Program Report

National action plan to reduce smoking during pregnancy: The National Partnership to Help Pregnant Smokers Quit

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Although there has been remarkable progress and momentum toward achieving smoke-free pregnancies in the United States since 1990, concerted action is needed to close the remaining gaps in treatment and prevention so that we can reach the Healthy People 2010 goal for pregnant smokers: a prevalence of 1% or less. This need for action led to the formation of the National Partnership to Help Pregnant Smokers Quit, a collaboration among more than 50 organizations and agencies, public and private, that have joined forces to help pregnant smokers quit by providing proven clinical and community-based interventions to every pregnant smoker. This article summarizes the action plan developed by the partnership, the strategies it outlines, and some of the actions taken by partners over the past year to put the plan into action. Action is planned and progress is being made in five strategic areas: offering help through the health care system; using the media effectively; harnessing community and worksite resources; promoting policies known to increase smoking cessation efforts and successes; and expanding national research, surveillance, and evaluation efforts.

Introduction

The 1990 Surgeon General’s Report on Smoking and Health (U.S. Department of Health and Human Services [USDHHS], 1990) provided compelling evidence for the harms of smoking and the benefits of quitting during pregnancy, and established smoking as the most important modifiable cause of poor pregnancy outcome among women in the United States. Since 1990, enormous progress has been made in promoting and achieving smoke-free pregnancies and creating unprecedented policy and environmental supports for quitting:

- The percentage of women who smoke during pregnancy has declined every year from 1989 to 2000, with current national estimates for smoking during pregnancy ranging from 12% to 20% (Martin, Hamilton, Ventura, Menacker, & Park, 2001). Tobacco use has fallen more rapidly among pregnant smokers than among the general population of women of childbearing age (USDHHS, 2001), and growing numbers of pregnant smokers are aware that smoking is harmful to their health and the health of their babies and are interested in quitting.

- Sufficient research evidence has been amassed to support, for the first time, an evidence-based recommendation for brief pregnancy-tailored counseling for routine use in prenatal care (Figure 1; Fiore et al., 2000). According to the Treating Tobacco Use and Dependence clinical practice guideline (Fiore et al.), these brief, easy-to-implement prenatal counseling approaches have been found to double or
1. Offering help through the healthcare system

**Aims**
- To ensure that every pregnant woman receives evidence-based smoking assessment and cessation counseling.
- Increase the number of providers who have access to training and materials on the 5 A's intervention and who use all components of the 5 A's.
- Collaborate with Native American/Alaska Native organizations to increase outreach, training, and intervention capacity for providers who work within these communities.
- Make the national partnership Web site a go-to resource for information on tobacco use and cessation in pregnancy and an effective conduit or portal to partner Web sites for science, provider, and consumer communities.
- Increase the availability, accessibility, and use of pregnancy-specific quitline resources.

**Overarching objectives**
- Work with leading professional associations and regulatory groups to define the 5 A's as part of best practice and postpartum care.
- Help to ensure that every healthcare provider who works with pregnant and postpartum women has the tools, training, and technical assistance needed to treat pregnant smokers effectively.
- Promote systems (e.g., office reminder systems, quality improvement integration) and policy changes (e.g., changes in covered benefits) shown to be effective if helping providers implement the 5 A's approach.

**Strategies**
- Work with leading professional associations and regulatory groups to define the 5 A’s as part of best practice and postpartum care.
- Help to ensure that every healthcare provider who works with pregnant and postpartum women has the tools, training, and technical assistance needed to treat pregnant smokers effectively.
- Promote systems (e.g., office reminder systems, quality improvement integration) and policy changes (e.g., changes in covered benefits) shown to be effective if helping providers implement the 5 A’s approach.

2. Using the media effectively

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

**Overarching objectives**
- Increase awareness among pregnant smokers that effective cessation services are available.
- Highlight the success of partners and raise the visibility of partner activities as they relate to pregnancy and smoking.

**Strategies**
- Implement coordinated media campaigns to bolster pregnant smokers’ motivation and self-efficacy to quit smoking.
- 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 avoiding unhelpful nagging and blame.
- Develop supportive print materials (e.g., self-help guides, posters) to reinforce provider counseling efforts in health care settings.

3. Harnessing resources in communities and worksite

**Aims**
- To develop resources in communities and worksites that enhance pregnant smokers’ motivation and ability to quit, and increase their access to evidence-based care.
- To support public policies that increase tobacco cessation and prevention.
- Develop a plan to conduct constituency relations outreach using partners’ extensive membership networks; make constituents aware of the partnership’s efforts and available materials and engage them in outreach activities.
- Increase number of employers offering health care and cessation coverage for pregnant smokers and assuring smoke-free workplaces.
- Expand the number of public and private prenatal health care systems that are working with community coalitions to strengthen community and worksite smoking restrictions.
- 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.

**Overarching objectives**
- Work with communities/Worksites Working Group to increase the number of businesses that negotiate prenatal smoking cessation benefits in their health plan contracts.

**Strategies**
- 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 or tobacco excise tax funds to support initiatives aimed at pregnant smokers

4. Capitalizing on state and federal funding and policies

**Aims**
- To promote economic and policy interventions that prevent and reduce maternal smoking, including increased funding for proven cessation interventions.
- Maintain or increase the number of states with coverage of smoking cessation services for pregnant women.
- Work with Communities/Worksites Working Group to increase the number of businesses that negotiate prenatal smoking cessation benefits in their health plan contracts.

**Overarching objectives**
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  - Preventing and reducing maternal smoking by increasing tobacco excise taxes
  - Promoting the wider use of state Master Settlement Agreement or tobacco excise tax funds to support initiatives aimed at pregnant smokers

5. Promoting research, evaluation, and surveillance

**Aims**
- To improve understanding of how to disseminate best-practice counseling interventions to pregnant and postpartum smokers.
- To develop and evaluate more powerful interventions for pregnant smokers and for all women of reproductive age.
- To strengthen national- and state-based surveillance of smoking in pregnancy, and of policy and programmatic supports for smoking prevention and treatment.
- Improve monitoring of the prevalence of smoking and the use and provision of proven cessation services during pregnancy.
- 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.
- Provide grant proposal workshops, forums, and active collaborations with major research funders to assist and support partnership members’ research and evaluation efforts.
- Assist and support efforts to strengthen the nation’s existing pregnancy-related public health surveillance systems and to maintain and expand collateral surveillance of policy and programmatic efforts and their cost benefits.

Figure 1. The 5 A’s intervention for pregnant smokers (based on Fiore et al., 2000).
triple pregnant smokers' quit rates compared with simply advising them to quit.

- Prenatal care providers have greatly expanded their efforts to help pregnant smokers quit. Data from the 1998 National Ambulatory Medical Care Survey documented that 96% of prenatal care providers report routinely asking about smoking status, a higher rate than for any other population subgroup (Thorndike, Rigotti, Stafford, & Singer, 1998).

- Both public and private coverage for recommended pregnancy-specific tobacco cessation counseling expanded considerably from the mid 1990s to 2000 (Ibrahim, Schauffler, Barker, & Orleans, 2002; McPhillips-Tangum, 2001; Schauffler, Mordavsky, Barker, & Orleans, 2001).

- Growing evidence and a new Centers for Disease Control and Prevention (CDC) Community Preventive Services Guideline (CDC Task Force on Community Preventive Services, 2001) support science-based community, media, and policy approaches (including tobacco tax increases, clean indoor air laws, tobacco cessation counter-advertising, reduced treatment copayments) that can expand and reinforce health care providers' efforts. State tobacco taxes increased in 29 states between 1998 and 2001, causing the average combined federal and state taxes to rise from 55 cents to 98 cents per pack and having a disproportionately great impact on quitting among pregnant smokers (Ringel & Evans, 2001).

- The Master Settlement Agreement and tobacco tax excise funds created unprecedented opportunities to fund effective cessation programs (although these opportunities have been realized in only a few states).

- Despite these achievements, the nation remains far from achieving the Healthy People 2010 goal of virtually eliminating tobacco use during pregnancy (reducing it to 1% or less), with challenges remaining in many areas:

- Smoking remains the most important preventable cause of poor pregnancy outcomes. Some 20% of low-birth-weight babies, 8% of preterm deliveries, and 5% of all prenatal deaths are linked to smoking during pregnancy, and new findings indicate impaired fetal brain and nervous system development and higher risks for sudden infant death syndrome (USDHHS, 2001).

- Progress in reducing smoking prevalence has been uneven, with high smoking rates remaining among pregnant women with the fewest educational and economic resources, particularly Native American women, non-Hispanic White women, and Hawaiian women. When ethnicity and education are considered together, the statistics are sobering: Nearly half (48%) of non-Hispanic White women with 9–11 years of education smoke during pregnancy (Martin et al., 2001).

- Growing public awareness of smoking harms in pregnancy appears to have increased the stigma associated with smoking during pregnancy. This awareness, coupled with pessimism or limited knowledge about the availability of helpful treatments, is believed to contribute to current high rates of smoking nondisclosure (Melvin & Gaffney, 2004) and low rates of demand for the evidence-based counseling treatments recommended as effective in routine prenatal care (Porter Novelli, 2000).

- Although relatively high proportions of providers advise their pregnant smokers to quit, they are no more likely to offer pregnant smokers the additional counseling and follow-up support needed than they are with other patients, revealing an even larger gulf between assessment of smoking status and effective intervention than for other U.S. smoker populations (Thorndike et al., 1998).

- Coverage expansion for the clinical practice guideline-recommended pregnancy-appropriate counseling interventions (Fiore et al., 2000) has lagged considerably behind those for other populations. Despite the much higher and more immediate return on investment for treating pregnant smokers (Marks, Koplan, Hogue, & Dalmat, 1990), in 2000, only 21 states covered nonmedication counseling services recommended for pregnant smokers, compared with 33 states that offered medications for smokers (Schauffler et al., 2001).

- Funding for research to disseminate existing evidence-based interventions for use during pregnancy, to develop more powerful interventions, and to systematically track the prevalence of tobacco use and tobacco dependence treatment in pregnancy at the state and national levels has been limited (Orleans, Barker, Kaufman, & Marx, 2000).

These circumstances led to the formation of the National Partnership to Help Pregnant Smokers Quit: on the one hand, remarkable progress and momentum toward the Healthy People 2010 goals for the high-risk pregnant smoker, and on the other, a clear need for concerted science-based action to close the remaining gaps before the decade's end. Capitalizing on other examples of effective collaboration and cooperation among diverse tobacco control funders, researchers, practitioners, and advocates, a national partnership made up of more than 50 organizations and agencies, public and private (Table 1), has been formed to work collectively to help the nation achieve the goal of no more than 1% prevalence of smoking during pregnancy by 2010. Members of the partnership came together out of a shared commitment to expand access to proven clinical and community-based interventions for every pregnant smoker in the United States. One of the strengths of the partnership is that member
organizations have unique but interrelated roles to play in the discovery, development, and delivery of effective interventions, both clinical and population-based: Some focus on research and surveillance; some on professional education and training; and others on programs, policies, and services. In addition, many of the nation’s leading public and private funders of smoking cessation in pregnancy research and programs are represented in the partnership.

The action plan developed by the partnership outlines strategies that health care providers, worksites, communities, state and federal government, and the research community can employ to make those interventions more accessible (National Partnership to Help Pregnant Smokers Quit, 2002). It also describes strategies to build demand for interventions among pregnant smokers and those who care about and for them, and to develop the next generation of more effective interventions. Each member organization makes a commitment to 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 all pregnant smokers to quit.

We describe here the process of forming the partnership and developing the action plan, present the chief aims and strategies incorporated by the partnership into the action plan, and highlight progress to date on reaching the partnership’s ambitious goals. Selected efforts and products of the partnership’s first-year activities are highlighted.

### Table 1. National Partnership to Help Pregnant Smokers Quit: Partner organizations and representatives, May 2003.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Representative</th>
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<tr>
<td>Agency for Healthcare Research and Quality</td>
<td>Mom’s Quit Connection</td>
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<td>Alliance for Community Health Plans</td>
<td>National Association of County and City</td>
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<td>American Academy of Pediatrics, PA Chapter</td>
<td>Health Officials</td>
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<td>American Association of Health Plans</td>
<td>National Cancer Institute</td>
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<td>American Cancer Society, Center for Tobacco Cessation</td>
<td>National Center for Health Statistics</td>
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<td>American College of Nurse Midwives</td>
<td>National Governors Association</td>
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<td>American College of Obstetricians and Gynecologists</td>
<td>National Healthy Mothers, Healthy Babies Coalition</td>
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<td>American Heart Association</td>
<td>National Perinatal Association</td>
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<td>American Legacy Foundation</td>
<td>National Pharmaceutical Association</td>
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<td>American Medical Women’s Association</td>
<td>Norris Cotton Cancer Center</td>
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<td>American Public Health Association</td>
<td>Office of Maternal and Child Health, Department of Health, Washington, DC</td>
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<td>American Social Health Association</td>
<td>Office on Women’s Health, U.S. Department of Health and Human Services</td>
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<tr>
<td>Asian Pacific Partners for Empowerment</td>
<td>Oklahoma State Medical Association</td>
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<td>Association of Maternal and Child Health Programs</td>
<td>Oregon Office of Family Health Services</td>
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<td>Association of SIDS and Infant Mortality Programs</td>
<td>The Robert Wood Johnson Foundation</td>
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<td>Association of State and Territorial Health Officials</td>
<td>Smoke-Free Families National Advisory Committee</td>
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<tr>
<td>Association of Women’s Health, Obstetric and Neonatal Nurses</td>
<td>Smoke-Free Families National Dissemination</td>
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<tr>
<td>Bolton School of Nursing, Case Western University</td>
<td>Office, University of North Carolina at Chapel Hill</td>
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<tr>
<td>California Smokers’ Helpline</td>
<td>Smoke-Free Families National Program Office, University of Alabama at Birmingham</td>
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<tr>
<td>Campaign for Tobacco-Free Kids</td>
<td>Smokeless States National Program Office, American Medical Association</td>
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<tr>
<td>Centers for Disease Control and Prevention</td>
<td>Society for Women’s Health Research</td>
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<td>CityMatCh</td>
<td>Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services</td>
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<tr>
<td>CJ Foundation for SIDS</td>
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<tr>
<td>Dana-Farber Cancer Institute</td>
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<td>Environmental Protection Agency</td>
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<td>Health Resources and Services Administration</td>
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<td>Maine Medical Center</td>
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### National partnership formation and structure

The Robert Wood Johnson Foundation (RWJF) and its Smoke-Free Families National Dissemination Office (SFFNDO) and National Program Office (SFFNPO), with communications support from the social marketing firm Porter Novelli, Inc., formed a steering committee representing eight partner organizations to set an initial vision and template for the National Partnership to Help Pregnant Smokers Quit. The steering committee, chaired by Cathy L. Melvin, was made up of representatives from the following organizations: Agency for Healthcare Research and Quality (AHRQ), American Association of Health Plans, American College of Obstetricians and Gynecologists (ACOG), Association of Maternal and Child Health Programs, CDC, Health Resources and Services Administration, Smoke-Free Families, and the RWJF. This group took the lead in translating the national partnership’s vision into operational terms, drafting an initial version of the action plan described below, and refining it based on input solicited from all partnership members. The work to develop and refine the action plan and to coordinate the partnership’s ongoing planning, organizational, and communications needs has been supported by generous in-kind contributions from a large number of partnership members and by a US$5 million grant from the RWJF to the SFFNDO and Porter Novelli.

After reviewing the evidence for treating tobacco use during pregnancy and finding that a brief intervention could increase cessation rates by 30%–70%
(Melvin, Dolan-Mullen, Windsor, Whiteside, & Goldenberg, 2000), the steering committee met early in 2000 to discuss approaches for disseminating, throughout the United States, the recommended 5 A’s intervention for pregnant smokers (see Figure 2). The steering committee decided that a broader, collaborative effort was needed to fully disseminate this proven intervention and invited relevant national organizations and agencies to an orientation and planning meeting in December 2000. At this initial partner meeting, over 30 organizations came together to consider how, in a collaborative effort, they might advance the science of cessation for pregnant smokers, build capacity within the health care system to deliver evidence-based interventions, and create demand for cessation services among health care providers and pregnant women and their families. Presentations on evidence-based approaches and findings led to a facilitated discussion aimed at achieving consensus on the partnership’s overall vision, goals, and aims. Participants left the meeting having developed a vision statement, two goal statements, and a number of aims for the partnership as well as a wide range of suggested strategies and tactics for achieving those goals and aims. The partnership’s vision is to provide the nation’s pregnant and postpartum smokers with access to treatments and supports proven to help them quit smoking. The members made a commitment to achieve this vision by translating science-based interventions into effective programs and policies.

Developing an action plan

Over the next year and a half, partner organizations worked with the staff of the RWJF, the SFFNDO, and Porter Novelli to review the literature supporting the proposed goals, aims, and strategies and to prepare an action plan based on this review and partner input. The action plan was mailed to all participants of the December 2000 meeting as well as other organizations that expressed an interest in joining the National Partnership to Help Pregnant Smokers Quit subsequent to that meeting. Revisions were made based on this input, and the revised action plan was adopted by all partnership members immediately before the official partnership launch in May 2002 (National Partnership to Help Pregnant Smokers Quit, 2002). The final action plan represented consensus and expert opinion on evidence-based approaches to reduce tobacco use during pregnancy at the population level. The specific aims, overarching

| 1. Ask | Ask all pregnant women about smoking status, using a specific multiple-choice question to improve disclosure. |
| 2. Advise | Advise those who smoke to quit, using clear, strong, and personalized messages about the impact of smoking and the benefits of quitting for the mother and her fetus. |
| 3. Assess | Assess willingness to make a quit attempt within the next 30 days. |
| 4. Assist | Assist those willing to quit by suggesting and encouraging the use of problem-solving methods and skills for quitting; providing support as part of the treatment; helping arrange support among family, friends, and coworkers; and providing pregnancy-specific self-help cessation materials. |
| 5. Arrange | Arrange follow-up contacts to assess smoking status and progress in quitting, encourage smoking cessation if still smoking, and refer for 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 clinical practice guideline (Fiore et al., 2000), for intensive counseling from a provider with special training in the treatment of tobacco dependence or appropriate use of effective pharmacotherapies. The guideline advises caution in the use of pharmacotherapies (nicotine replacement theory, bupropion) during pregnancy because they have not been tested for safety or efficacy among pregnant smokers.

Pharmacotherapies are recommended for consideration only among pregnant women who smoke heavily and are unable to quit using counseling alone, and when the potential benefits and likelihood of quitting outweigh the potential risks.

Figure 2. The aims, overarching objectives, and related strategies of the action plan: The National Partnership to Help Pregnant Smokers Quit.
objectives, and strategies are based on recommendations from a variety of sources, including the following:

- *Treating Tobacco Use and Dependence: A Clinical Practice Guideline* (Fiore et al., 2000)
- ACOG educational bulletin 260 (ACOG, 2000)
- The Guide to Community Preventive Services: Tobacco Use Prevention and Control (CDC, 2001)
- Smoking and Pregnancy: Research Findings from the Smoke-Free Families Program (Wakefield, 2000)
- Market research with pregnant smokers, obstetricians, and obstetrical nurses (Porter Novelli, 2000)
- A wide range of other relevant literature

The action plan contains a call to action from former U.S. Surgeon General David Satcher, the National Partnership’s vision and goals, a description of the issues involved in preventing maternal smoking, a partnership pledge and guiding principles, aims and strategies, and personal stories of pregnant women and their experiences with quitting smoking during pregnancy. The primary target audiences described in the plan are pregnant women and their families, health care providers and policy makers, communities and worksites, and researchers. Aims were set in five strategic areas, summarized in detail in the action plan, which can be viewed in its entirety at www.helppregnantsmokersquit.org:

- Improving the delivery of recommended screening and treatment services in the health care system by ensuring that the necessary tools and systems are in place
- Using the media effectively to reach pregnant smokers and those who care about and for them
- Harnessing community and worksite resources and policies to promote, assist, and support cessation among pregnant women
- Promoting knowledge of public and private policies known to increase smoking cessation efforts and successes, including those that improve access to and use of proven cessation treatments
- Supporting research and surveillance needed to develop more effective interventions, improve dissemination efforts, and strengthen national surveillance of the prevalence and cost of smoking in pregnancy and the use and cost benefits of available interventions

**Implementing the action plan**

Although the action plan outlined evidence-based approaches for meeting goals and aims of the National Partnership to Help Pregnant Smokers Quit, no mechanism had been developed for engaging partners in the work needed to accomplish these goals. At the May 2002 launch, five working groups with representatives from partner organizations were formed to put in motion the strategies and tactics defined in the five major strategic aims of the action plan. Working groups were charged with developing action steps that could be completed between 2002 and 2005 and setting priorities among those steps so that progress could be documented in the first year. One staff member from either the SFFNDO or Porter Novelli, and one representative from a partner organization were designated as co-chairs to help coordinate the communications and activities of each working group.

Since their formation in May 2002, the working groups have met monthly by phone to develop and implement specific overarching objectives and strategies for each of the action plan’s aims (Figure 2). Representatives from more than 30 partnership member organizations have taken part in regular calls and meetings to translate these objectives and strategies into practical accomplishments. Annual national partnership meetings provide a forum for collaborating face-to-face within and across working groups; for reporting results and refining these objectives and strategies; and for getting fresh views from the field, especially about model programs and strategies related to core partnership aims.

**Accomplishments: Overview and highlights**

In May 2003, the second annual meeting of the National Partnership to Help Pregnant Smokers Quit was held to review progress and make plans for the coming year. Member organizations presented the programs and activities they undertook over the past year in support of partnership aims and heard from national experts on how to realize the meeting theme, “We Can Achieve More Together Than We Can On Our Own.” The working groups met and provided orientation for new members; reviewed their progress; adopted formal benchmarks for documenting results and assessing future progress; and made plans for 2003–2004, including plans to reach out to additional organizations and agencies. The benchmarks were established through an iterative review process and involved the RWJF, the SFFNDO, and the working group co-chairs and members and were intended to measure the process and progress of working group activities. Full summaries of these accomplishments and benchmarks may be viewed at www.helppregnantsmokersquit.org. Beginning in 2003, the partnership will produce an annual report outlining its accomplishments and its progress with reference to these specific aims, objectives, and benchmarks. Selected highlights of progress made to date are presented below.
One example of the ways in which partnership members have worked together to accomplish more than any single organization could to advance the first aim (offering help through the health care system) is in the development and dissemination of products designed to assist clinicians in their adoption and use of the best-practice intervention. Key first-year accomplishments are listed below:

- **The ACOG** has developed an educational bulletin outlining the 5 A’s (ACOG, 2000) and a training manual designed to train clinicians on the implementation of the 5 A’s in their clinical practices (ACOG, 2002; Chapin & Root, 2004). This continuing medical education (CME)-approved activity includes a monograph describing the 5 A’s and ways to integrate the 5 A’s into routine prenatal care, photocopy-ready office tools, a quick-reference pocket guide on determining patient smoking status, a checklist and role assignment chart for launching the 5 A’s in a practice setting, case studies that lay out eight common clinician-patient scenarios and offer dialogue and key points to consider when counseling patients to quit, and the patient education booklet Need Help Putting Out That Cigarette?

- **The Association of Women’s Health, Obstetric, and Neonatal Nurses** has developed a research-based practice guideline on smoking cessation and is now testing it in diverse nurse practice settings around the country.

- **Many partners**, such as CDC grantees, have developed and provided training for health care providers across the United States through presentations at regional and national meetings of health care professionals, as well as through a variety of print, electronic, and interactive media. Most training has been professionally accredited and approved for CME or continuing education units.

- **The RWJF**, working in conjunction with the ACOG and Smoke-Free Families, funded the Interactive Media Lab at Dartmouth Medical School to develop an interactive “virtual mini-fellowship” as a distance learning tool for a variety of health care providers and students (e.g., obstetricians, gynecologists, family practice physicians, nurse midwives, nurse practitioners, pediatricians) to deliver state-of-the-art counseling to reproductive-age, pregnant, and postpartum smokers. This tool will be endorsed, promoted, and approved for CME credits by the ACOG and other professional organizations.

- **Smoke-Free Families** worked with the ACOG, the AHRQ, the American Legacy Foundation, and the RWJF to develop customizable patient education materials, including a quitline script and a patient education booklet, Need Help Putting Out That Cigarette? These materials are available in a number of ways, including online. Smoke-Free Families also has placed online a series of slide sets and bibliographies on various topics related to smoking and pregnancy, which are updated monthly.

- **The AHRQ** and Smoke-Free Families collaborated to develop “tear sheets” (in English and Spanish), which serve the dual role of decision support tools for providers and self-help aids for patients: *You Can Quit Smoking: Support and Advice From Your Prenatal Care Provider*.

- **The March of Dimes** developed and widely disseminated a new brochure in both English and Spanish: *The Facts About Smoking and Pregnancy*.

- **The partnership initiated** a formal needs assessment for Native American/Alaska Native providers to determine the availability of population-specific provider and patient materials, and worked with the CJ Foundation for SIDS, which awarded two Smoke-Free-Families-funded grants of US$25,000 each to support pilot initiatives by the Great Lakes Inter-Tribal Council and the Aberdeen Areas Tribal Chairman’s Board.

- **In the first year of the partnership**, several partner organizations devoted exhibit space or time in their annual meeting schedules for presentations and discussions on treating tobacco use during pregnancy.

The partnership’s work on the second aim, using the media effectively, offers additional examples of synergistic efforts and accomplishments. Some highlights follow:

- **In 2002**, the American Legacy Foundation launched its innovative Great Start program to help women quit smoking during pregnancy. As described by Haviland et al. (2004), this ongoing campaign uses paid and unpaid television spots and print media to educate pregnant women about the harms of smoking during pregnancy and encourages them to call the Great Start Quitline. Several partnership members have contributed to Legacy’s initiative: The American Cancer Society manages the campaign’s national telephone quitline, and the SFFNDO codesigned its quitline counseling protocols and materials for callers and their providers.

- To supplement Legacy-sponsored paid ads, the partnership, led by Porter Novelli, created and placed a television public service announcement, “The Help You Deserve,” featuring real women who successfully quit smoking while pregnant and providing the toll-free Great Start Quitline number. The announcement has aired over 36,000 times to date and has an estimated advertising value of almost US$3.5 million.

- Porter Novelli worked with several partnership organizations to develop a poster for display in doctors’ waiting rooms designed to prompt pregnant women to disclose their smoking status and ask for help to quit.

- The partnership worked to place stories about cessation in pregnancy in entertainment programming by reaching out to television and film writers...
and producers. Outreach included developing a poster similar to the one described above to be used on theatrical sets, which to date has been shown on the Lifetime Television for Women series *Strong Medicine*.

- The partnership’s Media Working Group worked closely with the *New York Times* to shape the editorial content of the newspaper’s November 2002 (Great American Smoke-Out) Tobacco Cessation supplement, which featured the work of several partnership organizations. The group also developed a half-page advertisement in the supplement to call attention to the partnership’s work.
- In fall 2002 and spring 2003, the partnership wrote and distributed two print releases and a radio release encouraging pregnant smokers to quit. Combined, these releases reached as estimated audience of nearly 35,000, with an estimated advertising value of over US$150,000.
- To coincide with Mother’s Day 2003, the partnership developed a video news release (VNR) featuring a pregnant smoker and the nurse practitioner who assisted her in quitting smoking. The VNR also included interviews with partnership chair Cathy Melvin and March of Dimes president Jennifer Howse. The VNR aired 113 times on 29 stations in 56 markets, reaching and estimated audience of 2.67 million people.

As these examples show, the synergy of member organizations working together has generated a large number of products and programs and used broad partnership networks to reach a wide audience of providers and pregnant smokers and their supporters. Similar accomplishments, summarized on the partnership Web site, have emerged from work on the partnership’s other major aims. As a Grantmakers in Health (2003) report notes, success in ambitious, unflagging efforts, and generous resources made it possible to translate the vision behind the action plan into the accomplishments and plans described in this article. Thanks also go to the Smoke-Free Families National Dissemination Office, including Daanne Barker, Catherine Rohsweder, Carolyn Busse, Karen Bauer, and Ginger Morgan, and to the staff at Porter Novelli, Inc., including Carrie Schum, Stephanie Marshall, Ayanna Robinson, Meagan Orser Johnston, Maria Droumbanis, Jennifer Hoyer, and Bobbi Williams, for their invaluable organizational support, and Dawn Young for assistance with manuscript preparation. We also acknowledge the financial support of the Robert Wood Johnson Foundation.

**Conclusion**

The overarching aim of the National Partnership to Help Pregnant Smokers Quit is to collectively achieve a greater impact than the sum of the partners working alone—through coordinated and strategic action. A comprehensive approach to preventing and treating tobacco use during pregnancy and postpartum has been developed and outlined in the partnership’s action plan. Working groups are undertaking collaborative and coordinated efforts to accomplish the stated aims, and benchmarks have been set to measure implementation of strategies and tactics and to assess their impact on improving intervention delivery and reducing smoking prevalence among pregnant women. Continued momentum and success will depend on the work of each partner and the collective work of all partners. Our first year’s accomplishments have shown us the potential of the national partnership to provide leadership, initiate change, and apply the best of what we know. As we move forward, we hope others will join us and help every pregnant smoker and new mother get the help they want and the support they need to quit smoking and stay tobacco free.

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