The National Partnership To Help Pregnant Smokers Quit

ACTION PLAN

May 2002

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A Message From The Former Surgeon General

I am very pleased that over 40 leading health, business and government organizations are bringing together their resources and strategies to reach out to pregnant smokers through the National Partnership To Help Pregnant Smokers Quit. We know that as many as 20 percent of all women smoke during their pregnancies, far above the goal of 2 percent set in *Healthy People 2010*. This is a goal that must be met—or surpassed.

The 2001 *Surgeon General's Report on Women and Smoking* offers dramatic proof of the need for action. Smoking during pregnancy can lead to miscarriage, ectopic pregnancy, premature delivery, stillbirth, low birth weight, and Sudden Infant Death Syndrome. Smoking before pregnancy can increase the risk of conception delay and infertility. And exposing children to secondhand smoke after they're born can impair lung development. All told, smoking may cause 10 percent of all infant deaths and 12 percent of all deaths from perinatal conditions in America.

But these outcomes are almost completely preventable. Women who quit smoking before or during pregnancy can reduce or eliminate these risks. Every percentage point decline in the prevalence of smoking during pregnancy will prevent 1,300 low-birth-weight babies and save $21 million in direct health care costs each year.

Recognizing the enormous harms of smoking and the benefits of quitting during pregnancy, the National Partnership's goal is to provide proven clinical and community-based interventions to every pregnant smoker. The Action Plan developed by the National Partnership describes strategies that health care providers, worksites, communities, state and federal government, and the research community can use to make these interventions available. It also describes strategies to build demand for interventions among pregnant smokers and those who care about them.

I believe that this new National Partnership has the vision and commitment to succeed, for a number of important reasons:

1. Pregnancy is an opportune time to reach out to women and provide access to cessation services. Pregnancy is a "teachable moment" — a time when women are more open to quitting than at other times in their lives because they want to protect the health of their babies. Indeed, about 30 percent of women who smoke stop smoking during pregnancy. Now it is time to assist the other 70 percent.
2. Pregnant women interact more frequently with health care providers. This gives providers many opportunities to help their patients quit or to offer cessation referrals to their patients who smoke. This is especially important, as support from providers has been proven to be highly effective in helping pregnant smokers quit.
3. A brief easy-to-implement approach to counseling during prenatal care has been proven to double or triple quit rates among pregnant smokers. These methods have been formalized into a U.S. Public Health Service Guideline, and they are equally if not more effective for the low-income women who are most likely to smoke during pregnancy.

We have an extraordinary opportunity to save lives, reduce health care costs, and raise healthier babies and families by helping women to quit smoking during pregnancy. Smoking during pregnancy is one of the nation's most important public health challenges, but it's a challenge that we can overcome.

I want to salute all the members of the National Partnership To Help Pregnant Smokers Quit for working together to protect the health of women, their babies, and their families now and for generations to come. I urge you to join us in this effort.

David Satcher, M.D., Ph.D.
Former Surgeon General and
Assistant Secretary for Health

An Introduction and Invitation To Join the National Partnership To Help Pregnant Smokers Quit

We are a group of organizations that have joined forces to help pregnant smokers quit smoking, forever. Our member organizations are committed to working together to reduce the number of pregnant women who smoke to 2 percent or less by 2010. Achieving this goal will dramatically improve the health of mothers and their babies, save lives, and reduce health care costs for families, employers, and society.

With your help we can make all this possible. Join us as we develop new breakthroughs and implement proven strategies. By adding the leadership and resources of your organization to the National Partnership, you can help us move our vision one step closer to reality. Working together to help pregnant smokers quit is one of the most important steps we can take to help families live healthier lives, now and for generations to come.

Contact us to enlist your organization in the National Partnership, or visit our website at www.smokefreefamiles.org.

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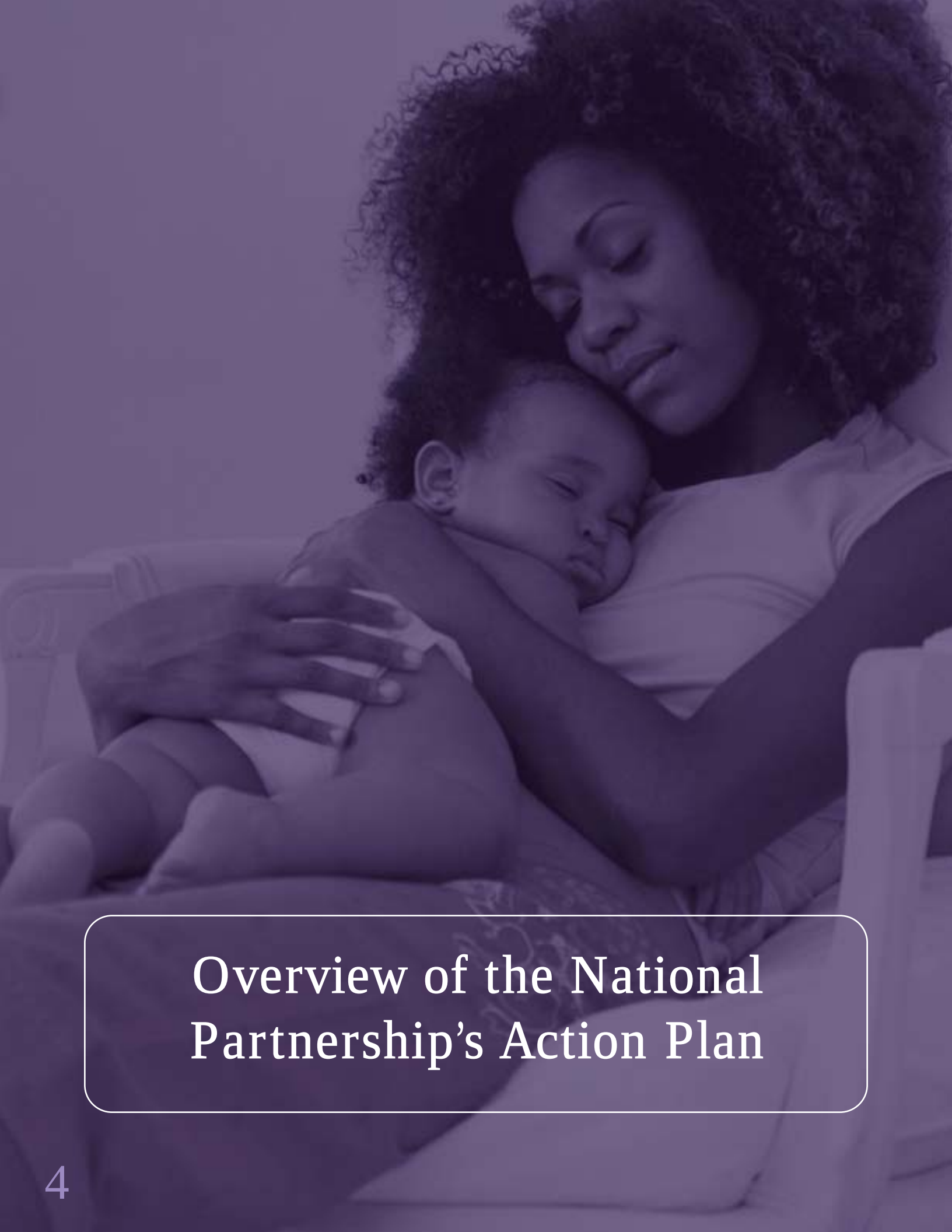
Helping Pregnant Smokers Quit Takes a Team. Join Ours!

Members* of the National Partnership To Help Pregnant Smokers Quit include:

Addressing Tobacco in Managed Care National Program Office, www.medicine.wisc.edu/npo/
Agency for Healthcare Research and Quality, www.ahrq.gov
Alliance of Community Health Plans, www.achp.org
American Academy of Pediatrics, www.aap.org
American Association of Health Plans, www.aahp.org
American Cancer Society, www.cancer.org
American Cancer Society & The Robert Wood Johnson Foundation Center for Tobacco Cessation
American College of Nurse-Midwives, www.midwife.org
American College of Obstetricians and Gynecologists, www.acog.org
American Heart Association, www.americanheart.org
American Legacy Foundation, www.americanlegacy.org
American Medical Association, www.ama-assn.org
American Medical Women's Association, www.amwa-doc.org
American Public Health Association, www.apha.org
Association of Maternal and Child Health Programs, www.amchp.org
Association of State and Territorial Health Officials, www.astho.org
Association of Women's Health, Obstetric and Neonatal Nurses, www.awhonn.org
Bridging the Gap National Program Office, www.impacteen.org
Campaign for Tobacco-Free Kids, www.tobaccofreekids.org
Center for Health Improvement, www.healthpolicycoach.org
Centers for Disease Control and Prevention:
- Office on Smoking and Health: www.cdc.gov/tobacco
- Division of Reproductive Health: www.cdc.gov/nccdphp/drh/

CityMatCH, citymatch.org
DC Healthy Start
Environmental Protection Agency, www.epa.gov
Health Resources and Services Administration, www.hrsa.gov
March of Dimes, www.modimes.org
National Association of County & City Health Officials, www.naccho.org
National Cancer Institute, cancer.gov
National Governors Association, www.nga.org
National Health Care Purchasing Institute, www.nhcpi.net
National Healthy Mothers, Healthy Babies Coalition, hmhb.org
National Medical Association, www.nmanet.org
National Perinatal Association, www.nationalperinatal.org
National Pharmaceutical Association
Office on Women's Health, U.S. Department of Health and Human Services, www.4woman.gov/owh/
Partnership for Prevention, www.prevent.org
Pharmacy Council on Tobacco Dependence
Smoke-Free Families National Dissemination Office, www.smokefreefamilies.org
Smoke-Free Families National Program Office, www.smokefreefamilies.org
SmokeLess States National Tobacco Policy Initiative–American Medical Association, www.ama-assn.org/ama/pub/category/3229.html
Society of Behavioral Medicine, www.sbmweb.org
Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, www.samhsa.gov
The Robert Wood Johnson Foundation, www.rwjf.org
Washington Business Group on Health, www.wbgh.com

* Website addresses are listed when the organization's site has relevant content.



Overview of the National Partnership's Action Plan

GOALS

Vision and Goals

Our vision is to provide all pregnant smokers (and new mothers) with the help they want and the support they need to quit smoking and stay tobacco-free. We will achieve this by translating science-based interventions into effective programs and policies. This will entail:

1. Ensuring that systems are in place to screen all pregnant woman for tobacco use, and that all pregnant and postpartum smokers receive best-practice cessation counseling by 2005.

2. Effectively using the media to promote the benefits of smoking cessation for pregnant smokers, and to show their partners, families, friends, and neighbors how to assist them in their quit attempts.

3. Making smoking cessation services and support widely available in communities and workplaces to encourage pregnant women to quit and support them in their efforts to do so.

4. Promoting policies that support smoke-free environments and improved access to cessation treatments, and encouraging economic support for such policies.

5. Promoting research and evaluation efforts to develop more effective cessation interventions.

Our goals for the National Partnership are:

1. To ensure that all pregnant women in the United States will be screened for tobacco use, and that all pregnant and postpartum smokers will receive best-practice cessation counseling as part of their usual care by 2005.

2. To reduce the prevalence of smoking during pregnancy to two percent or less by 2010, in accordance with the Healthy People 2010 goal.

The National Partnership to Help Pregnant Smokers Quit

"THE PLAN AT A GLANCE"

Use the media to promote the benefits of cessation and cultivate social support for quit attempts

Ensure that every pregnant woman receives evidence-based assessment and cessation counseling as a routine part of prenatal care

Providers Pregnant Smokers

Conduct research and evaluation to develop more effective cessation interventions

Integrate cessation and support services into community organizations and workplaces that serve pregnant women

Communities

Promote policies that support smoke-free environments and improved access to cessation treatments

STORY

Stephanie Conner's Story

Stephanie started smoking at age 14, and at times smoked as much as a pack and a half a day. "I always really enjoyed smoking," she says. "I felt like it completed things, almost like dessert after a meal."

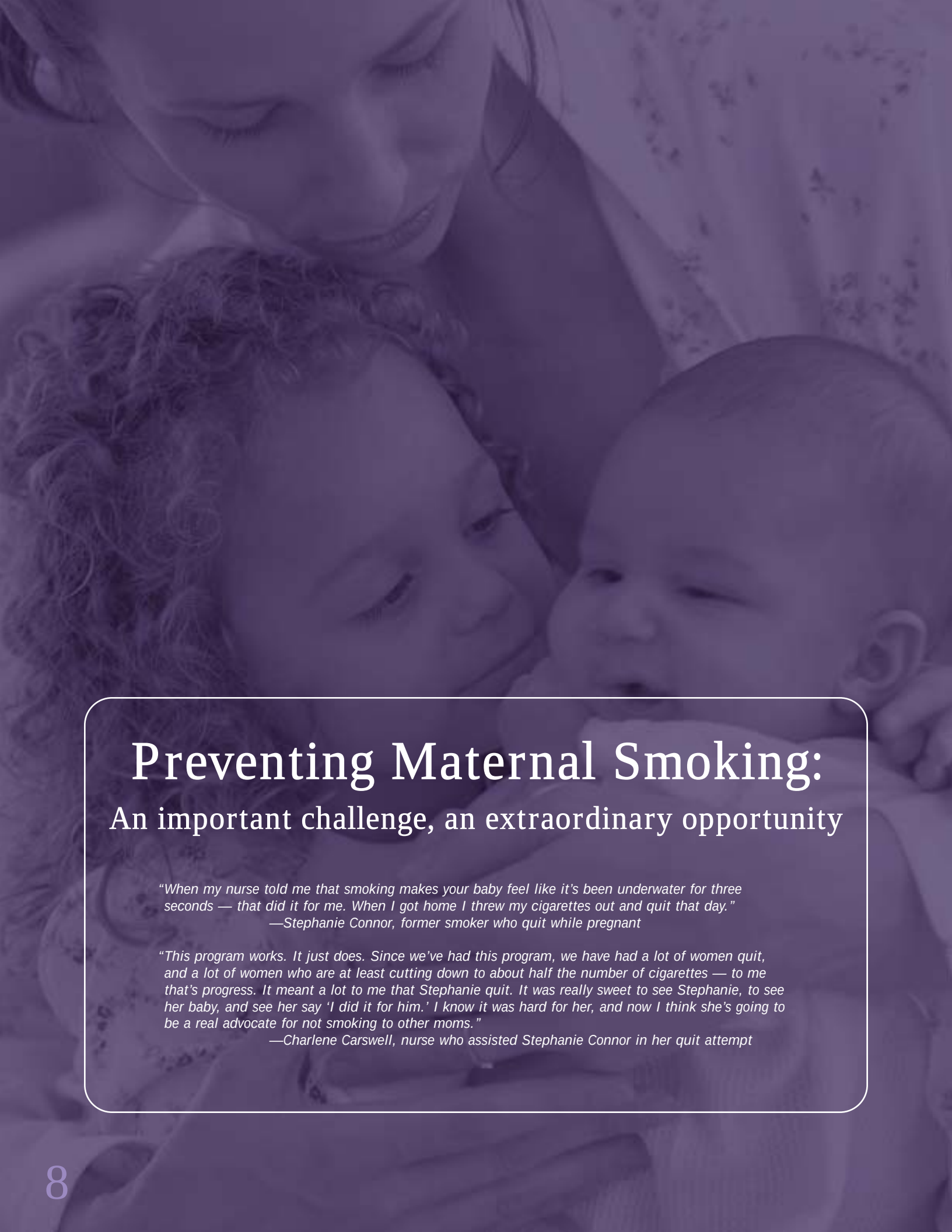
When she was pregnant with her first child five years ago, smoking made her so nauseated that she quit, but she started smoking again soon after her son was born. The reason? "It wasn't my choice to quit then, and after I had the baby, I chose to start again." She and her husband discussed quitting together when her uncle, a lifelong smoker, died of emphysema and lung cancer; they decided to make a quit attempt if she became pregnant again.

When Stephanie found out she was pregnant earlier this year, she enrolled in a cessation counseling program at the urging of the nurse at her health department. "When my nurse told me that smoking makes your baby feel like it's been underwater for three seconds — that did it for me." Stephanie says. "We set a quit date for two weeks after I met with her, but when I got home I threw my cigarettes out and quit that day. My husband tapered down and quit about three weeks later."

Stephanie says her second quit attempt was much harder than her first. "The first time was easy — if I smoked, I'd get sick. This time, I would not have made it if I didn't have the support and the people to talk to about how hard it was." Stephanie and her nurse met or talked on the phone at least every two weeks during her pregnancy. "She'd just check in and say hi, ask me how it was going — little things, but they helped me know that she was there for me." A gift bag she was given at the start of the program also helped. "At first I thought it was kind of corny — one of the things in the bag was a straw they had cut down to the size of a cigarette. After two days, I didn't think it was corny any more — I carried it around with me everywhere, and it really helped. It gave me something to do with my hands and my mouth."

Not only have Stephanie and her husband remained smoke-free after her son's birth, she doesn't allow anyone to smoke in her home, in her car, or around her children. "My whole family smokes, but they respect my decision, and they don't smoke around me," she says. Stephanie still relies on the support of her husband and her nurse to stay smoke-free. "Sometimes I feel like something is missing, and I realize that I'm missing a cigarette. But I recognize it, I talk about it, and I move on. If I wasn't able to talk about it with someone who understood what I was going through, I wouldn't have been able to do it."

The best things about being smoke-free? "I have asthma, and I breathe better. I just overall feel better and less rundown. Plus, we used to spend $30 a week on cigarettes, and now we use that money to do things as a family. We go out to dinner, or take the kids to the theater, and I look at them and see how much fun they're having and realize that we wouldn't be able to do this, we wouldn't be able to share as a family if we still smoked."



Preventing Maternal Smoking:

An important challenge, an extraordinary opportunity

"When my nurse told me that smoking makes your baby feel like it's been underwater for three seconds — that did it for me. When I got home I threw my cigarettes out and quit that day."
—Stephanie Connor, former smoker who quit while pregnant

"This program works. It just does. Since we've had this program, we have had a lot of women quit, and a lot of women who are at least cutting down to about half the number of cigarettes — to me that's progress. It meant a lot to me that Stephanie quit. It was really sweet to see Stephanie, to see her baby, and see her say 'I did it for him.' I know it was hard for her, and now I think she's going to be a real advocate for not smoking to other moms."
—Charlene Carswell, nurse who assisted Stephanie Connor in her quit attempt

CONSEQUENCES

The Consequences of Smoking for Women and Their Children

According to the Surgeon General, smoking is the most important modifiable cause of poor pregnancy outcome, with some 20 percent of low-birth-weight births linked to smoking during pregnancy. Eliminating smoking during pregnancy might lead to a 10 percent reduction in all infant deaths and a 12 percent reduction in deaths from perinatal conditions.[1] New research has shown that smoking during pregnancy may impair normal fetal brain and nervous system development,[2] and babies whose mothers smoked during their pregnancy are more likely than those whose mothers did not smoke to die from Sudden Infant Death Syndrome.[3]

The health consequences of smoking for women, and their family members, do not begin and end with pregnancy. Women who smoke can have a difficult time becoming pregnant,[4] and those who smoke and use oral contraceptives can experience serious medical complications.[5] Smoking doubles a woman's lifetime risk of dying prematurely from any cause,[6] and for children of parents who smoke, exposure to tobacco smoke causes them to be more vulnerable to respiratory illness, impaired lung function,[7] and middle ear infections.[8]

Beyond the toll that smoking takes on the health of young women smokers, their families, and their children, there are important financial costs as well. The direct medical costs of a complicated birth are 66 percent higher for smokers than for non-smokers, reflecting the greater severity of complications and the more intensive care that is required.[9] And the costs don't stop there. Currently, 27 percent of U.S. children aged six years and under live with a parent or other family member who smokes; the annual direct medical costs associated with this exposure to parental smoking is estimated at $4.6 billion.[10]

Fortunately, quitting smoking during pregnancy and staying tobacco-free after delivery can eliminate most, if not all, of these health and economic burdens. One study estimates that cost savings of between $1142 and $1358 per pregnancy can be achieved for each pregnant smoker who quits.[11] While women who quit smoking early in their pregnancies reap the greatest benefits, quitting at any time during pregnancy, especially if the woman can avoid relapse after her child is born, offers critically important health benefits to both mother and child.

"Smoking cessation programs for pregnant women could be expected to prevent several thousand low-birth-weight births and save several hundred lives each year. In addition, such programs would save more than $6 per $1 spent, more than doubling the overall cost savings attributed to the rest of prenatal care."

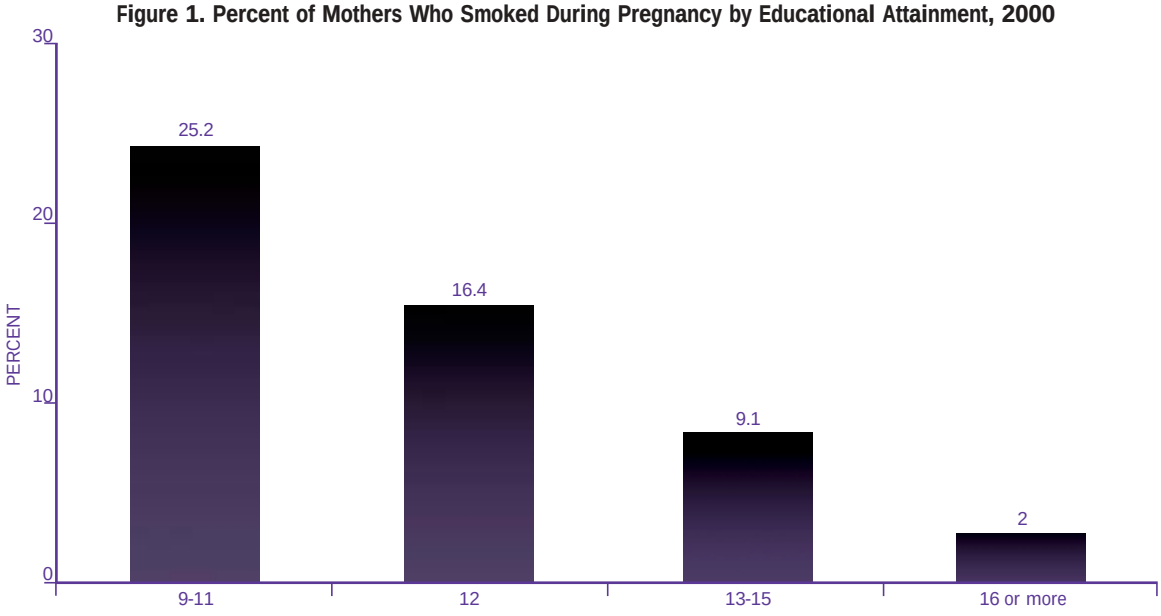
—James S. Marks, M.D., M.P.H., Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

The Challenge

While the percentage of women who smoked during pregnancy declined every year between 1989 and 2000, far too many pregnant women still smoke. Current estimates for smoking during pregnancy range from 12 to 20 percent; in some populations, the rates are even higher. Unfortunately, the exact number of women who smoke during pregnancy is not known, since some women are reluctant to disclose their smoking status.

Regardless of the exact number, the challenge is clear: Far more than two percent of women smoke during pregnancy (the goal set in *Healthy People 2010*). Although the overall percentage of mothers (i.e., women giving birth in a given year) who reported smoking while pregnant declined again in 2000 for the 11th year in a row,[12] some statistics for 2000 are troubling. Although smoking among mothers aged 18–19 declined in 2000 after five years of increasing rates,[13] this group still has the highest rate of smoking (19.2 percent), followed by women aged 20–24 (16.8 percent).[14] Smoking among mothers aged 20–24 rose for the second straight year.

Figure 1. Percent of Mothers Who Smoked During Pregnancy by Educational Attainment, 2000



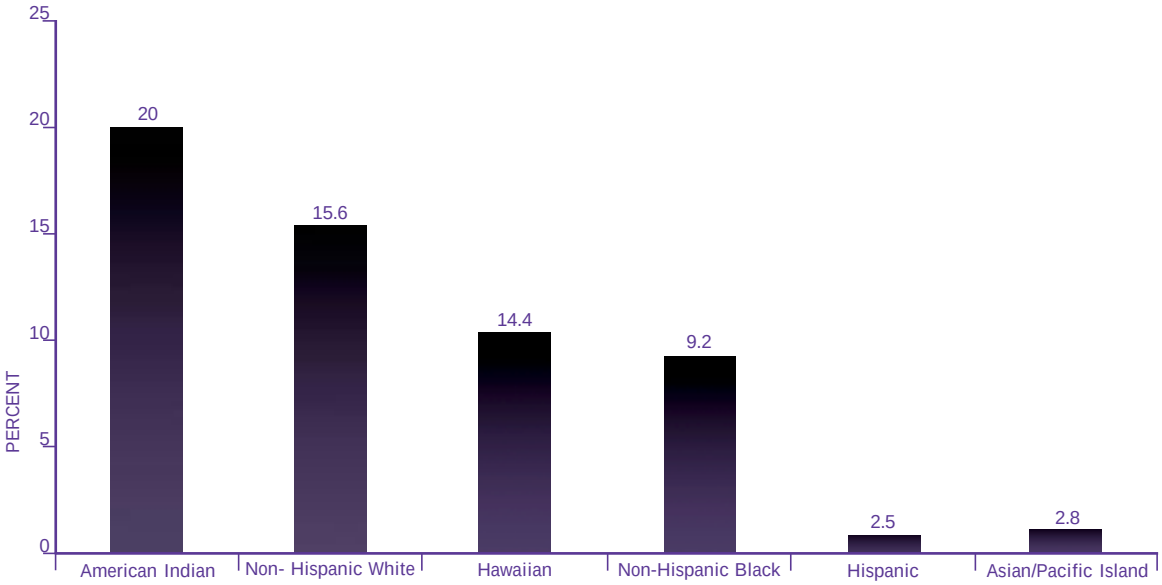
Source: Martin JA, Hamilton BE, Ventura SJ, Menacker F and Park MM. (2001). Births: Final data for 2000. *National Vital Statistics Reports,* 50(5), 11-12.

Women with the fewest educational and economic resources, and their newborns, are most at risk. Recent statistics from the Centers for Disease Control and Prevention (CDC) show that smoking rates in pregnancy are at least 12 times higher among women with 9 to 11 years of education (25 percent) than among women who hold a college degree (2 percent).[15] According to state-specific data from the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS), 15.9 to 38.5 percent of women who receive services funded by Medicaid smoke during pregnancy.[16]

Smoking during pregnancy is particularly common among non-Hispanic white women, American Indian women, and Hawaiian women, and less common among Hispanic women and Asian/Pacific Islander women (excluding Hawaiian women).[17]

When ethnicity and education are considered together, the statistics are even more sobering: Nearly half (48 percent) of non-Hispanic white women with 9 to 11 years of education smoke during pregnancy.[18] And, as mentioned above, these statistics almost certainly underestimate the true prevalence of smoking during pregnancy.

Figure 2. Percent of Mothers Who Smoked During Pregnancy by Race/Ethnicity, 2000



Source: Martin JA, Hamilton BE, Ventura SJ, Menacker F and Park MM. (2001). Births: Final data for 2000. *National Vital Statistics Reports,* 50(5), 11-12.

The Opportunity

Because the benefits of smoke-free pregnancies for mothers and babies are so dramatic and occur so rapidly, helping pregnant smokers quit presents an extraordinary opportunity to improve the health of this and future generations. Today, external circumstances also combine to make this a unique time for the National Partnership to come together:

- Pregnant smokers are more aware than ever before that smoking is harmful to their health and the health of their babies, and more interested in quitting; spontaneous quit rates among pregnant smokers have increased in recent years.
- Prenatal care providers have greatly expanded their efforts to help pregnant smokers quit: 96 percent report that they routinely ask about smoking status, and over half say they provide some counseling.
- According to the Year 2000 U.S. Public Health Service Clinical Practice Guideline — *Treating Tobacco Use and Dependence* — brief, easy-to-implement, prenatal counseling approaches have been shown to double or triple quit rates compared to simply advising patients to quit.
- Public and private health insurance coverage of smoking cessation treatments for pregnant and postpartum smokers has expanded significantly in the past five years.
- There is growing evidence, and a new CDC Community Preventive Services Guideline (2001), supporting science-based community, media, and policy approaches that can expand and reinforce health care providers' efforts.
- Through Master Settlement Agreement funds, the result of the landmark 1998 multi-state settlement with the tobacco industry, states may have access to more funding than ever before for effective tobacco cessation programs.

Partnership Pledge

We, the members of the National Partnership To Help Pregnant Smokers Quit, will work through health care providers, the media, worksites, communities, and states to deliver best-practice cessation programs, create supportive environments, and promote policies that can motivate and assist every pregnant smoker in her efforts to quit.

The National Partnership's Guiding Principles

Fulfilling our vision and achieving our goals will require coordinated action among many organizations and across many areas. Key aims and strategies for each of these areas, with examples of initiatives already underway, are described below. Uniting each of these separate efforts are five guiding principles:

1. Our work is based on the best scientific evidence currently available on clinical and community strategies to increase tobacco-use cessation for pregnant women in the U.S.
2. To achieve change, we will work on multiple fronts, including clinical practice, media, policy, and community and social supports.
3. We will work to remove systems and other barriers to tobacco treatment for pregnant smokers.
4. We will use the best available dissemination science to successfully promote and implement evidence-based strategies.
5. We will work together, because partnerships, leadership, and coordinated action are essential for success.

STORY

Tamar Gillan's Story

Tamar Gillan was a high school sophomore when she took her first drag from a cigarette. Peer pressure was tough back then, and she always thought that she could quit. Now pregnant with her second child, Tamar is still struggling to quit, but she finds it difficult to give up her cigarettes.

"It's like losing my best friend. Cigarettes are comforting to me. Smoking is something that I have control over, or thought I did," said Tamar. "The reality is that cigarettes have control over me."

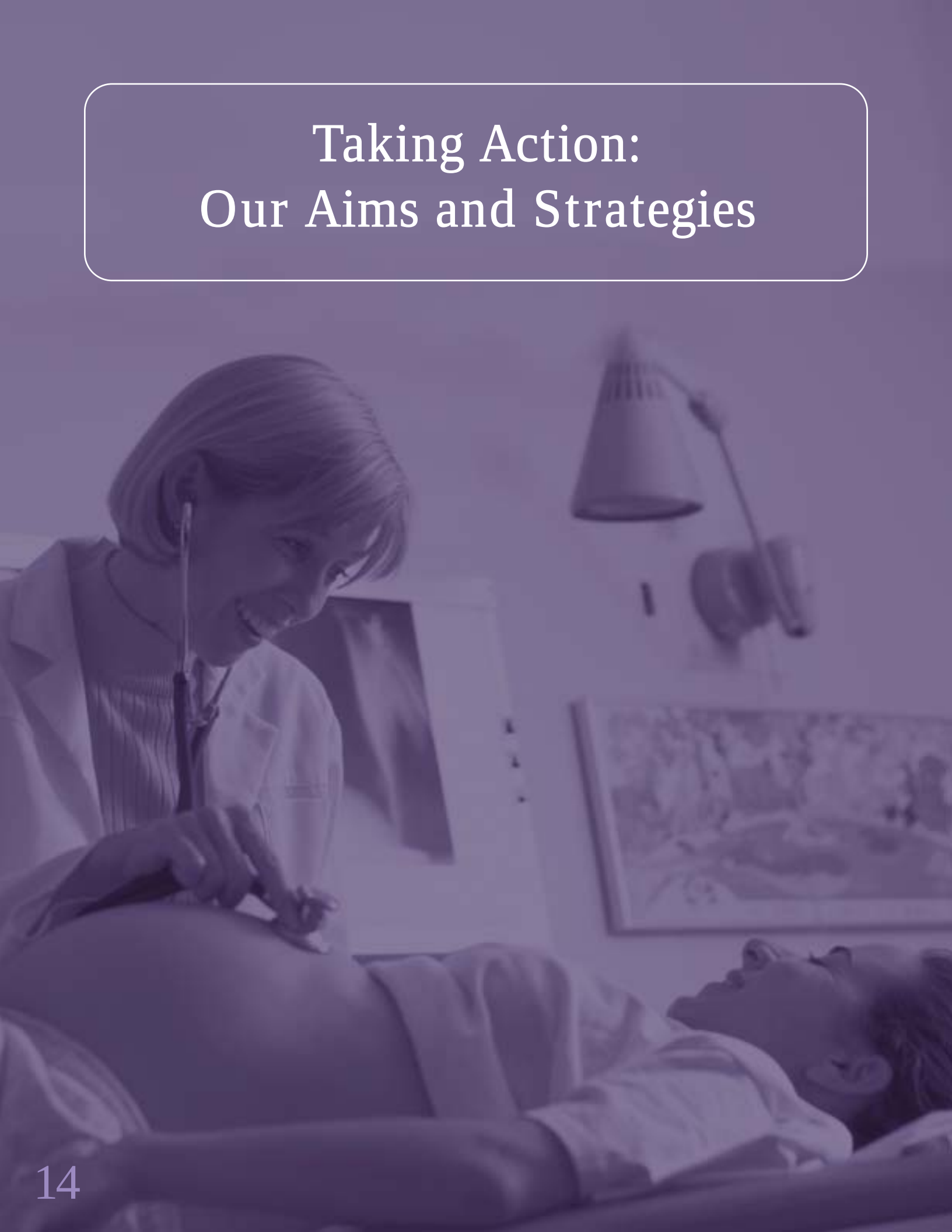
Through a friend, Tamar heard about Great Start, a counseling program for pregnant smokers sponsored by the American Legacy Foundation in cooperation with the American Cancer Society. "I was two months pregnant then, and I really wanted to quit smoking to protect the health of my new baby and everyone in my family," Tamar says. "When I found out about Great Start, I thought to myself, 'This is great.' It couldn't have landed in my lap at a better time."

Tamar called Great Start's toll-free quit line (1-866-66-START). With the help of a counselor, Tamar set a quit date and began her counseling sessions. "Great Start was the first cessation program I ever knew about that is specifically geared to the needs of pregnant women," she says. "The counseling is my favorite part because you can speak honestly about how you feel and no one looks down on you or thinks that you are a terrible mother."

Tamar was making progress — until the morning of September 11. Her husband, a member of the New York Police Department Emergency Services unit, called her at 9:00 a.m. to tell her he was on his way to deal with a problem at the World Trade Center. Then, as she watched the disaster unfold on her television, Tamar didn't hear from him again until 3:00 p.m. that afternoon. She says, "Those six hours felt like six years. I felt hopeless, and I began to smoke again."

With the support of her husband and family, Tamar began a new quit attempt on November 1. She says, "I can't say that I don't have my moments, but I can say that I'm making progress, that I'm smoking less, and that I'm optimistic that I'll quit. I know the important thing is to keep trying. I can't say enough about my counselor, Phoenicia. She's shown me that I can break the habits that lead to smoking, and I've discovered that changing is not as difficult as I thought it would be. Support is the key word. That's what I think a smoker really needs in order to quit, and that's what I've gotten from Great Start."

Taking Action:
Our Aims and Strategies



I. Offering Help Through the Health Care System

Aim of the National Partnership

To ensure that every pregnant woman receives evidence-based smoking assessment and cessation counseling.

It is recommended that all pregnant smokers receive a brief, 5-to-15 minute counseling intervention delivered by a trained health care provider and augmented with pregnancy-specific self-help materials. This counseling approach has been shown to double or, in some cases, triple quit rates among pregnant women.

The "5 A's" Approach

In June 2000, the U.S. Public Health Service (PHS) issued the first evidence-based Clinical Practice Guideline — *Treating Tobacco Use and Dependence* — that made specific recommendations addressing the needs of pregnant smokers. A counseling approach, commonly known as the "5 A's," adapted to meet these recommendations for pregnant smokers, is based on these five steps:

Ask the patient about her smoking status using a multiple-choice question to improve disclosure;

Advise her to quit, using clear, strong and personalized messages about the impact of smoking and the benefits of quitting for her and her fetus;

Assess her willingness to make a quit attempt within the next 30 days;

Assist her with ways to quit by suggesting and encouraging the use of problem-solving methods and skills for quitting; providing support as part of the treatment; helping her arrange support among family, friends, and co-workers; and providing pregnancy-specific self-help cessation materials;

Arrange follow-up contacts with her to assess her smoking status, encourage smoking cessation if she continues to smoke, and refer her to more intensive help if needed.

When the "5 A's" Approach Isn't Enough

Pregnant smokers who are unable to quit with the help of the "5 A's" may benefit from recommendations of the general PHS guideline. This guideline recommends intensive counseling from a provider with special training in the treatment of tobacco dependence; such intensive counseling might help heavily addicted smokers to quit. The guideline also advises providers to carefully consider use of medications used to treat tobacco dependence in other populations — nicotine replacement and bupropion — for pregnant women because they have not been tested for safety and efficacy among this population. Pharmacotherapies should be used only for pregnant women who smoke heavily and are unable to quit using counseling methods, and only when the potential benefits and likelihood of quitting are likely to outweigh the potential risks.[19]

Key Elements of Success

Changing Provider Practice. While much progress has been made over the past decade, many pregnant smokers still do not receive all components of evidence-based smoking assessment and cessation counseling. The American College of Obstetricians and Gynecologists (ACOG) — a member of the National Partnership — conducted a survey of its members in 2000. They found that, while 96 percent of obstetricians/gynecologists routinely ask about smoking during a patient's first prenatal visit, and 93 percent routinely advise patients to stop smoking, only 56 percent consistently discuss cessation strategies, and only 35 percent provide self-help materials.[20]

Changing Health Care Systems and Policies. To make consistent identification, documentation, and treatment of every pregnant tobacco user a routine practice in health care settings, a number of proven health system changes and policies are needed. They include:

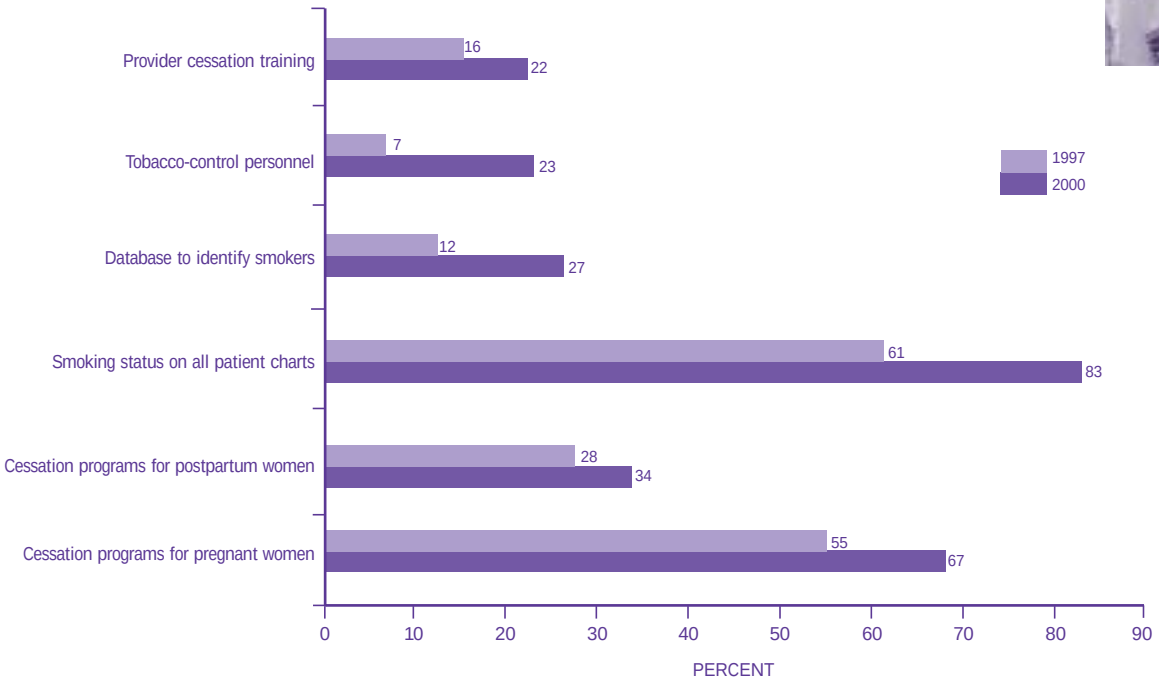
- Implementing reminder systems that identify patients who use tobacco products, and which prompt providers to advise and counsel them to quit, and
- Reducing patients' out-of-pocket costs for effective cessation treatment by including it as a covered service in their health plans.

> *"We need to let our colleagues know how powerful this simple intervention can be. So many of us already take a few minutes to address this important issue with our patients. The new intervention tells us what to say, what kinds of materials to offer and how to use the time we're already investing for best results. We can now intervene with more skill and confidence."*
>
> —Sharon Phelan, M.D., Chair, ACOG Advisory Committee on Prenatal Smoking Cessation, Associate Dean, University of New Mexico Health Science Center, School of Medicine

Focus groups conducted recently for The Robert Wood Johnson Foundation with a variety of prenatal care providers — obstetricians, nurses, and nurse midwives — revealed a strong conviction about the value of helping pregnant patients quit smoking. In fact, prenatal care providers see helping a patient quit smoking as one of the best things they can do to ensure she has a healthy baby, and view smoking cessation services as one of the most important heath care services they can provide. However, they also expressed a real need for tools, training, and systems and policy supports to inform and support their efforts.

Considerable progress has been made over the past several years in implementing these and other health system changes. The American Association of Health Plans (AAHP) — a National Partnership member that represents over 1,000 managed health care plans and has a combined patient enrollment of 160 million — surveyed medical directors of member health plans in 1997 and 2000. The survey results show significant increases not only in the proportion of plans offering smoking cessation programs specifically for pregnant and postpartum women, but also in plan-wide system supports for these programs.[21]

Figure 3. Percent of Health Plans With Selected Policies and System Supports for Smoking Cessation: 1997 and 2000



Source: McPhillips-Tangum C. (2001, February). *2000 Addressing Tobacco in Managed Care Survey of Health Plans.* Presentation at the 4th Annual Addressing Tobacco in Managed Care Conference, Nashville, TN.

Partners in Action: American Association of Health Plans (AAHP) Helping Implement System-Wide Change

AAHP's national Tobacco Control Achievement Awards recognize health plans for their system-wide efforts to help pregnant smokers quit. The 2001 winner of the AAHP's National Tobacco Control Achievement Award for programs aimed at pregnant and postpartum women was Aetna's Smoke-Free Moms-to-be™ program.

Smoke-free Moms-to-be is a component of Aetna's coordinated comprehensive maternity management program, the "Moms-to-Babies™ Maternity Management Program." The Moms-to-Babies program sends pregnant members a risk assessment survey that includes questions about smoking, and specifically asks members if they smoke more than five cigarettes per day. Those who do are given the option of enrolling in Smoke-Free Moms-to-be, which provides a smoking cessation kit that includes an individualized smoking cessation plan, printed educational materials, a video tape, a mock cigarette to help satisfy oral needs, and follow-up contact by mail. It also asks participants to choose and commit to a specific quit date.

Arnold W. Cohen, M.D., an obstetrician/gynecologist, National Medical Director of Women's Health at Aetna, and director of the program, says, "Responses to the survey questions really allow us to tailor the response to the individual's smoking habits — what her triggers are, what her habits are, what brand she smokes. We use the information to create a customized smoking-cessation book for each participating member." In addition, Aetna sends information to the member's obstetrical care

provider to encourage them to promote smoking cessation at each prenatal care visit.

During 1999, 6,255 pregnant members who identified themselves as smokers participated in the smoking cessation program. Of those members, 81 percent reported that they stopped smoking or decreased the number of cigarettes smoked each day by 50 percent or more: 45 percent quit smoking altogether and 36 percent decreased the number of cigarettes smoked by 50 percent or more. Women who stopped smoking had fewer pre-term deliveries and low-birth-weight babies when compared to the group that continued to smoke.

Word-of-mouth response has also been overwhelmingly positive. "Doctors like it because we work closely with them, keep them informed, and encourage them, so they are proactively involved in their patients' attempts to quit smoking," says Dr. Cohen. At the same time, he notes, "Patients like it because it lays out a course of action for them. Pregnancy is an opportunity to capitalize on the mother's health concerns for her unborn baby, and this program is successful because it provides a structure and a vehicle to take advantage of that opportunity."

"This program is an example of what managed care and insurance can do: develop an organized approach, measure outcomes, and help improve the quality of care when an opportunity is identified," says Dr. Cohen. And, most important, "A large number of women have stopped smoking and have had healthier babies, which is why I do what I do," he says proudly.

Strategies for Achieving Success

1. **Work with leading professional associations and regulatory groups to define the "5 A's" as part of best-practice prenatal and postpartum care.**

Partners in Action: American College of Obstetricians and Gynecologists Helping Providers Help Their Patients

ACOG has developed a four-page bulletin outlining how to identify pregnant patients who smoke and how to provide effective treatment to increase quit rates. Essential elements of the "5 A's" intervention are described, as well as information on the epidemiology of smoking during pregnancy, treatment issues pertaining to pregnant women who smoke heavily, smoking reduction, pharmacotherapy, health care support systems, and physician coding for the intervention. The bulletin has been distributed to ACOG's 40,000 members, and is also available to the public. Requests should be sent to resources@acog.org.

2. **Ensure that every health care provider who works with pregnant and postpartum women has the tools, training and technical assistance to effectively help pregnant women quit smoking.**

Members of the National Partnership will continue to work together to develop and enhance provider tools, including patient education materials, and make them available in a number of ways, including on-line. Presentations at regional and national meetings of health care professionals; print, electronic and interactive media and other learning opportunities will be used to offer providers the training they need to achieve cessation among pregnant smokers.

Partners in Action: Smoke-Free Families: Helping Provide Tools for Providers

The Smoke-Free Families website (www.smokefreefamilies.org) maintains an up-to-date listing of materials designed to inform and support providers in their efforts to help pregnant smokers quit, including background information on the science base for the "5 A's." Links to other organizations offering training opportunities are also listed.

3. **Promote systems (e.g., office reminder systems, quality improvement integration) and policy changes (e.g., changes in covered benefits) shown to be effective in helping providers implement the "5 A's" approach.**

STORY

Murray Nussbaum's Story

Dr. Murray Nussbaum has practiced and taught obstetrics and gynecology for over 40 years. He says, "On one of the very first days of medical school, they showed us what the lungs of a dead person who smoked a lot looked like. I'll never forget it. It was a very powerful image, and I can say that I've been interested in smoking cessation ever since."

Dr. Nussbaum oversaw a curriculum and lecture series throughout New York state to educate providers on the effects of smoking on women, pregnancy, and the fetus.

He notes, "Certain things made a huge impact on everyone we spoke to. They were impressed by all the unique things that happen to women who smoke, like irregular periods, cramps, and premenstrual disturbances. They were struck by the fact that smoking interferes with ovulation and therefore fertility, and the fact that there is a direct relationship between smoking and ectopic pregnancy, which is still one of the primary causes of death in young women in America. I don't think most providers knew that smoking can cause earlier menopause, or that it can lead to osteoporosis. In addition, one of our aims was to show exactly how nicotine affects the developing fetus, so that providers could explain it to their patients."

The aim of the program was not just to educate, but to empower providers to help their patients. Dr. Nussbaum says, "If you ask the average doctor why they don't offer smoking cessation counseling, they'll say 'I don't have the time.' We were able to counter that by showing that if you take just a few minutes to talk to your patients about this, you can have a pretty good result. They'll also tell you that they don't get paid for it, because most managed care programs don't reimburse the physician for time spent on cessation counseling. But we have found out that there are codes that they could use to charge, and we were able to find some companies that reimburse for them. So we provide that information."

He points out, "A huge number of doctors renew their contracts with insurance companies, HMOs, and managed care each year. They have the opportunity each year to look and see if they will be reimbursed for smoking counseling, and if they're not they should ask for it. It's really simple, very practical, and as the doctors learn to do this, they are getting more successful in getting coverage. And that's part of our work."

Dr. Nussbaum stresses that successful cessation intervention doesn't have to be complicated. He says, "We need to make smoking one of the principal and basic first questions. You take a patient's temperature, you take her respiration, you check her blood pressure, and then you mark on the chart whether she is a smoker or not. And then every single time the patient comes, there is a label on the chart that says 'smoker,' and that reminds you to bring it up with her at every single visit."

He concludes, "If we could get women to stop smoking during pregnancy, we'd see a direct 10 percent reduction in neonatal death, premature birth, and low birth weight. You know, if you look at our statistics in this country, they aren't that great, and we could really use 10 percent more healthy babies."

II. Using the Media Effectively

Aims of the National Partnership

1. **To increase pregnant smokers' motivation and confidence in their ability to quit.**
2. **To create the expectation among pregnant smokers that their prenatal care providers will offer them effective and nonjudgmental cessation assistance.**
3. **To increase the quality and effectiveness of social support offered to pregnant smokers by their partners, friends, families, and other members of the community.**
4. **To increase pregnant smokers' knowledge of effective and accessible communication resources to help them quit.**
5. **To increase the number of pregnant smokers who utilize available quitline and other counseling services.**

Media campaigns and other forms of communication can extend the reach and effectiveness of interventions launched in the health care system. The *CDC Community Preventive Services Guideline* strongly recommends the use of sustained media efforts as part of a multi-component program to inform and motivate smokers to quit, citing strong scientific evidence that such campaigns are highly effective in increasing smoking cessation among all smokers.[22]

Marketing research conducted recently by Porter Novelli on behalf of The Robert Wood Johnson Foundation points to a number of challenges that must be addressed in media campaigns targeting pregnant smokers, and the people who influence them. Pregnant smokers are generally aware of the harm of smoking for themselves and their babies, and they often have feelings of shame or guilt as a result. Most pregnant smokers, however, don't believe their babies will be harmed. This appears to be protective, as many smokers said they lacked the confidence that they could quit, making it harder to fully acknowledge the risks. Thus, the first challenge is to help women gain greater confidence in their ability to quit.

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The second challenge uncovered in the marketing research is that pregnant smokers feel that society at large, including their health care providers, partners, families, and friends, give them "attitude" about smoking rather than empathy and helpful support. There is undoubtedly some truth to this perception: recent focus groups with prenatal care providers, for example, confirmed that they often rely on guilt- and fear-appeal tactics rather than encouragement and empathy. In fact, in the focus groups, many pregnant smokers cited these tactics, and the lack of tangible help available from their prenatal care providers, as the reason that they conceal their smoking from their provider.

Key Elements of Success

The National Partnership's media outreach will be designed to influence pregnant smokers by:

- Conveying the benefits of smoking cessation.
- Demonstrating (or modeling) skills that can help in a quit attempt.
- Enhancing smokers' sense of self-efficacy (the belief that "I can do that") by featuring other pregnant smokers who have successfully quit.
- Reforming pregnant smokers' expectations about the help that is available to them at their prenatal care provider's office.
- Promoting other cessation resources, such as toll-free quit lines.
- Encouraging pregnant smokers' partners, friends, and family members, as well as other members of the community, to offer effective help and support to pregnant smokers as they try to quit smoking.

Strategies for Achieving Success

1. **Implement coordinated media campaigns to bolster pregnant smokers' motivation and self-efficacy to quit smoking.** The tone and theme of these communications will convey that effective help is available, will avoid arousing guilt or placing blame, and will refer pregnant smokers to appropriate cessation resources. Members of the National Partnership will also receive assistance on the design and content of media efforts aimed at helping pregnant smokers quit.

Partners in Action: The American Legacy Foundation: Helping Reach Pregnant Smokers Through the Media

The American Legacy Foundation developed "Great Start," the first nationwide media broadcast and quitline counseling campaign to help pregnant smokers quit. The campaign features the first national toll-free quit line, 1-866-66-START, offering pregnant smokers free sessions with a counselor specially trained to help them quit. English and Spanish-language counselors are available 24 hours a day, seven days a week. Legacy has partnered with the American Cancer Society to operate and manage the quit line. To draw additional attention to the issue early in the campaign, ads in 16 states included a special message from their state's First Lady.

The Great Start campaign also includes an educational booklet (developed by Smoke-Free Families, and designed and produced by Legacy) that complements the counseling sessions, a Great Start video for pregnant smokers (produced for Legacy by the I Am Your Child Foundation), and a web site at www.americanlegacy.org/greatstart. Legacy is also developing public service announcements for national use.

2. **Conduct complementary media efforts aimed at friends and family members of pregnant smokers so that they understand the necessity of providing positive support for quitting smoking and avoid unhelpful nagging and blame.**

3. **Develop supportive print materials (e.g., self-help guides, posters) to reinforce provider counseling efforts in health care settings.**

Partners in Action: The Agency for Healthcare Research and Quality (AHRQ) and Smoke-Free Families: You Can Quit Smoking – Support and Advice from Your Prenatal Care Provider

This one-pager, available in 50-sheet tear-off pads in both English and Spanish, is intended for use in providers' offices to counsel pregnant smokers to quit. It contains information on the good things that happen for both a woman and her baby as soon as she quits, keys for quitting and a personalized quit plan, and information on how to contact your prenatal care provider. Free copies are available through AHRQ, CDC, or the National Cancer Institute.

RESOURCES

III. Harnessing Resources in Communities and Worksites

Aims of the National Partnership

1. **To develop resources in communities and worksites that enhance pregnant smokers' motivation and ability to quit, and increase their access to evidence-based care.**
2. **To support public policies that increase tobacco cessation and prevention.**

Creating a supportive environment in communities and worksites is an important component of an overall plan to assist pregnant women in quitting smoking. Community resources such as local quit lines, smoking-cessation programs, and related health improvement programs (e.g., weight loss, exercise, stress management), can be an asset for pregnant smokers and their family members who want more support or need more intensive help to quit. These programs can be especially important for low-income and underserved populations, who have limited access to the healthcare system, as they are often located in alternative delivery sites, such as cultural centers and faith-based centers, and they often integrate smoking cessation assistance with other services that address the broader health and social service needs of pregnant women.

Quitting smoking can be hard work, particularly when dealing with the additional demands associated with pregnancy. Therefore, community resources that are not traditionally associated with smoking cessation, but that help reduce the burden of quitting, can be offered to pregnant smokers as an additional incentive to quit. As an example, providing daily reduced-cost or free childcare services that allow women to take some time for themselves (e.g., by taking a walk) may be an approach worth exploring.

In addition, many health plans and health care providers across the country are working effectively with community coalitions to increase local tobacco taxes, strengthen local clean indoor air ordinances, implement community and worksite smoking restrictions, enforce laws reducing youth access to tobacco products, and limit youth exposure to tobacco marketing. These community-wide strategies are proven both to increase cessation and prevent youth initiation of tobacco use.

Employers also have a critical role to play, because they help to select and shape the health services and benefits available to more than 152 million employees and their families. As the major purchasers of private health insurance in the U.S., employers can benefit from reduced annual medical costs and tobacco-related absenteeism, yet a 1997 Partnership for Prevention survey indicated that fewer than one-third of employers provide insurance coverage for smoking cessation.[23] Employers exert a powerful influence over smoking and quitting practices. In fact, the recent *Surgeon General's Report on Women and Smoking* notes that women are more likely than men to state their smoking patterns are influenced by worksite smoking policies.[24] Employers can assist employees by adopting non-smoking worksite policies, ensuring that health coverage includes smoking cessation programs and pharmacotherapies when appropriate, and by sponsoring worksite smoking-cessation services to assist employees who are trying to quit.

Strategies for Achieving Success

1. **Expand the number of prenatal health care systems that build effective partnerships with community and worksite programs and resources (e.g., local quit smoking clinics, telephone quit lines) to support quit attempts and provide more intensive treatment for pregnant smokers who need it.**

2. **Expand the number of public and private prenatal health care systems that are working with community coalitions to strengthen community and worksite smoking restrictions.**

3. **Educate employers, purchasing alliances, health and welfare fund directors, and employer benefit consultants about the benefits and cost-effectiveness of evidence-based tobacco-dependence treatment programs for pregnant smokers.**

POLICIES

IV. Capitalizing on State and Federal Funding and Policies

Aim of the National Partnership

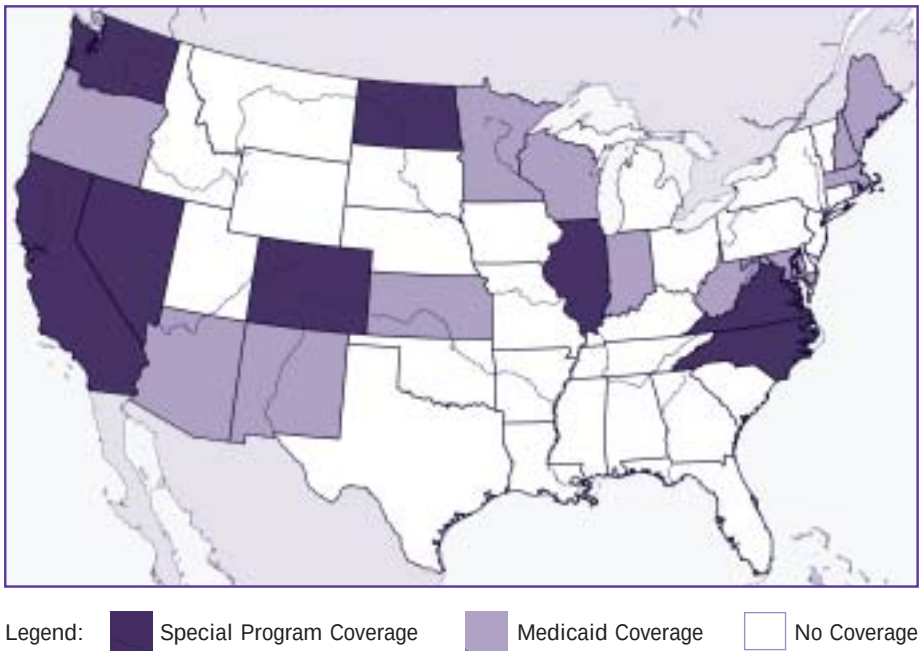
To promote economic and policy interventions that prevent and reduce maternal smoking, including increased funding for proven cessation interventions.

States can use a variety of funding sources, programs and policies to help pregnant smokers quit. These approaches range from mandating coverage of cessation treatments for insurance policies issued in the state, to allocating Master Settlement Agreement funds for prevention programs and cessation services.

Medicaid provides health insurance coverage for approximately one-quarter to one-half of all pregnant women. State Medicaid programs have been encouraged to provide coverage for smoking-cessation drug therapy and counseling for all populations; to urge health care providers to screen all pregnant women for tobacco use; and to provide smoking cessation counseling and appropriate treatment as needed. In addition, states have been asked to ensure that services are available to pregnant women and girls under age 21 as appropriate under the EPSDT (Early Periodic Screening, Diagnostic and Treatment component of Medicaid) program, and to ensure that Medicaid managed care contracts with health plans specifically reflect tobacco treatment coverage.

Despite this urging, while 33 states and the District of Columbia provided coverage for some type of tobacco treatment in 2000, only 13 states provided coverage under their general Medicaid program for non-medication counseling services appropriate for most pregnant smokers. An additional eight states provide counseling to pregnant women either through a special program for pregnant women or a home visiting program.

Figure 4. Coverage for Smoking Cessation Services for Pregnant Women by State: Medicaid and Special Programs, 2000



Sources: Centers for Disease Control and Prevention. (2001). State medicaid coverage for tobacco-dependence treatment—United States, 1998 and 2000. *Morbidity* and *Mortality Weekly Report*, 50(44), 979-982; and personal communication with MMWR study authors.

Moreover, funds from the 1998 Master Settlement Agreement between the state attorneys general and the tobacco industry are an underused source of funding for improved cessation services. As of January 2002, 41 states had allocated some portion of their tobacco settlement funds to tobacco prevention programs. For 26 of these 41 states, however, the amount allocated is modest or minimal, and below funding levels recommended by CDC in its *Best Practices for Comprehensive Tobacco Control Programs* (August 1999). Many state tobacco coalitions are working to change these statistics — raising the number of settlement dollars apportioned for tobacco-prevention and -cessation programs and initiatives.

One economic intervention, increasing tobacco excise taxes, is not only an important source of funding for effective multi-faceted tobacco prevention and cessation programs, but is also an extremely effective cessation and prevention tool in its own right. Projections indicate that a 50-cent increase per pack in the federal cigarette tax would result in $279.6 million in cost savings and 244,850 fewer smoking-affected births over a 5-year period.[25] The CDC Task Force on Community Preventive Services strongly recommends raising the unit price of tobacco products as a way to both prevent smoking initiation and promote smoking cessation. States that have both raised excise taxes and allocated a portion of the revenues specifically for media campaigns and treatment services designed for pregnant women and their families have achieved especially large declines in smoking rates.

Excise Taxes Reduce Smoking Rates

A new study shows that increased cigarette excise taxes can substantially reduce smoking rates among all groups of pregnant women. This study reported that a tax hike of 55 cents per pack would cut smoking rates among pregnant women nationwide by about 22 percent. Since many pregnant women are already motivated to quit, tax hikes may be more effective during pregnancy than at any other time in their lives. States like Arizona, Michigan and Massachusetts have seen large drops in smoking rates as soon as their tax hikes went into effect.[26]

Strategies for Achieving Success

1. Work to inform state-level health-care decision makers and policy makers of the health benefits and cost savings of:

- Covering best-practice tobacco-dependence treatments for all pregnant smokers.
- Preventing and reducing maternal smoking by increasing tobacco excise taxes.
- Promoting the wider use of state Master Settlement Agreement and/or tobacco excise tax funds to support initiatives aimed at pregnant smokers.

Partners in Action: The National Governors Association: Helping To Keep State Policy Leaders Informed

The National Governors Association (NGA) actively provides its members with tools and information to assist them in delivering cessation services to pregnant smokers in their home states. The NGA Issue Brief on Preventing Maternal Smoking, published in July 2001, summarizes the health consequences of smoking, outlines effective interventions for pregnant smokers (highlighting the "5 A's"), and gives examples of effective programs in several states. The Issue Brief specifically suggests that:

- States promote information about quitting smoking and remaining smoke-free as part of existing campaigns to reduce infant mortality;
- State maternal and child health and tobacco-prevention and -control programs share resources, research, and findings to put together effective maternal smoking prevention programs;
- States can provide enhanced prenatal care services through Medicaid to low-income pregnant women and reimburse providers for rendering smoking-cessation services; and
- States that have decided to allocate a portion of their Master Settlement Agreement funds toward tobacco prevention could invest in maternal smoking-prevention programs that target pregnant women.

IV. Promoting Research, Evaluation, and Surveillance

Aims of the National Partnership

1. **To improve understanding of how to disseminate best-practice counseling interventions to pregnant and postpartum smokers.**
2. **To develop and evaluate more powerful interventions for pregnant smokers and for all women of reproductive age.**
3. **To strengthen national and state-based surveillance of smoking in pregnancy, and of policy and programmatic supports for smoking prevention and treatment.**

Ongoing research and evaluation are indispensable for several reasons. First, we need to identify the best methods for changing provider practices and health care systems and policies, so that the "5 A's" become a routine part of every pregnant and postpartum woman's care. Much remains to be learned about how to successfully make these changes. The National Partnership thus encourages coordinated research efforts to determine how best to motivate and enable prenatal and postpartum care providers to fully implement the "5 A's" in a variety of settings.

Ongoing research also is needed to improve upon the current best-practice intervention. Such research will help identify better ways to help the most addicted pregnant smokers quit; identify how and under what circumstances pharmacotherapy is safe and effective; determine how to successfully involve partners of pregnant smokers in their cessation attempts; determine how treatments can best be tailored to the needs of culturally diverse populations; and determine how to prevent postpartum relapse and help women remain tobacco-free.

These efforts must include consumer research that yields insights from pregnant smokers, their providers, and their families and friends on ways to package or "re-design" proven interventions to expand their appeal and increase consumer demand, thereby enhancing their impact. Additional research should explore ways to increase the number of pregnant smokers who tell their provider that they smoke; encourage women to quit smoking before they conceive and early in their pregnancy; and better understand how broader tobacco-control policies and initiatives affect pregnant smokers and their infants and families.

Finally, improved surveillance at the national and state level is needed to better understand the true and full nature of the epidemic, and to more effectively evaluate the impact of cessation and prevention efforts. Collecting valid and reliable state-level data on smoking rates during pregnancy will likely require funding for research to develop methods that reduce under-reporting of smoking status in surveys. In addition, the prevalence of relevant provider, health plan, worksite, community and state/federal interventions, programs and policies must be systematically monitored and tracked. Only by linking data on trends in smoking during pregnancy with data on trends in intervention efforts can we gain needed insight into the programs and policies that are most effective.

Strategies for Achieving Success

1. Identify and evaluate the most effective training tools, technical assistance, and quality-improvement methods for reaching and influencing providers, and evaluate promising changes in health care systems and policies.

Partners in Action: The Oregon Department of Health and Smoke-Free Families: Helping To Develop and Evaluate Systems Change Tools and Processes

Through a demonstration grant, the Oregon Department of Health is working with Smoke-Free Families to develop and test systems change tools that promote the use of the "5 A's" among public and private prenatal care providers in Oregon. Senior health department leaders and maternity case managers will use continuous quality improvement methods as they develop system-wide approaches to implementing change in the provision of cessation counseling services for pregnant smokers in Oregon.

2. Provide grant proposal workshops, forums, and active collaborations with major research funders to assist and support National Partnership members' research and evaluation efforts.

3. Assist and support efforts to strengthen the nation's existing pregnancy-related public health surveillance systems [e.g., the CDC-funded Pregnancy Risk Assessment and Monitoring System (PRAMS)] and to maintain and expand collateral surveillance of policy and programmatic efforts.

Partners in Action: The CDC: Helping Estimate the Prevalence and Costs of Smoking During Pregnancy

One of the primary activities and responsibilities of the Centers for Disease Control and Prevention (CDC) is to educate the American public about the health hazards of using tobacco. In support of this goal, the CDC has developed the *State Prenatal Smoking Databook*, which provides national and state data on the prevalence of smoking during pregnancy, its effects on infant health and health care costs, and states' efforts to reduce the use of tobacco by pregnant women. For each state, this databook provides:

- Prevalence of smoking during pregnancy by the mother's ethnicity, age, and education, and the infant's birth weight;
- Smoking-attributable infant deaths due to SIDS;
- Neonatal illness and health care costs attributable to smoking;
- Summary birth statistics;
- Medicaid programs for pregnant women;
- Federal/state grant programs to reduce smoking-related adverse outcomes during pregnancy;
- State cigarette tax and regulatory policies; and
- Maternal and Child Health smoking-cessation programs.

CDC also helps states and other groups estimate the costs associated with maternal smoking through its development and promotion of Maternal and Child Health Smoking Attributable Mortality, Morbidity and Economic Costs (MCH SAMMEC) software. MCH SAMMEC is an online application that allows the user to estimate the number of smoking-attributable deaths and years of potential life lost for infants in the United States, as well as neonatal medical expenditures for certain user-defined populations. Annual estimates for the United States, individual states, and other user-defined populations can be calculated.

The databook is available on the Division of Reproductive Health web site: www.cdc.gov/nccdphp/drh. MCH SAMMEC is available at www.cdc.gov/tobacco/SAMMEC.

STORY

Tammy Young's Story

Tammy Young quit smoking shortly after she found out she was pregnant. She had been a smoker for two years, since a friend gave her her first cigarette when she was 14, and smoked about a pack a day.

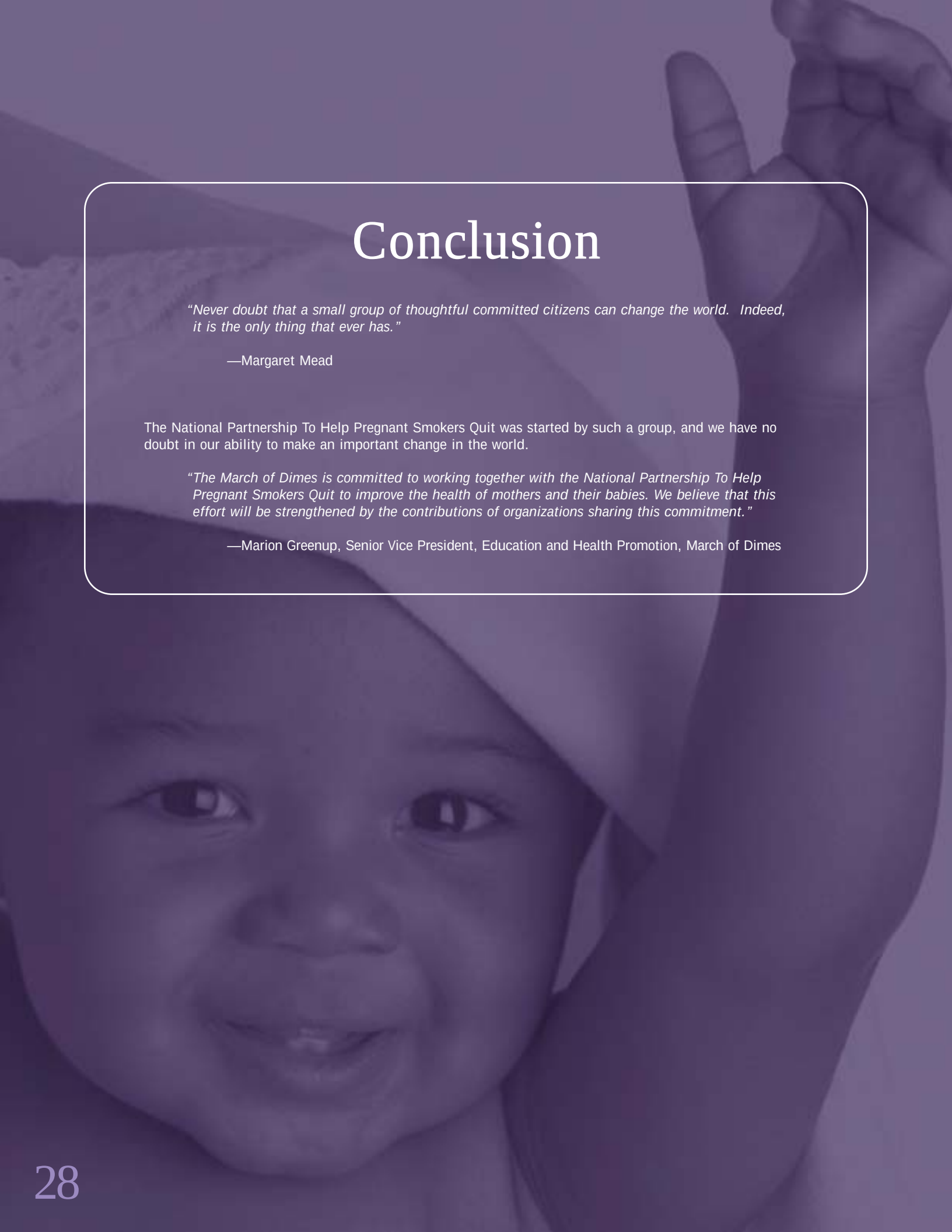
When she first tried to quit, when she was about six weeks pregnant, she couldn't. She cut down to about three cigarettes a day, but Tammy found it hard to give up her cigarettes completely. "Even cutting down helped a lot," she notes now. "I have asthma, and the smoking made it bad, and I knew that from gaining weight with the pregnancy, it would get even worse. But I just couldn't quit."

When Tammy went to the health department to begin her prenatal care, the nurse she met with asked her if she smoked, and then enrolled her in a cessation assistance program modeled on the "5 A's."

Tammy says, "Talking to the nurse helped a lot, just hearing the facts about what happens to the baby, what smoking does to it as you get further along — it just didn't feel right to smoke. I set a quit date for two weeks out, but quit before I even got there."

"The program was something to look forward to," she says. "There were incentives to stay quit, so I got a present every month. It's really hard for me because my mom smokes, people at school smoke — I get the urge when I'm around them. But my sister keeps on me, like a big sister should, and I talk to her about it. And I talk to my nurse at least once a month. Smoking really helped me calm down, so whenever I'm upset I get the urge to smoke. Now I do something else to take my mind off it, either squeeze the stress ball my nurse gave me, take a nap, something like that."

Tammy believes that if she weren't pregnant, she wouldn't have quit. "It's all for the health of my baby," she says. "I have to do it for the baby, because my needs are not as important."



Conclusion

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has."

—Margaret Mead

The National Partnership To Help Pregnant Smokers Quit was started by such a group, and we have no doubt in our ability to make an important change in the world.

"The March of Dimes is committed to working together with the National Partnership To Help Pregnant Smokers Quit to improve the health of mothers and their babies. We believe that this effort will be strengthened by the contributions of organizations sharing this commitment."

—Marion Greenup, Senior Vice President, Education and Health Promotion, March of Dimes

Acknowledgements

The National Partnership To Help Pregnant Smokers Quit became a reality due in large part to the efforts of the Smoke-Free Families National Dissemination Office Steering Committee and its partners. Special acknowledgement and thanks go to the following individuals and organizations:

Agency for Healthcare Research & Quality*
Joanne Alexandre
Harriett V. Bennett
Ernestine W. Murray, B.S.N., R.N., M.A.S.
Nate Robinson

Alliance of Community Health Plans
Jonathan Gelfand, M.B.A., M.P.H.

American Association of Health Plans*
Anne Cahill, M.S.
Barbara Lardy, M.P.H.

American College of Nurse-Midwives
Emalie Gibbons Baker, C.N.M., M.S.

American College of Obstetricians & Gynecologists*
Janet Chapin, R.N., M.P.H.
Wendy Root, M.P.H.

American Heart Association
Katherine A. Krause

American Legacy Foundation
Amber Hardy Thornton, M.P.H., C.H.E.S.
Lyndon Haviland, Dr.P.H.

American Medical Women's Association
Meghan Kissell, M.S.W.

American Public Health Association
Barbara Hatcher, Ph.D., M.P.H., R.N.

Association of Maternal & Child Health Programs*
Deborah Dietrich
Frances Varela, R.N., M.S., M.A.L.A.S.
Carol Watson, M.P.H.

Association of State & Territorial Health Officials
Kathleen Nolan, M.P.H.
Kristen Tertzakian

Association of Women's Health, Obstetric & Neonatal Nurses
Karen Kelly Thomas, Ph.D., R.N.C., C.N.A.A.

Bolton School of Nursing - Case Western University
Judith Maloni, Ph.D., R.N., F.A.A.N.

Campaign for Tobacco-Free Kids
Matthew L. Myers

Centers for Disease Control & Prevention*
Alyssa N. Easton, Ph.D., M.P.H.
Robert K. Merritt, II, M.A.
Carole C. Rivera

DC Healthy Start
Juliet Ogwo

Environmental Protection Agency
Alison Freeman
B. Christopher Griffin, M.P.A.

Health Resources & Services Administration*
Doris Barnette , A.C.S.W.
Ellen Hutchins, Sc.D., M.S.W.
Karen Thiel Raykovich, Ph.D.

March of Dimes
Marion Greenup

National Association of County & City Health Officials
Shari Sitron, M.P.H.

National Cancer Institute
Glen D. Morgan, Ph.D.

National Governors Association
Emily V. Cornell

National Healthy Mothers, Healthy Babies Coalition
Anita Boles, M.P.A.

National Perinatal Association
Sheila Sorkin, M.S.W.

National Pharmaceutical Association
Marcellus Grace, Ph.D., R.Ph.

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Office on Women's Health, U.S. Department of Health & Human Services
Karine Martirosyani, M.D.
Janelle Rowe, M.D.

Partnership for Prevention
Molly E. French, M.S.C.R.P.

Porter Novelli
Ed Maibach, Ph.D., M.P.H.
Kathryn Kahler Vose

The Robert Wood Johnson Foundation*
Joseph Marx
Michael McGinnis, M.D.
Kellie Murphy
C. Tracy Orleans, Ph.D.
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Trinita Ashford, M.P.H.

SmokeLess States National Tobacco Policy Initiative – American Medical Association
Madeleine Solomon, M.P.H.

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
Nancy Brady

University of Nebraska Medical Center
Magda G. Peck, Sc.D., P.A.

University of New Mexico Health Sciences Center
Sharon T. Phelan, M.D.

Washington Business Group on Health
Julianna S. Gonen, Ph.D.

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A single copy of the bulletin is available without charge by e-mailing The American College of Obstetricians and Gynecologists Resource Center at resources@acog.org. Please include your name, affiliation and mailing address with your request. Packages of 15 bulletins are available at member and non-member prices by calling the ACOG Distribution Center at 800-762-2264 and asking for item number AT260.

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The clinical practice guideline is available on the Surgeon General's web site (www.surgeongeneral.gov/tobacco/default.htm) or through the Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907; phone: 800-358-9295. *The Clinical Practice Guideline, A Quick Reference Guide* and a consumer version are available.

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- Orleans CT, Barker DC, Kaufman NJ and Marx JF. Helping pregnant smokers quit: meeting the challenge in the next decade.
- Melvin CL, Dolan-Mullen P, Windsor RA, et al. Recommended cessation counseling for pregnant women who smoke: a review of the evidence.

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This report is available on the Surgeon General's web site (www.surgeongeneral.gov) and on the Centers for Disease Control and Prevention web site (www.cdc.gov/tobacco). Printed copies may be obtained by calling CDC at (770) 488-5705, and selecting 3 to request a publication, or by writing to CDC's Office on Smoking and Health, Publications, Mail Stop K-50, 4770 Buford Highway, NE, Atlanta, GA 30341-3717.

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