quit-line on top and the weakest reason on the bottom.  
(Interviewer: Hand colored cards to respondent and have her stack them in order and hand back to you. Write down rank order at the end of this form when interview is completed)

12. Using your own words, how would you say this top message if you were speaking to a friend?  
(Interviewer: Write down respondent's answer verbatim in the space below)

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**END OF SURVEY. THANK YOU!**

Rank order messages:

Interviewer: Write the corresponding number next to each message below. 1=message on top, 7=message on bottom.

Getting help to quit smoking is taking care of yourself. You can't take care of your children unless you take care of yourself.

You're not just risking your own health; you're risking the health of your baby.

It's free and convenient.

You get a live person who really understands and phone quit counseling has worked for a lot of women.

Life is stressful, but it would be a lot harder if smoking hurt your baby.

Your child wants to live a long and healthy life and wants you to be around to be part of it.

Getting the help you need is a good example for your child.

## Appendix E: Radio ad script

5756 VCU Health Disparities

Radio "Heartbeat" ©

:30 radio

4 2 09 approved for taping and testing

(VO is child 8-11 years old, older sibling)

**SFX:** Fetal heartbeat

**VO:** Do you know what that is? It's my baby brother using the only voice he has. He's saying, "I'm really glad you quit smoking. You're giving me the chance to start life healthy and strong." My little brother is happy about that, and so am I. Thanks Mom.

**ANCR:** If you're pregnant, there's still time to get help to quit smoking. Call 1-800- QuitNow and give your baby the best chance for a healthy start.

**SFX:** Fetal heartbeat grows louder

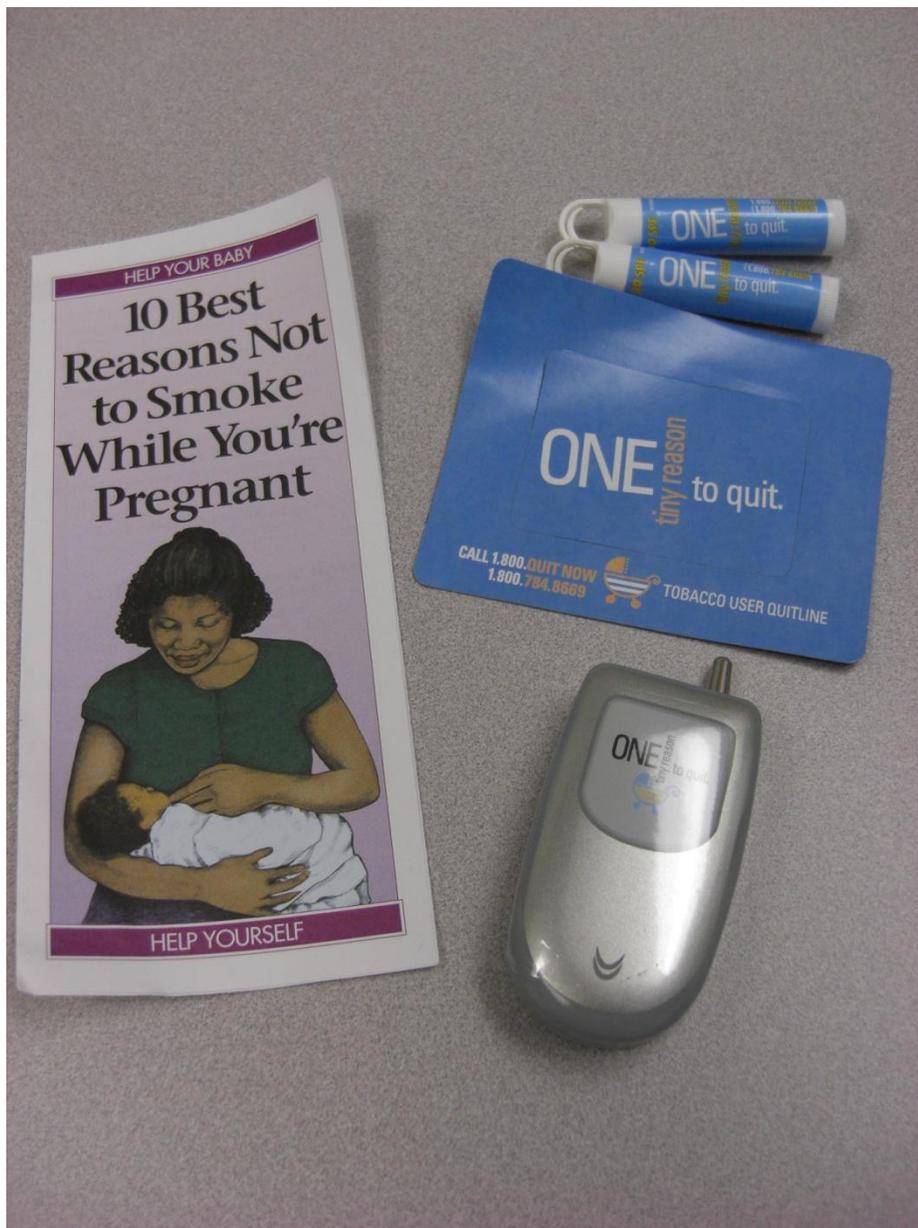
**VO:** You have one tiny reason to quit— so call 1-800-QuitNow.

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## Appendix F: Print media

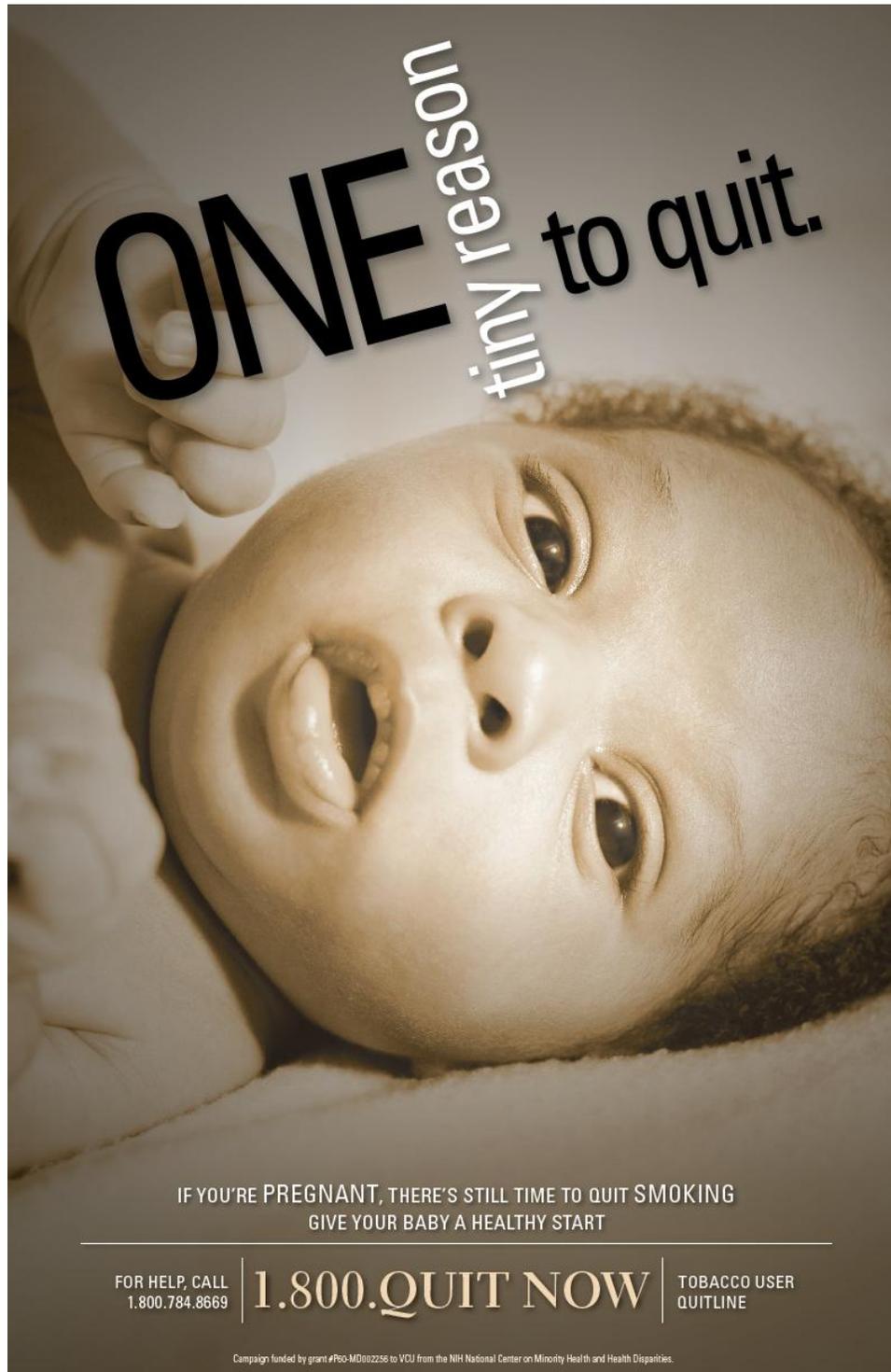
Give-away items:

- “10 Best Reasons not to Smoke While You’re Pregnant” brochure. Available for purchase from Journeyworks Publishing: <http://www.journeyworks.com/Ten-Best-Reasons-Not-to-Smoke-While-Youre-Pregnant/productinfo/5069/>
- Mint flavored lip balms imprinted with campaign slogan and quitline phone number
- Cell phone shaped tin of mints imprinted with campaign slogan and quitline phone number
- Photo frame magnet imprinted with campaign slogan and quitline phone number



Posters:

- Posters for display in various sizes (e.g., 8x10, 11x17, 24x36)
- For size and/or minor text modifications, please contact Susan Dubuque at Neathawk Dubuque & Packett: [www.ndp-agency.com](http://www.ndp-agency.com)



Billboards:



## Appendix G: Outreach Worker Materials

### “One Tiny Reason to Quit” Outreach Worker Training Protocol

- I. Welcome and Introductions
- II. Review of project history and purpose
  - a. Overview of IM and disparity among AA women
  - b. Purpose of “One Tiny Reason” project (media + outreach workers)
  - c. Importance of community outreach workers
  - d. Questions?
- III. Face-to-Face Contacts: Three primary messages to communicate

#### *Hand out Cue Cards*

- a. (1) Even if you’re already pregnant, it’s not too late to quit smoking
    - i. Review *10 Best Reasons to Quit Smoking* brochure
  - b. (2) Call the Quitline to increase the chances of giving your baby a healthy start
    - i. Give information for calling the Quitline:
      - 1. Give her *mint tin* and *business card* with Quitline info
      - 2. 1-800-QUIT-NOW (free call)
      - 3. Hours of operation: 8:00 a.m. – Midnight, 7 days/week
      - 4. No limit to how many times you can call
      - 5. Free cessation counseling service if uninsured or on Medicaid
    - ii. If she is interested in the service but states that phone access is a barrier, give information for Safelink Wireless
  - c. (3) Tell other pregnant women about the Quitline
    - i. It’s a free, convenient service
    - ii. Give *lip balm* to woman – one for you, one for a friend
- IV. Distributing printed materials
    - a. Introducing the project (from cue card)
    - b. List of campaign endorsers (letter)

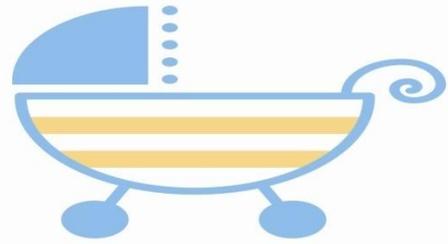
#### *Distribute bags and familiarize with supplies*

- V. Role play
  - a. Trainer(s) demonstrate an interaction with each other or with a volunteer from the audience
  - b. Break into dyads and role play interaction with trainer(s) observing
- VI. Tracking and Incentive process
  - a. Team captains
  - b. Explanation of tracking sheets
  - c. Weekly drawing for gift card(s)

**ONE** tiny reason to quit.

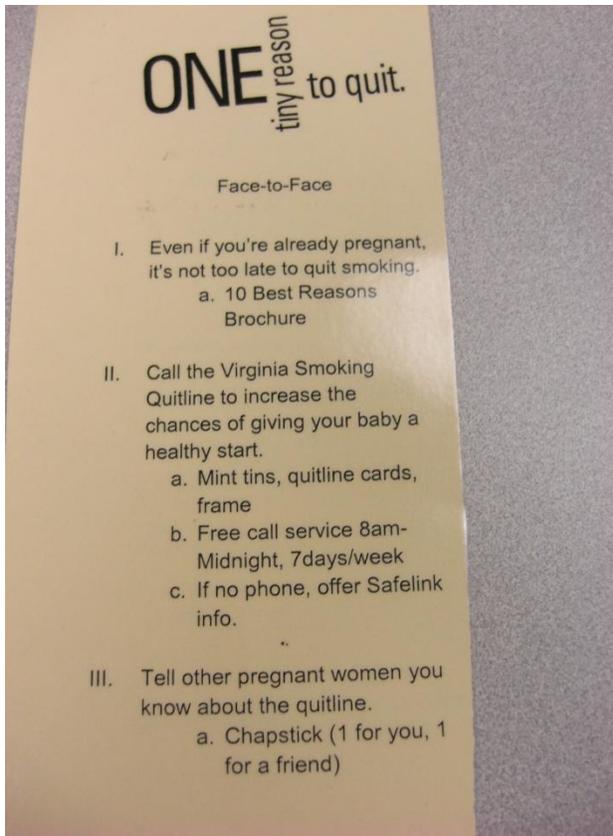
Face-to-Face

- I. Even if you're already pregnant, it's not too late to quit smoking.
  - a. 10 Best Reasons Brochure
- II. Call the Virginia Smoking Quitline to increase the chances of giving your baby a healthy start.
  - a. Mint tins, quitline cards, frame
  - b. Free call service 8am-Midnight, 7days/week
  - c. If no phone, offer Safelink info.
- III. Tell other pregnant women you know about the quitline.
  - a. Chapstick (1 for you, 1 for a friend)

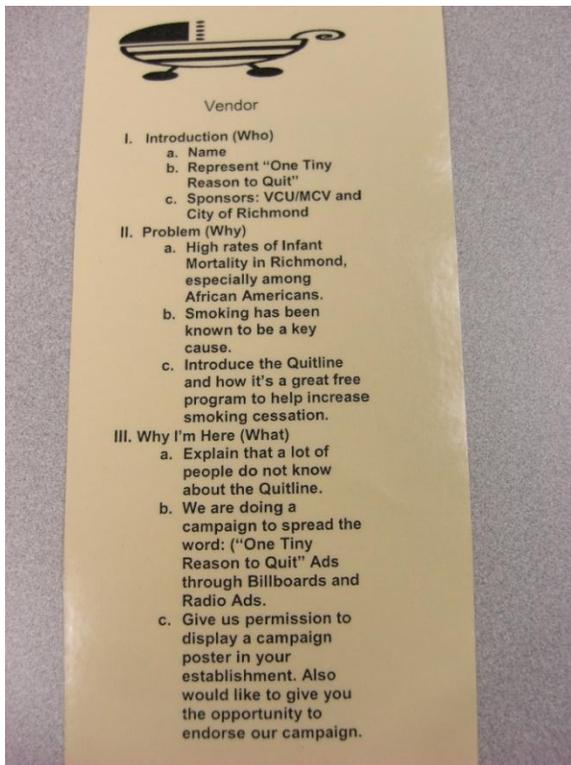


Vendor

- I. Introduction (Who)
  - a. Name
  - b. Represent "One Tiny Reason to Quit"
  - c. Sponsors: VCU/MCV and City of Richmond
- II. Problem (Why)
  - a. High rates of Infant Mortality in Richmond, especially among African Americans.
  - b. Smoking has been known to be a key cause.
  - c. Introduce the Quitline and how it's a great free program to help increase smoking cessation.
- III. Why I'm Here (What)
  - a. Explain that a lot of people do not know about the Quitline.
  - b. We are doing a campaign to spread the word: ("One Tiny Reason to Quit" Ads through Billboards and Radio Ads.
  - c. Give us permission to display a campaign poster in your establishment. Also would like to give you the opportunity to endorse our campaign.



Sample photo of Outreach Worker cue cards, printed double sided on laminated cardstock



**Sample letter supplied to all Outreach Workers for use when distributing campaign materials to local vendors**

Dear Community Leader:

The bearer of these campaign materials has been trained as an official outreach worker for the “One Tiny Reason to Quit” campaign, sponsored by Virginia Commonwealth University and the Richmond Healthy Start Initiative.

Richmond, VA has an infant mortality rate that is higher than the national average. Further, the infant mortality rate among African-Americans is 4 – 5 times higher than that of whites. This means that a disproportionate number of African American babies in Richmond will die before their first birthday. There are many reasons why this happens, both behavioral and biological. One of the key behavioral factors is smoking during pregnancy.

The purpose of the “One Tiny Reason to Quit” campaign is to encourage pregnant women who smoke to call 1-800-QUIT-NOW for free, effective smoking cessation help.

We sincerely hope you will take part in this important effort by placing a poster in a window or other visible location in your facility.

Other major campaign endorsers include:

- Richmond City Health District
- Virginia Department of Health
- Virginia Premier Health Plan
- March of Dimes Virginia Chapter

Thank you for taking the time to hear about the “One Tiny Reason to Quit” campaign!

**Sheryl Garland, MHA**  
VP, Department of Community Outreach  
Virginia Commonwealth University

**Rose Stith-Singleton**  
Project Director  
Richmond Healthy Start Initiative

**Tracking Cards used by Outreach Workers to report number of contacts made**

*“One Tiny Reason to Quit”*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Team Captain: \_\_\_\_\_

Campaign Activities:  
Face-to-Face Contact or  
Distributing Campaign Materials

If face-to-face contact – give DOB.  
If distributing materials – give location.  
(Ex: 3-14-1976 or McDonald’s on Broad St.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please return this sheet to your team captain after completing a **total of 3** campaign activities for entry into the prize drawing.

Notes:

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*“One Tiny Reason to Quit”*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Team Captain: \_\_\_\_\_

Campaign Activities:  
Face-to-Face Contact or  
Distributing Campaign Materials

If face-to-face contact – give DOB.  
If distributing materials – give location.  
(Ex: 3-14-1976 or McDonald’s on Broad St.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please return this sheet to your team captain after completing a **total of 3** campaign activities for entry into the prize drawing.

Notes:

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## Appendix H: Press Release and Media Invitations

### VIRGINIA COMMONWEALTH UNIVERSITY

#### **MEDIA ADVISORY**

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VCU Institute for Drug and Alcohol Studies  
Phone: (804) 628-0326  
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Richmond Department of Social Services  
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or

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#### **\*\*\*MEDIA ADVISORY\*\*\***

#### **VCU launches smoking cessation campaign for pregnant women in Richmond “One Tiny Reason to Quit” focuses on reducing infant mortality**

RICHMOND, Va. (June 15, 2009) – The Virginia Commonwealth University [Center on Health Disparities](#), in partnership with the City of Richmond Department of Social Services Healthy Start Initiative, is launching a new media campaign to help pregnant women stop smoking.

“One Tiny Reason to Quit” will encourage expectant mothers to get information and support about smoking cessation by calling a toll-free number, 1-800-QUIT-NOW (1-800-784-8669.)

**Reporters are invited to cover the launch of “One Tiny Reason to Quit” on Wednesday, June 17, at 11 a.m. in the auditorium at Pine Camp Arts and Community Center, 4901 Old Brook Rd. Media should arrive between 10:35 a.m. and 10:50 a.m. Parking is available in front of the building.**

Representatives from VCU Health System, City of Richmond Department of Social Services Healthy Start Initiative, Richmond City Health District and Virginia Department of Health will explain the campaign and answer questions.

Richmond has one of the highest infant mortality rates in Virginia, according to the Virginia Department of Health. The infant mortality rate among African Americans is especially high. In 2007, 36 of the 41 infant deaths reported in Richmond were African American infants.

Smoking during pregnancy is one of the most significant behavioral causes of infant mortality. The “2001 Surgeon General's Report: Tobacco Use and Reproductive Outcomes” estimates eliminating maternal smoking could lead to a 10 percent reduction in all infant deaths and a 12 percent reduction in deaths from perinatal conditions.

“One Tiny Reason to Quit” is funded through a research grant from the National Center for Minority Health and Health Disparities in response to the heightened infant mortality statistics in the City of Richmond and the disparities in rates between African Americans and whites.

###

An invitation was hand delivered to the major local news outlets (radio, TV, newspapers) a few days prior to the written press release. Two small baby blocks filled with chocolate candies, as well as the details about the press conference were included inside.



## Appendix I: Earned media

Richmond Free Press June 25-27, 2009 A5

### Local News

#### Anti-smoking campaign launched

Virginia Commonwealth University and the City of Richmond plan to spend \$100,000 in a media campaign encouraging pregnant African-American women to stop smoking.

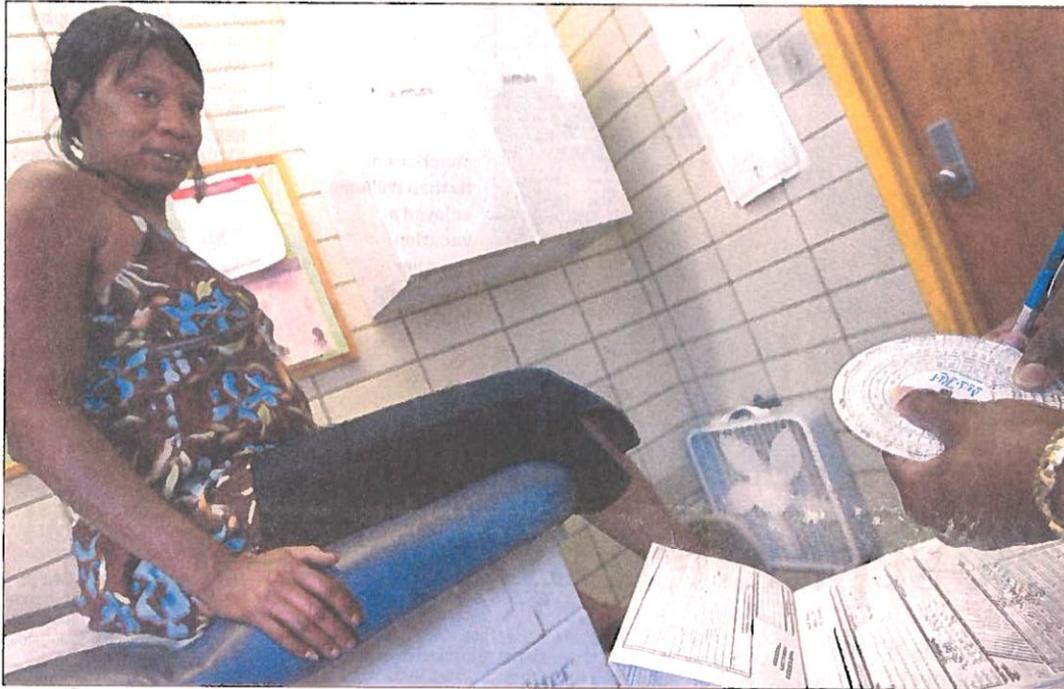
"We're focusing on African-Americans because there is such a high disparity between infant mortality in this population and the rest of the community," said Sheryl Garland, director of VCU's Center on Health Disparities.

The "One Tiny Reason to Quit" campaign is an outgrowth of a \$6.4 million grant for health promotion from the National Center on Minority Health and Health Disparities.

The Virginia Department of Health reports that 36 of the 41 infants who died in Richmond in 2007 were African-American. Infant mortality is defined as the death of a baby less than 12 months old, Ms. Garland said.

Richmond's Healthy Start Initiative, a coalition of health and government officials, asks pregnant women who are struggling with smoking to call the 1-800-Quit-Now hotline.

## Reducing infant mortality in Richmond



EVA RUSSO/TIMES-DISPATCH

Renee McCoy Wiggins said she stopped smoking as soon as she learned she was pregnant four months ago. Wiggins was at the Richmond Health District's Tenth Street Clinic yesterday for a prenatal visit with nurse practitioner Tracey Avery-Geter.

# Campaign urges not smoking while pregnant

**BY TAMMIE SMITH**  
Times-Dispatch Staff Writer

In hope of reducing the city's high infant mortality rate among African-Americans, Richmond officials this week are starting a campaign urging pregnant women not to smoke.

Cigarette smoking in pregnancy is linked with early labor

and low-birthweight babies (under 5 pounds, 8 ounces). Both are risk factors for newborns not making it to their first birthday.

The city's infant mortality rate, at 12.4 infant deaths per 1,000 live births in 2007, is higher than the state average of 7.7 deaths for every 1,000 babies born.

Just as troubling for health officials, though, is the fivefold racial

disparity. In Richmond, the infant mortality rate for African-American babies is 19 deaths per 1,000 live births compared with about four deaths per 1,000 live births among whites.

In terms of lives lost, 41 Richmond infants died before reaching age 1 in 2007 — 36 black and

See **PREGNANT**, Page **A8**

### Infant mortality

Parenthetical number is the actual number of infant deaths in each locality in 2007. Rate (total, black, white) is per 1,000 live births.

Locality	Rate	B	W
Richmond (41)	12.4	18.9	3.7
Chstrfld. (25)	6.4	12.5	5.1
Henrico (23)	5.6	10.1	4.4
Petersburg (11)	16.9	19.2	6.4

NOTE: Other localities in the region had fewer than 10 infant deaths in 2007.

### No smoking in prison

• Virginia facilities to ban tobacco by Feb. 1. Page **B1**.



The campaign will feature billboards and posters giving "One tiny reason to quit."

## Pregnant

From Page A1

five white.

"There are many things that can impact someone having a healthy birth, and we know that smoking is one of those things," said Rose Stith Singleton of the Richmond Healthy Start Initiative, a Richmond Social Services program.

"The disparity is a huge problem," Stith Singleton said. "There are many thoughts about why that exists. Some look at stress, cumulative stress. Not just during the nine months of pregnancy, but the stress African-American women experience over their life course."

Overall infant mortality has declined in the United States during the past two decades, but the black/white gap has widened in some places. Other cities with an infant mortality rate higher than the state average and with a significant black/white disparity include Chesapeake, Norfolk and Roanoke.

Officials are providing details of the campaign today at 11 a.m. at Pine Camp Arts and Community Center in Richmond.

In the campaign, billboards and posters with the image of a newborn will give women "One tiny reason to quit" and have the number to the state's free telephone counseling quit-smoking line, 1-800-784-8669.

The messages were tested in groups of women around the city.

"These women said for an issue like this, having a message from a child versus a peer or grandmother would be more important," Stith Singleton said.

Radio spots will begin airing Monday on WBTJ-FM 106.5, an urban contemporary music station.

Stith Singleton said the project group also wants to run placards on buses with routes in neighborhoods with the highest infant mortality rates: in the 23222 ZIP code area in North Side; 22223 in the East End; and 23224 in South Side.

The effort is being supported financially by the VCU Center on Health Disparities. In 2007, VCU researchers were awarded a \$6.4 million, five-year grant from the National Institutes of Health National Center on Minority Health and Health Disparities to study poor pregnancy outcomes in African-American women.

About \$100,000 of that is going annually for community outreach, said Sheryl L. Garland of the VCU Center on Health Disparities. "We went to the researchers and then we went to community partners to ask what things you think we should address," Garland said.

"The idea all along has been to come up with culturally sensitive messages where we can change a behavior that contributes to negative birth outcomes."

Garland said in a survey of 404 pregnant patients at a VCU clinic, about one-third admitted to smoking at some point during their pregnancy.

For others, pregnancy is a powerful incentive to quit.

"I wanted to stop anyway a long time ago, but it was kind of hard," said Richmond resident Renee McCoy Wiggins, who came to the Richmond Health District Tenth Street Clinic yesterday for a prenatal visit. She used to go through a pack of cigarettes every three to four days.

"Now, since I am pregnant, and I want a healthy baby, I just decided to give them up. . . . I had to choose between a cigarette or my baby's health, so I chose my baby's health."

• Contact Tammie Smith at (804) 649-6572 or T.Smith@timesdispatch.com.

# New anti-smoking campaign targets expectant mothers

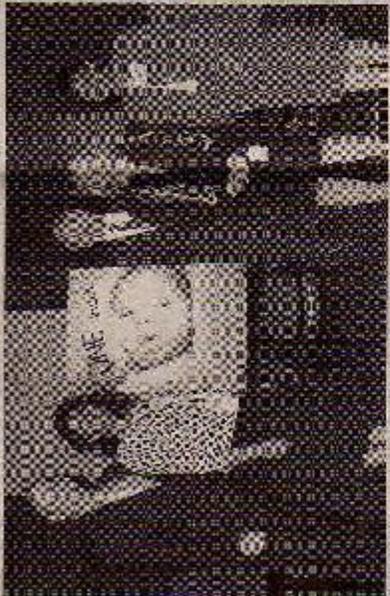
By Tiffany Satchell  
Staff Writer

As a way to reduce infant mortality rates in the city of Richmond, VCU has partnered with the Richmond Department of Social Services Healthy Start Initiative.

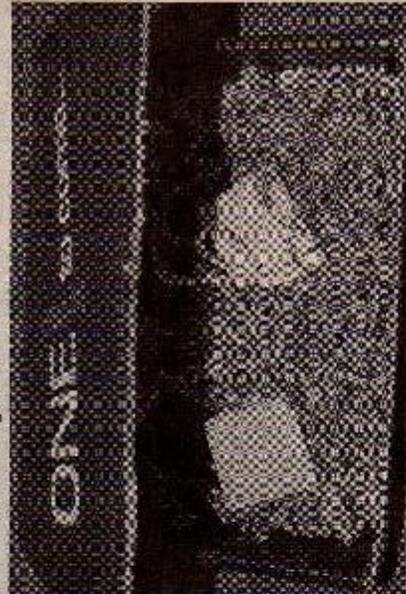
Last week, representatives kicked off the smoking cessation campaign, "One Tiny Reason to Quit." It is meant to educate expectant mothers on the effects of smoking while pregnant as well as provide them resources to help fight quit smoking.

Dr. Karen Remley, Virginia's commissioner of health, shared infant mortality rates during the launch of the campaign.

In Virginia, the infant mortality rate is 7.7 per thousand live births. When broken down by city and by race, Richmond has an infant mortality rate of 12.4 while the African American infant mortality rate is 18.9 per a thousand live births.



Representatives of VCU, the Virginia Department of Health, Richmond Department of Social Services, and Richmond City Health District during the kick-off of Richmond's Healthy Start Initiative.



smoking during pregnancy.

"We all can say what you should do and what you shouldn't do. The hard thing is trying to figure out how we help people walk away from what they should and shouldn't do.

"It truly is an addiction and our job is to not lecture, but to support those women as they walk through that process," said Remley.

Melissa Haywood, 29, a mother of an 18-month-old boy, admits that she smoked during her pregnancy and currently is a smoker. The campaign is providing her resources to help her quit.

She said she wishes that this assistance was available during her pregnancy.

See "Reason to Quit" on pg. 18

## Reason to Quit From Page 4

"I think about all the stress I could have saved myself," said Haywood. "No matter where I went, I didn't have anyone giving me reliable consistent information."

She shares that her 18-month-old doesn't seem to have been affected by her smoking habit while pregnant, "but it is one of those things you really don't know.

"Every little thing that may go wrong, I'm worrying and it's always in the back of my mind that I smoked during my pregnancy.

"It's a life-long stress that I am going to have," she said.

Haywood also admits that she was aware of the effects of smoking before her pregnancy, however, it was difficult to stop the habit.

"By that time you are used to smoking because your body craves it," she said.

Haywood is "thrilled" that this service is available to offer her with counseling and support. The fact that "it's free, reliable and consistent information that can help you improve your life and the life of your unborn child" is something to cherish as well.

For more information on this campaign call 1-800-QUIT-NOW.

## Appendix J: Exposure survey

### Exposure and Concept Testing for “One Tiny Reason to Quit”

Are you 18-44 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you smoked cigarettes in the last 2 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a baby in the past 24 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

1. Do you currently smoke cigarettes?

Yes       No

2. Would you say you are/were a light, moderate, or heavy smoker?

Light  
 Moderate  
 Heavy

3. Have you seen or heard a media campaign about smoking and pregnancy?

Yes       No

*[If YES, ask:]* Can you tell me something about it?

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4. Have you seen or heard the slogan “One Tiny Reason to Quit”?

Yes       No

*[If YES, ask:]* Where did you see or hear about it?

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5. Have you seen or heard the slogan “One Tiny Reason to Quit” from any of the following?  
(check all that apply)

Billboard

- Poster
  - Bus ad
  - Facebook page
  - Radio spot on 106.5 *The Beat*
  - Friend or family member
  - Health professional
  - Received a give-away item (mints, lip balm, magnets) with the campaign logo
  - Other (please specify)
- 

6. [For those who have **NOT** heard anything about “One Tiny Reason to Quit”]  
If you had to guess what the campaign was about from its name, what would you say?

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7. [For those who **HAVE** heard “One Tiny Reason to Quit”]  
How would you sum up the key message of the “One Tiny Reason to Quit” campaign?

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8. Have you tried to quit smoking in the last year?  Yes  No  
 Did you try to quit smoking this summer?  Yes  No  
 Were you able to quit?  Yes  No

9. [If **NO** to question 8, ask:] On a scale of 1-5, where 5 is a very strong intention to quit smoking, how strong would you say your intention to quit smoking is? \_\_\_\_\_

10. [If **YES** to question 8, ask:] On a scale of 1-5, where 5 is a very strong intention to stay quit, do you intend to stay quit after your baby is born? \_\_\_\_\_

11. Do you know of a free smoking telephone quitline?

- Yes  No

[If **YES**:] What is this number, spelled out in call letters (like, 1-800-something)?

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- Correct  Incorrect

12. Have you called the quitline?

- Yes  No

[If **YES**, ask:] When? \_\_\_\_\_

Before or after June 17, 2009:

- Before  After

13. [If **NO** to question 12, ask:] Have you thought about calling the quitline?

Yes       No

[If **YES:**] On a scale of 1-5, where 5 is a very strong intention to call, how strong is your intention to call the quitline? \_\_\_\_\_

14. Have you told someone else about the quitline?

Yes       No

15. Do you plan to tell someone else about it?

Yes       No

16. Do you have any comments to make about the “One Tiny Reason to Quit” campaign? (e.g., that you could really relate to it, that there was something you didn’t like about it, etc.)

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