

AMCHP 2008 ANNUAL CONFERENCE

WE ARE MAKING A DIFFERENCE:

Culturally Appropriate Social Marketing:

Integrating State MCH and Tobacco Cessation Initiatives for Native American Women of Reproductive Age

March 1st to 5th, 2008

ANITA GAILLARD: Good afternoon. I'm glad to be here, I said I need to, I want to start off with some confessions. I have to confess a couple of things and then I'll get in to the presentation. I managed \$36 million or \$34 to \$36 million at the beginning after just two years. Our legislature cut it by 70% which anyone who's in tobacco control understands exactly what I'm talking about. So now, it's around \$10 million, somewhere between \$10 and 50 million and hopefully in the course of telling the Indiana story you will see how we have been able to maintain our programs, especially in our minority community. The second confession is, even though its title "Social Marketing Tobacco Control in the African-American Women", in Indiana we don't have enough money to completely target the African-American woman of childbearing age and the pregnant African-American woman. So you'll see very quickly that most of what we do is social marketing is targeted at the entire population, because that's what we have money to do. And then some of the outreach that I go for would be directly to the African-American woman and hopefully you'll be able to discern what's general and then what goes straight to the African-American woman.

So just by way of a quick history lesson, we have a little bit more time this time than before. No slides for this part. The master settlement agreement that set money to the states happened in 1999. The board was appointed in 2000 and staff was hired in 2001. We are a full-blown state agency not affiliated with the Indiana State Department of Health directly. In other words, we are not part of the health department. We work very closely with the health department, but we are not a health department, we're a separate entity. We're finally known as ITPC. In Indiana we had the assist project which was the first huge tobacco control project in the United States, which is CDC-funded and then we had ITPC and now we blended those as of about today or yesterday. So that's what's happening in Indiana. We do have 92 counties. Is that a lot of counties to anybody? No? Mississippi, has that many counties?

UNKNOWN SPEAKER: [unintelligible]

ANITA GAILLARD: Eighty-one? Okay, 'cause sometimes, people are surprised by the 92 counties. So, we do have 92 counties and we've spent these past seven years, building infrastructure. Tobacco control work and you probably know this, is done at the community level. So, we have a staff of five regional directors, which isn't enough but five regional directors who have about 18 counties each divided geographically in the state of Indiana, who are the state liaison to community coalitions, and then in the counties, we have community

coalitions and we have minority coalitions. So we have some counties have two coalitions doing tobacco control, one that's focusing specifically on the minority community. Right now, we have 85 coalitions in the 92 counties in the state of Indiana. We have 12 minority coalitions representing 10 counties. Now, just to give you an idea of and we have seven statewide programs that kind of complement all of that work. When we started after the first couple of years, we had 92 coalitions and 92 counties. We had 25 minority coalitions and we had 20 statewide coalitions, or statewide programs. So that kind of gives you an idea of what the 70% budget cut did. The good news is we were able to maintain our community coalition infrastructure fairly well and that's important tobacco control. Thank goodness we did. The bad news is, we did lose of some of our coalitions. And what we lost primarily is our marketing campaign. We had millions of dollars in what we call a public health, public education campaign. And I may say this again, but our legislators don't like the word media. So, we don't say media campaign, we say public education campaign, but what it is a media campaign. So, but that took up a big hit and our consumer name which I don't think is anywhere is in this presentation is WhiteLies.tv and our Youth Empowerment Program is voiced and you'll see that in it's Voice.tv. So, it used to be in the earlier years, when somebody said where do you work, I could say WhiteLies.tv and anyone and everyone in the State of Indiana would say "ohh". And that's because we were spending \$7 million on our Public Education Campaign and everybody saw WhiteLies.tv. Now when I say it, they look at me and say,

“where?” because we’re not even close to being on TV like we were. But we’re doing some creative things to get there.

So that’s the history of ITPC. I personally have a fondness for pregnant moms and women of childbearing age and I was first influenced by David Satcher, Dr. David Satcher, the former surgeon general, because I went to Meharry Medical College which he was the president at the time I was there, and I didn’t get to spend a lot of time with him but he did a presentation once and he talked about how important it was to deal with tobacco in women, most especially women of childbearing age and pregnant women because when you impact her, who else do you impact? You impact her, you impact obviously who, the baby, and who else? The kids in the home. Right, and who else? Pardon me? The partner, the spouse, right? And actually when you think about it, it’s the whole household ‘cause I don’t know about you guys but most of the time, and I think the data shows that we as women make the decisions about healthcare. So when we have one, not in mama’s kitchen, it’s from Mississippi actually, and we decide when the household is completely smoke free. We decide when you can’t smoke in your vehicle. We kind of have an impact on all of that. So that when we reach out to pregnant women and women of childbearing age, we actually make a lot of strides in tobacco control. Not to mention what? The money that would be saved, if she stops or if she doesn’t smoke. So, those are all things that David Satcher, Dr. Satcher was one the first I heard say something about how important it is. If

you can't do anything else then do that because you impact so many people by helping a pregnant mom quit smoking.

So let's take a journey. It's going to be pretty fast journey but these are the things, this is the Indiana story. So, you all know where Indiana is, right? Okay. Midwest and I say you all like. She said, do you want a glass? No I'm a country girl. I'm from Indiana but I am a misplaced southern belle. I'd rather be in Mississippi than Indiana, especially now, and I am going south when I retire. But this is, some national some, Indiana come on home. Actually South Carolina is where I want to land. But this is some Indiana, some national and I'll jump back and forth and try to make sure that I'm clear, but this is what we're going to talk about, the problem, the consequences, the cause, the solution and that should probably say the solutions because there'd be more than one solution and then the challenges.

And these are things I think you as a maternal and childcare professionals already know, but this is what it looks like in Indiana. It's not good. The national average for women who smoke during pregnancy is 10%. In Indiana our state average is 18% and that means a lot of women that who are smoking. It's come down a little bit since we've started our work but not nearly enough and then of course there's lot of money involved too. But look at this one, 72 of the 92 counties have a smoking during pregnancy rate that's higher than the average of 18%. So when we talked to our coalitions, it's Indiana we have a problem. That's

a lot of counties. What does it mean really? It means the low counties are what? Really low and the high counties are above 18%. So we've got a problem and there's no rhyme or reason. When you look at the map and you look at the numbers, it's go figure. A little, maybe a few, more higher numbers in the southern part of Indiana, if you think about it, we are on the Ohio river, we border Kentucky. I don't know if it that has anything to do with it or not.

And Indiana actually has five media markets, so one corner has a lot of Ohio, I don't know it has anything to do with it or not. But when you really look at it, it was scattered all over. The high numbers are scattered all over the state. So we have a huge problem pregnant women smoking. It ranges from 33 to 5%. I think I live in the county that has 5%, believe it or not, I'm not sure how that happened. But we have a problem with women who smoke during pregnancy in Indiana.

This one I just put up 'cause you all know all of these consequences, but the impact is just looking at the long, long, long, long, long list. That's the impact of the slide. Don't even try to read it, its not important. What's important is it's long it's devastating, it's expensive, it's all those things that we don't like to talk about when it comes to being pregnant and smoking, and we know that it's a problem. These are the kinds of things we try to teach our coalition coordinators. We try to fund our coalitions at a rate where they could hire at least a part time coordinator. We're learning, we need full time coordinators in these counties. Our full-time coordinators are able to accomplish much more than our part time coordinator. So if you have the opportunity to assign dollars for tobacco control, think about

assigning enough dollars to hire somebody fulltime. So this is what they do. It's not part time one thing, part-time another because tobacco control and all of the idiosyncrasies in tobacco are hard to understand and if somebody can truly concentrate on it, it would be a worthy investment. At least that's what we're finding out in Indiana.

So, these are some of the things we're talking about. Now, these are the Indiana numbers. This is what is causing us in Indiana. I was talking about earlier. Currently, we have a governor, his name is Mitchell Daniels. He was Bush's budget agency--what are they called--he was the director of the budget agency for President Bush and he's a well-known and quite accomplished businessman from Indiana. So, he understands the problem of tobacco control. He understands how helping people to quit saves the state money. He understands how much is costing the state in dollars to support a huge smoking population in Indiana. He also understands about having a healthier workforce which would bring business into the state. Right now, we're spending over \$2 billion in medical costs in Indiana and whenever I have a chance to talk to people, I have them guess and I tell them the second word begins with the B. That's a lot. I don't know, maybe. It's a lot of money to me.

And then, Medicaid is about 487 million and we're working on the Medicaid population in Indiana. It's complex. It's hard. It's hard just to understand. We have manage care organizations that are managing our Medicaid population and

we're just now starting to break into relationships, believe it or not, after all of these years with them because it make sense. They make their money when they keep their population healthier. So, they understand but we're just now breaking into building our relationships with the Medicaid population. These are some of the other statistics about cost. And you probably know these. It's 66% higher of the complicated birth causes cost to go up to 66% and then 228 million a year in neo-natal cause. Bottom line is what? What is it? When it comes to cost, tobacco use pregnant women, women of childbearing age, babies, what is it? Anybody? It's expensive and it's cost a new (inaudible) chances are, right? Chances are, it's an expense that we're incurring. So you guys care 'cause you're maternal and child health professionals. But what we're trying to do is help to educate the general public about how much this is costing them, because they should care too.

So here's some of the solutions that we've had in Indiana. When I was talking to our PR guy, we have, and I may say this more that once, in Indiana, we have a Public Relations/Advertising Company who helps us everything that we do with our messaging, with our commercials, with our printed pieces, with everything that we do. And then, they have an ethnic marketing expert company that helps them and us with the ethnic marketing. So I talked to our Ethnic Marketing guy, and he was saying that the solutions in Indiana for the African-American woman, the pregnant woman, the woman of childbearing age is the same across all ethnicities. It really is. And that's part of the reason why we don't have any

targeted marketing. The other reason is what I just said earlier, right? We don't have enough money. There just isn't a way to segment the market and spend it directly on African-American pregnant women and still have money left to do something else. So...

UNKNOWN SPEAKER: [unintelligible]

ANITA GAILLARD: Our budget, I'm not good with numbers, it's about, let's see, we have a \$17 million budget right now, and I think we have a 1 to 2 million dollar marketing budget, now, yeah. That's how much we're spending on marketing. But here are some of the solutions. I have to remind myself with this presentation that we are talking about social marketing. So, in Indiana, what we believe is that we have to change a person's belief and attitude in order to change his or her behavior. So everything we do and how we measure what we're doing has to do with changing her beliefs and their attitudes first, before actually to change their behavior and that it's no secret to people who are in traditional in the marketing business. This is what they try to do. But here in Indiana, what we were caught and I bet everybody else does is policy changes. Now the advantage to policy changes is that we can change the norm with more people with one big policy than we can. One or two or 10 or 12 at a time, for instance, in a cessation class. So we have finally got our coalitions to take policy that we started with the lowest tiny fruit and believe it or not in Indiana, it was government buildings and county

buildings and some of those. Then we went to schools and probably parallel with schools, we did hospitals and healthcare centers.

My hospital healthcare story is, the executive director and I were presenting to they're called Critical Access Hospitals in Indiana which are the rural hospitals 'cause Indiana's made up four, five big cities and then a lot of it is rural after that. So, we're presenting to the Critical Access of Rural Hospitals' CEOs and they're a lot of them, they're a whole lot of them. And in many cases, they're the major healthcare provider of that particular community. And I was trying to figure out how to start, so you know, she and I have been doing tobacco control for a long time. So I said to them, "Is it too much and tell us 'cause we're narrow, we have blinders on with this tobacco control stuff, but is too much to ask the hub of the healthcare provider in a community to have a completely tobacco-free campus policy or are we expecting too much for the hospital, in the community that takes care of most of the people in the community to have a completely tobacco-free policy when it's still the number one preventable cause of death and disease in the United States then of course that's kind of a loaded question, and they're like no, no. Then the question becomes okay, so what are you going to do, CEO of the hospital, to change all of that? And fortunately, we've been moving in that direction very, very quickly so that most of our hospitals and I don't have the exact number, but we're close to 90% now--which makes sense, it makes sense--are now, have a campus-wide policy. So, not only are they not smoking in the building but they're not smoking on campus. Some even have car policies and

those kinds of things. So, we know policy works. And in Indiana, we've been working on it.

So, we started with government and then even in mean times when the money was cut, when we couldn't do nearly as much, we still stuck to the policy message because remember we kept our coordinators in place pretty much and if you can think about it, changing policy doesn't cost a lot of money, it's staff time and we we're paying for that anyway. So, when some of the other things went away, we were able to maintain our staff so were able to maintain the momentum for policy change which was where we went when we didn't have money to do a lot of other things. What we required of our coalitions both our minority and our community coalition is to work together. And in Indiana, the minority population is primarily Hispanic and Hispanic Latino or African American and after that the numbers go way down. So we almost always have a coalition that concentrates on either both of those communities or maybe even a separate coalition for each one of those communities. So what we did to begin with, just to kind of tell you about the African American communities, is we identified what 95% of the, actually it was the minority people of Indiana live and then we went to work to establish coalitions in those communities. Now, we ran into some problems because capacity is different. But that's where we had, remember when we had the 25 minority coalitions, that's what we had, and now we've got, about 12 or 13. With the communities, we have 35 policies in place and I don't now because I know there are some completely smoke-free states here, but in Indiana, that's

pretty good. We got one of the awards for the second highest number of policies passed in a year in 2006 and 28 of those 35 meet the Surgeon General's requirement. So that means they're pretty comprehensive and if they exempt, they exempt whole organizations or whole entities, whole buildings and then we have some that aren't any good, but we know that we're moving in the right direction. I know the states that are here probably had hundreds of communities or municipalities with policy before. They got their stay, how many live in the state policy, state that has a completely smoke-free policy, completely smoke-free states? Okay, so I'm way out numbered. So, you guys know how it is. Don't come to Indiana, 'cause you still, you'll get mad at us sometimes but we're working on it.

And then, here's a big one for us, with healthcare providers, we have an initiative now. We're really, really starting to tap in to the healthcare providers and we are concentrating on the Medicaid, the providers who take care of Medicaid patients. So, that's a little bit more targeted than we've been able to get to before. The other thing we did is, this year we did special grant process. We call that Supplemental Grant. When we have our grantees write their proposals, we don't always know what our funding levels are going to be because it's every other year we're still in session or they're still in session, so we're not sure and our funding came out higher this year than we thought it would, so we were able to offer up what we call the Supplemental Grant and we focused on contacting health care providers or talking to and educating health care providers in the

State of Indiana, because we know that will make a big difference. So we're still doing policy and we're now working on health care providers. The other thing is that when homes, when someone declares their home is completely tobacco free, we find that the attitude and the beliefs of that household change. Even if there's a smoker, if the smoker has to go outside or the smoker can't smoke in the car, we find it those change.

So this is another one of our solutions, everybody have a quit line in there? A statewide quit line? And everybody who must have quit knows that you have a state wide free quit line in your state? Probably not, well, that's we're we are working on. Ours is relatively new. I don't know how old yours is, but ours is about 18 months old. We were planning to do the state wide quit line when the budget was cut significantly. So we've been four or five years trying to get it back. So we do have our Indiana tobacco quit line. We're talking about a systems change in Indiana now which you may have in your states, but we don't have it Indiana, so we've got a fax referral system with the Indiana Tobacco Quit Line, so that's why they work with the providers, so that they can ask, advise, and then refer with the fax referral at the Quit Line do all of the work after that. We did just start, it's limited time, but we did start at two-week free Nicotine Replacement Therapy Program for anyone who calls the Quit Line and enrolls, that's been pretty successful in the State of Indiana. And we have an Indiana benefits, that cessation benefits for the medicate patient. It's the best kept secret in the state of Indiana. It's underutilized beyond underutilized. It's very underutilized and you

kind of battle with the state about talking about it and not talking about it. They have mixed emotions how much they're going to talk about and how much they're not going to talk about, but that's one of the things that we're working on. And don't make the mistake of thinking that the African-American and Latino community won't use a telephone counseling system, the data shows they do. We do. I do. I don't but we do. We do use. We are not opposed to the telephone counseling way of quitting. So that's something that we know we can do.

The other thing is that we've tried to keep our local community and minority coalitions motivated on this subject, so that we wrote into the plan that they must figure out where the women of childbearing age and where the pregnant women in the community are getting their health care a partner with that organization, not create anything new, but figure out which they should already know but if they didn't they had to find it they had to identify it and they had to identify to us in their proposal and then they had to develop a work plan that thought us how they were going to work with the organizations that are already target women of child bearing age and pregnant women. And that's really worked and we made it a contract deliverable. You must do this. You can figure out how to do it in your county that you say is unique, even though it looks like every other county, but you must do this..

Here is the other solution I came up with and that's you, the Maternal and Child Health Care Professional, we count on in Indiana, you count on you to talk about

stopping smoking or changing the behavior with every contact with patients, with every visit, with every encounter to teach your peers about what we mean when we talk helping about people to quit smoking. And that's probably the most important step of all this whole presentation, because I've already told you our marketing is general and our community coalition are doing what they can. But it's the Maternal and Child Health Professional who comes in contact.

Are there some conflicts? Or is anybody skeptical about that? You really don't have to really tell me in this room. But I went to our work one, No it was medic aide counselor meeting and when they introduced to me, I heard somebody say "who invited her?" and it was their supervisor because many of them smoke themselves and don't feel comfortable talking to their patients or their clients about not smoking even so much as talking about second hand smoke. And it was an intimidating situation for me. There just isn't always the cooperation that I expect people to have or the desire to do the counseling to talk about not smoking. So it was a rude awakening and it helped me to understand the work that we have to do at least in Indiana to kind of move the people who have the opportunity to talk about not smoking or at least not smoking in the house along, in order to accomplish the things we want to accomplish. So I've told you what we did in Indiana, we require the coalition to partner with specific organization that work with pregnant women. We have partnered with the Indiana Public Health Association (IPHA) and they are going to help us reach the local boards of health in the county. We have Boards of Health in every county and one county

has two, I can't figure that out quite, so we have 93 local Boards of Health and they're separate from the Indiana State Department of Health, and they all have a health officer, but the health officer isn't accountable to the health commissioner. They have a relationship but there's no direct accountability. So we have to figure out a way to reach local boards of health and we partner with the Indiana Public Health Association for that. Then the other thing we've done is in our office, we have designated staff assignment for certain organizations, so that we can have a relationship with certain other state organizations, certain other civic organization, certain to have community organization on state wide level, so that we could begin to make end roads into what we need to do.

Now here's the actual marketing things, the ones that I directed at pregnant woman but might help. The picture you see of the woman is our board chair. She is the Indiana State Department of Health commissioner. She's the state health commissioner, Doctor Judy Monroe and she's the Chair of our board. So that's how close our relationship is. The first solution you see there influence, we're calling it Influence Woman Events. We have this bright idea, actually it was originally designed around Indiana raising a cigarette tax, the Legislator was just about over, there was a cigarette tax bill on the table and I know you're probably have limited lobbying requirements like I do, so what we did was we came up with this idea of just educating, of course, women and this time, it was women. She's the first female health commissioner in the state of Indiana. So we kind of use that up to our benefit and we had an influence women event and a women

like this, we had them wear black and white, we said were black and white, leave seeing red, and we gave them a red scarf or something red while they were at the event, and then we told them about how the tobacco industry targets us. We told them how much it was costing the state for pregnant woman and woman with childbearing age and we told them what would happen to all of that likely if the cigarette tax was increased so could get support. And we did invite legislators. We invited women-owned business leaders and anybody and everybody you can think of. And then what we did was we put together a tool kit. We put together all of the different things that we used to create that event and we sent it to all of our partners, so they could do an Influence Women Event in their community, and we've had over 30, and Dr. Monroe has traveled the state talking about tobacco issues with women all over the State of Indiana. So you talk about social marketing. That's been one way we've been able to do it and we have been able to concentrate on pregnant women and women of child-bearing age. We haven't had to spend a lot of money doing it either. It's called Influence Women.

Another thing we've done, is we have the Q to W, is the Quit to Win Contest. It's the first time we've ever tried anything like this, but we had we had a State Wide Contest inviting Hoosiers--you know we called Hoosiers--Hoosiers to quit smoking for at least 30 days, that don't seem long enough to me but that's what we did. It was from September 15th to October 15th:and so we have all of the se marketing paper materials passed out al over the state, they would sign-up, and

then at the end of the contest, we had to go to contacting them, testing them, asking them, having them signed an affidavit testing them, and then we had prizes that were donated, and so we had five winners, The Quit To Win Contest. We've launched that contest at the largest African-American event in the State of Indiana which is Black Expo. So we tried to target African-American Men and Women by launching it at Indiana Black Expo and we actually spent more money in our ethnic marketing by radio primarily, we called the Ames Brown Show, but primarily marketing to the African-American community. And we're in that process of evaluating them. So that's our Quit to Win contest.

The voice youth movement, it's important just to share this with you. When I talked to our PR guy, he wanted me to share the voice commercials which, that's when getting writers do. Tell me when I'm, because I'm talking about, okay. The reason he thought, showing you the voice commercials, would be the best way to talk about social marketing in the state of Indiana, it's because it's targeted, it's specific, it's not to women but it's working for youth in our state and it's what we have to show you that's targeted and that's working. And he said this and this is, I think what's important about it, and that is, is that you have to meet people where they are, figure out where they are, pregnant women, women of child bearing age, youth whoever they are, and then target your marketing campaign based on that information and that's what our voice movement does. So that's what I've brought because that's what we have in Indiana for you to see. Then I

have just a couple of print ads and a poster for you to see. So let's go ahead and try to this.

This is the poster. Can you see that? This obviously as for the African-American community, and hold up one of those cards, we've put them on note cards and we've put them on a poster so that we kind of got to that very emotional issue of slavery, but not slavery as in the old times, but slavery to nicotine and tobacco. This campaign really worked, 'cause free yourself is something that resonates with the African-American community. So we were very successful with the Leg Iron post card and the Leg Iron poster.

This was our teen poster, we have the voice movement, with teens you talk about how the tobacco industry is duping them. They've researched them. They know exactly what it takes to get them to smoke and that what's that about. So this is one of the posters "don't let the tobacco companies play you" and you'll see that obviously when I show you the voice movement commercials. So let me go ahead and do that, and remember it's not women but it is target marketing. It is a social marketing campaign and this is what we did in Indiana.

UNKNOWN SPEAKER: [Unintelligible]

ANITA GAILLARD: I'm just going to run through this 'cause I'm really out of time.

UNKNOWN SPEAKER: [Unintelligible]

ANITA GAILLARD: This is the last one. Yes, questions?

UNKNOWN SPEAKER: [Unintelligible]

ANITA GAILLARD: What do you think? Oh no, that's not we're going to do. Okay, that's what we want to do. Just let me close with some of the challenges in the learnings.

I've already said that what we trying to do in the Indiana is to change socio-norms and we know that's starts with attitude and beliefs. We put our money where our priorities are. Our priority is where we put our money. However you want to say it, but we try to identify what our priorities are and invest significantly, not spread our self too thin, but just kind of focus on what we want to happen and make sure we funded at the level that make sense. And I've already said this, diversity in Indiana is not just ethnic diversity. When we did a minority report, our hard-to-reach populations are Indiana rural youth, African-American men, pregnant woman, and young adults. And that's who we asked our partners to concentrate on. We always let the experts to turn them into strategies. When somebody calls us, I say I have this great idea. I always have them call the PR company or the advertising company and let them decide. And then we evaluate, evaluate, evaluate, adjust and evaluate. So we've got a work to do yet in Indiana, but we think were o the right track.