

## **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

CHERYL FOGARTY: Thank you Karen. I do want to say, when you mentioned us jointly earlier, I don't want anyone to think that I'm an American-Indian expert. But I have been privileged to work on a variety of projects with American-Indian groups and that's one of them that I'll be talking about today.

This is Building Foundations for Tobacco Cessation Marketing to American-Indian Women in Minnesota. This was a project that was conducted by a very small nonprofit community-based agency in Minneapolis called The Indigenous People's Task Force, and it was grant-funded by our foundation that was created with tobacco dollars from Minnesota's Tobacco Settlement. It's called the Clear Way Foundation, and so they fund a variety of research projects and this was one of them. Let's see, oh here we go.

So this was to be a community participant research seeking indigenous knowledge to help women stop smoking in pregnancy and this was a project that took place in '03 and '04 so I had to kind of dig back into my files and make sure I

remembered what was going on then. I was--as the infant mortality person at the health department for the whole state, of course in Minnesota, infant mortality has to focus a lot on racial and ethnic disparities. And since we have been measuring disparities in infant mortality in Minnesota which probably started in the late '80s, we started monitoring that very closely. Everybody's infant mortality rate has decreased. Everybody's doing better, all populations, but the American-Indian population has always and continues to have a two or three times the higher rate than the white population. So back in the late '80s their rate was about 16 deaths per 1000 live births versus the White rate at about seven. And now in the early 2000s, their rate is about 10.5 per 1000 live births while the White rate is 4.5. So you can see that every one has improved but the disparity is the same and so we're very concerned. So when--the other piece of my work has been the generous opportunity I have from AMCHP. After I got to know Jean Mahony at ACOG and I was constantly calling her up and saying Jean, I need some more of those packets that ACOG made for providers to teach themselves the 5 aides, and we we're distributing them at conferences and health fairs and talking to small groups about how to use these ACOG packets, and finally Jean connected me to Sarah Gordon and we got a state team together to get technical assistance to improve tobacco cessation for pregnant women in the state of Minnesota. So I had that piece in mind and then the disparity in mind. And so when the Indigenous People's Task Force invited me to come and work with them on this project, I jumped at the chance because I thought I might learn something. I knew that there were problems with the disparity and I knew that

tobacco was playing a role and I didn't know how to fix it. So, I was very pleased to be invited to work with them during that time.

So, my role was to secure the data from the State Health Department. Well I guess I have to do it one at a time and help the community researchers. I tell you how they came about, understand this quantitative data that we had on smoking in pregnancy.

So Anita, we got you beat. I'm sorry to say. During the years we were working on this project and this was the data that we were using was from '99 to '03. There were rates of smoking during pregnancy by Minnesota's American Indian women, ranging from 39% to 41%. And in our state, White women have the second highest rate at 12% which is distinctly lower but still a concern and Minnesota we learned altogether that we had a highest rate of American Indian smoking in the U.S. The overall U.S. American Indian rate of smoking during pregnancy is 18%. Now remember, we're getting this data primarily from the birth certificate where smoking is greatly under reported but even so, very high rates were reported, and Minnesota is part of the Indian health service called the Bemidji Area Indian Health Service and includes Michigan, Wisconsin and Minnesota, and within the Bemidji area, Minnesota had higher rates than either Michigan or Wisconsin. So we were just over the top in that area.

So what we were trying to do was to work with a group of community researchers within the Indian community to understand this kind of boring data but important data. And just a little bit about Minnesota and the Indian population within our state, we have about four and half million people and about 60 to 65,000 American Indians. It's a very small population. We have more than 70,000 births a year now and about 1,400 to 1,600 of those are American Indian, about a third, 36% of those occur in the twin cities. But in Minnesota there are two tribes, the Dakota and the Ojibwa tribes, and they have 11 reservations. There are four Dakota reservations in southern Minnesota and 7 Ojibwa reservations in North and Central Minnesota but the people live sometimes on the Reservation and sometimes for better opportunities of education and jobs, they may live in the twin cities, not on the Reservation. So it's a very interesting mix.

Okay. What we did learn is that trying to simplify this for a group of community researchers that being college-educated and living in the metro suburbs where the only protective demographic factors for American Indian women smoking during pregnancy. So this is kind of how we presented that to the group who smokes least, who smokes most, and for the college-educated actually that only included about five percent of the population. So very, even though college is protective against smoking in pregnancy for American Indian women, it didn't effect very many of them because there were so few with college educations. And then on the other side who smokes most, for the alcohol and drug users, their rates were well over 50%. They were closer to 80 % and then again the

same if they had late pre-natal care, or if they have many children, their rates of smoking during pregnancy were very high.

So the project coordinator Jennifer Irving, who is a Lakota woman from South Dakota, was working in the Twin Cities with the Task Force at that time. She recruited community researchers who were all American Indian women. There were seven to ten of them. They were all paid to do some qualitative research and every time they had a meeting or training they were also provided with transportation and childcare and meals for them and their children. And she presented, we had a social epidemiologist consultant on this research team as well from the University of Minnesota and he suggested various kinds of methodologies for qualitative research because it's very small population. We want to get at the heart of why these situations are the way they are? Why are these rates so high?

So between Michael and Jennifer, they presented these methods to the women and they selected Photovoice and that was what they wanted to do and that is the research process by which people can identify, represent, and enhance their community through a specific photographic technique. So all the women were trained and they were given cameras and they were told to go out into their communities and take pictures that had something to do with tobacco use in their community and especially pregnancy or women and children and to bring back the pictures with comments from the subjects if possible or to comment on them

themselves, and this process promotes, it records and reflects strengths and concerns in a community, it promotes dialogue and knowledge through discussion and the actual purpose is to reach policy makers. That's the ultimate purpose of Photovoice.

So this process brought together scientific methods and researchers and also indigenous methods and researchers. The purpose was to gain deeper understanding of the place of tobacco in the lives of pregnant American-Indian women, and the medicine wheel model was used to guide the process and the wheel represents balance. Each aspect--learning, listening, reflecting and sharing--is equally important and no segment stands alone.

So with the advice of the social epidemiologist, they had all these photos and they had these comments and they had to analyze this data and they used the showed method of discussion and had regular sessions where they put the photos on the table and talked about them. The showed method of discussion is what do you see here, what is really happening, how did this relate to our project, why does it exist and what we can do about it?

So Photovoice told the story, and here some samples of what the photos look like. Someone took a picture of the entrance to the Minnesota Science Museum, it was very, we have a new museum, its lovely, a lovely building, it was perfectly clean and just pristine, and then she took a picture of the American-Indian Center

entrance in Minneapolis that was strewn with cigarette butts. Then someone had a picture of an Indian child dancing at Pow Wow that was very beautiful with the blue sky background, and somebody else had a picture of an Indian mom lighting a cigarette on a gas stove. So these are pretty tough images sometimes. A full ashtray on a table next to a baby bottle and all the cigarettes were smoked all the way down to their nubs and then people took pictures of the tobacco ads in the community that are marketing directly to American Indians using Native American imagery and advertising cheap smokes. So, that was part of it. And then, there were lovely photos of mothers and their children and then a funeral photo that was very interesting but tragic. And the comment was, in loving remembrance and it was about someone who had died prematurely from a tobacco-related illness.

So, ultimately, there was discussion about how we are going to raise awareness of this situation? And their short-term decision was to put some of the photos and quotes into a calendar for 2005 and each month had a picture. One of the pictures with a brief quote from the subject or the research team about tobacco and then there were facts about tribal history and the sacred use of tobacco and tips for quitting and staying quit, and that's where I came in trying to incorporate some of the five As and some of the information from the national partnership to help pregnant women quit. They let me weave some of that into their calendar.

There were also monthly health motivators. One month was quitting smoking, reduces asthma especially with the children. You're able to run and participate in sports. Your taste and smell improves. You have a reduced cancer risk and fewer early deaths. So, this calendar was a tool to raise awareness within the community and it was widely disseminated and printed out really nicely in color and widely disseminated across the state by the task force. And there was also ongoing analysis of what else this project had learned 'cause there was so much information.

And so other key findings and themes of the Photovoice, they found that there's an unconscious and continuous presence of commercial tobacco in key spheres of influence that affect American Indian women and this is a major obstacle to cessation. The most notable finding was the complete absence of healthcare or social service provider as a source of messages or cessation strategies. And the comments were some women in the Photovoice project actually took pictures of the posters that we have about smoking in pregnancy and even and some from the partnership and others that have been developed about smoking in pregnancy. So because that was on their mind, they took these pictures and they brought them to the session but the discussion was, we really don't pay attention to this stuff, which really not, you know? We weren't reaching them with our posters and that was a big important aha for me and I think for other people on the research team. Underlying this followed the themes emerged that the focus of Indian life or the sphere of influence is within Indian community. Most

important to them is what happens in Indian country or within the family. They're just not as interested in people in Minnesota. The healthcare system is primarily White system. That's not their major sphere of influence and the complete absence of healthcare or social service provider says the source of messages was a big challenge.