Starting Smokefree

Report on the
National Smokefree Pregnancy Forum

Butterfly Creek, Auckland Airport
13 October 2005

Prepared by
Stephanie Cowan and Judith Clarke
Education for Change
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Contents

"The needs of children have an urgent quality about them. Children do not keep. They are exquisitely sensitive to time. The food they demand, the love they require and the stimulation they need cannot be put off without harm to their growth.

Developmental needs must be met or development is stifled. Providing the best care we know how to give is no guarantee of a trouble free future. Nothing is. But that care will make it more likely that our children will be equipped to face the problems that are an inescapable part of the human condition."

Leon Eisenberg (1987)
Preventative Paediatrics: the promise and the peril.
Paediatrics 80 (3): 415-422

Acknowledgements

We wish to thank the many people who assisted us with the Smokefree Pregnancy Forum.

Most importantly, we thank the participants themselves, most of whom were leaders of their professional bodies and all of whom made space in their busy schedules to contribute.

We also thank the three speakers Judith Lumley, Lesley McCowan and Ashley Bloomfield for their willingness to speak, their stimulating presentations and we acknowledge the importance of these to informing the afternoon discussions.

We thank our two guests, Victoria Hotene and Krystal Black for bringing a personal perspective of changing smoking to the day. We value the cultural guidance of Whaea Mina Timu Timu before, during and after the forum. We appreciate, in particular, her cultural care of the two young women, and of us all, through her karakia to open and close the forum and in leading the waiata. Also, we thank Anna Cossey for supporting our guests with transport to and from the forum.

We are grateful to Nick Baker, Sue Bree, Ken Clark, Michelle Mako and Iain Potter for leading group discussions and bringing forth the summaries despite the inevitable challenge of diminishing time.

We were pleased to get good media coverage for the forum and are most grateful to Liz Price for her efforts in supporting us with this, and to the Health Sponsorship Council for footing the bill.

We thank Katrina Hogg and Katie Nind for their administrative support in preparing documents, resources and mail outs and their willingness to go the extra mile for this project.

Last, but not least, we are most grateful to Lesley McCowan and Jo Waddingham for their professional advice and enthusiasm as members of the project group.

In all these various ways we felt supported and encouraged in arranging this forum. We thank you all.

Stephanie Cowan and Judith Clarke
Education for Change
18 November 2005

Organisations represented

Auckland Tobacco Control Research Centre

Christchurch School of Medicine, University of Otago

Department of Obstetrics and Gynecology, University of Auckland

Education for Change Limited

Fertility Centre (New Zealand Centre for Reproductive Medicine Limited)

Health Sponsorship Council

Maternity Services, Canterbury District Health Board

Midwifery and Maternity Provider Organisation

Midwifery Council

Ministry of Health

Mother and Child Health Research, La Trobe University, Victoria, Australia

National Maori Midwives Caucus

National Women's Health, Auckland District Health Board

New Zealand College of General Practitioners

New Zealand College of Midwives

Paediatric Society of New Zealand

Pegasus Health

Public Health Association

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

Royal New Zealand Plunket Soc. (Inc)

School of Population Health, University of Auckland

Wellington School of Medicine and Health Sciences, University of Otago

Executive Summary

The outcomes of discussions at the Smokefree Pregnancy Forum held at Butterfly Creek, Auckland Airport on 13 October, 2005 are summarised below as the Butterfly Creek Smokefree Pregnancy Standard.

The Butterfly Creek Smokefree Pregnancy Standard
1. Make achieving smokefree pregnancies a high priority for policy
2. Develop systems to support health professionals to intervene in a consistent way
3. Provide professional education to support effective interventions
4. Support pregnant women to be smokefree with equitable access to effective interventions
5. Increase public awareness that the issue is serious and that "something can be done"

Introduction

The human child has nine months in which to prepare to be born. These nine months are like no other. Opportunities for best care, lost or gained during these months last a lifetime. Exposure to smoking during the crucial nine months of pregnancy is not the same as smoking during nine months of adulthood. There is much more at stake. The need to protect is urgent. A child needs a smokefree place to grow and develop during pregnancy in order to have the best chance to be healthy, develop normally and survive.

Forum Goals

The purpose of the Smokefree Pregnancy Forum was threefold:

- to bring together a multidisciplinary group able to provide health leadership in promoting smokefree pregnancies
- to decide the key elements of national policy and strategy to guide best practice
- to establish a working group to move this initiative forward.

Size and scale of the problem

While the current prevalence is not known, an estimated one third[1] of pregnant women continue to smoke in pregnancy, in New Zealand. This exposes around 18 000 pregnant women and unborn children to the harmful effects of tobacco each year, to a greater or lesser degree. As well, there are an estimated 90 000 preschool children living with smoking at home.

The high prevalence and serious effects makes smoking in pregnancy the number one modifiable risk factor for adverse pregnancy and child health outcomes. The effects are many, varied and far-reaching for both the woman and her baby and contribute to infertility, pregnancy complications, intra-uterine growth restriction, preterm births, stillbirths, asthma, glue ear, SIDS, bronchiolitis, hospital admissions, learning difficulties and more. Although there is a dose effect of reduced risk from reduced smoking, even women smoking 5 cigs/day have a significantly increased risk of having a "small for gestational age" baby[2].

Issues

From the authors' experience in providing services to address smoking in pregnancy at personal, professional and organisational levels, we have identified challenges to consider in designing a coordinated strategy for addressing smoking in pregnancy and its effects.

[1] Borman B, Wilson N, Mailing C. Socio-demographic characteristics of New Zealand smokers: results from the 1996 census. NZ Med J 1999;112:460–3 Borman

[2] Mitchell et al. Smoking, nicotine and tar and risk of small for gestational age babies. Acta Paediatr. 2002;91(3):323-8.

Invisibility: There is low awareness, by professionals and the public, of the status of smoking in pregnancy as the main cause of preventable risk for pregnancy and child health. And there is low awareness of the vulnerability of the smoke-damaged child once born. Adding to invisibility is poor data on prevalence, patchy coverage for dedicated smokefree pregnancy services, a media focus on second hand smoking and low-level responding by health professionals. In all these ways, addressing smoking gives way to competing priorities for time and importance at all levels, reducing its visibility.

Inconsistency: As well as low awareness, in New Zealand we have no agreed standard of care for a woman who smokes while pregnant, or for her child once born. Smokefree identification is under-recorded in pregnancy and paediatrics[3], interventions are reliant more on champions than protocols and a systematic approach to care is the exception more than the rule. Confusion continues around the safety of pharmacotherapy in pregnancy and there are tensions between the goals of increasing self- efficacy for the parents and reducing exposure for the child.

Inequality: Maori, Pacific and low income women carry a disproportionate burden of pregnancy complications due to smoking, and their children carry an unfair burden of death, disease and hardship. With wide-spread under-recording of smokefree status, it is likely that many people are missing out on access to interventions, too many from priority groups.

Low confidence: Major barriers to change are in the low confidence of women in their ability to be smokefree, especially from the demands of nicotine addiction, when others smoke at home, the need to rationalize smoking and minimize risk information, the immobilizing effect of ambivalence, publicity that "smoking outside" is good enough, pregnancy as an extrinsic motivator, temptation from smoking by others, the relationship between smoking and stress, low birth weight being seen as a benefit in a "small is good" culture, risk information not supported by personal experience, fear of judgment from health professionals and more.

As well barriers present in the low confidence of health professionals to address smoking, a belief that it takes a lot of time and makes little difference, unrealistic expectations for overcoming nicotine addiction, little understanding of the role of social determinants of smoking, the lack of immediate evidence from intervention and the urgency of the presenting issue

Language: Language is an important carrier of culture. Currently, we use positive smokefree language to promote a culture of smokefree environments yet negative smoking language to promote a culture of smokefree people (quit, cessation, give up, cut down, smoker). The language of smoking is a focus on the problem and risks stereotypical thinking by professionals and a reluctance to disclose smoking status by parents. The language of smokefree is positive, a focus on the solution and encourages discussion.

[3] Cowan S and Langley L. Identifying and addressing exposure to smoking for patients in NZ hospitals. Education for Change (2004)

Preparation

The Smokefree Pregnancy Forum was a Ministry of Health funded initiative within the *Safe Start* programme of Education for Change. Beginning discussions were held with Karen Guilliland, Chief Executive, New Zealand College of Midwives; Lesley McCowan, Associate Professor of Obstetrics, National Women's Health and Candace Bagnall, Leader of the Tobacco Programme, Ministry of Health. A comprehensive review of the literature and an expert interview with Professor Richard Windsor from The George Washington University Medical Centre also informed the design of the project.

A project group of four worked over six months to design and arrange this forum. The group was Lesley McCowan, Obstetrician Advisor, from University of Auckland and Judith Clarke, Project Coordinator, Jo Waddingham, Midwife Advisor, and Stephanie Cowan, Project Director all from Education for Change. Communication was via face to face meetings, email and telephone.

Forum design

The forum was designed to achieve leadership on the day. Invited participants were health leaders spanning fertility, pregnancy, neonatology, paediatrics, well-child, general practice, Maori health, public health, research and Ministry of Health. A list of participants and a brief professional biography for each person is given in the Appendix (p 21). A briefing paper and selected research articles were sent three weeks in advance to give people the opportunity to update, discuss and share within their networks prior to the day. Participants were prepared for a focus on decisions more than discussion on the day itself.

The morning programme was for expert presentations on the impact of smoking in pregnancy and the afternoon programme for discussions and decisions about how to respond. Group discussions were facilitated by the participant representatives for midwifery, obstetrics, paediatrics and public health. A "person flow" approach to discussion was suggested, from pre-pregnancy through pregnancy and infancy looking for ways to optimize intervention opportunities and effectiveness.

There were three ways in which the ideas of people were gathered: a collective statement from the whole group discussion on policy, pooled responses from small group discussions on strategy and, as a final check for how much agreement there was, individual responses on a pre-prepared tick-box sheet for a minimum smokefree pregnancy service standard. These three mechanisms for feedback were to identify areas of agreement and allow group and individual contributions.

This feedback was to provide the elements of a leadership document for guiding best practice and a working group was to be established to take the next step.

Participation

Twenty-nine people attended the first smokefree pregnancy forum to be held in New Zealand. The forum was held at Butterfly Creek, Auckland Airport on Thursday 13 October 2005, form 9.00 a.m. – 4:00 p.m.

Presenters

- **Professor Judith Lumley** Director, Mother and Child Health Research, La Trobe University, Victoria, Australia

  Judith's work, which has influenced the care of the 250,000 Australian women who give birth each year, has shown that helping women become smokefree during pregnancy reduces the risk of low birth weight and premature babies. Judith has also influenced management of post-natal depression, highlighted inconsistencies in antenatal care, and argued for better evaluation of the effect of early discharge after birth. Her presentation was of her very recent updated Chochrane Review of smoking in pregnancy interventions.

- **Lesley McCowan** Associate Professor, Department of Obstetrics and Gynaecology, University of Auckland

  Lesley is a subspecialist in maternal fetal medicine and her clinical practice is with women with major pregnancy risk factors, many of whom have previously had preterm , growth restricted or stillborn babies. Her current focus is to reduce the burden of pregnancy complications due to smoking in New Zealand women. Lesley's presentation was of the clinical evidence for maternal and fetal harm from smoking in pregnancy.

- **Ashley Bloomfield** Chief Advisor Public Health, New Zealand Ministry of Health

  Ashely trained in medicine and public health at the University of Auckland and has worked in the health policy field for the past 8 years with the National Health Committee, National Screening Unit and Ministry of Health. He has a long standing interest in tobacco control, and oversaw the development of the NZ smoking cessation guidelines. Ashley's presentation placed smokefree preganancies within the broader public health context.

- **Stephanie Cowan** Director, Education for Change

  Stephanie has twenty years experience in the design and delivery of education programmes for addressing difficult issues. Her organisation has health-funded services for addressing smoking at personal, professional and organisational levels. Her presentation was of ten principles with multi-level application for designing interventions to achieve smokefree pregnancies.

Guests' Interview

The last part of the morning programme was a facilitated discussion with two participants of the Smokechange programme. Both women were invited as experts in achieving change at a personal level. They presented their understandings of what is important for addressing smoking and achieving smokefree pregnancies and how health professioanals can make a positive difference. Whaea Mina Timu Timu spread "a cloak of aroha" around the young women through her beginning karakia and departing waiata, in which everyone joined.

Discussions

The afternoon programme was discussion. Michelle Mako, representing the Public Health Association, facilitated the whole group policy discussion through the expert panel. The main topics were:

- the size, scale and seriousness of the problem and the scope of a coordinated smokefree pregnancy strategy
- the place of nicotine replacement in a smokefree pregnancy strategy
- the use of the term fetal tobacco syndrome[4] to describe the consequences for the child of maternal smoking behaviour
- the concept of biological relativity[5] raised by Nick Baker, for understanding the impact of time duing rapid development and the legitimacy of a specific focus on pregnancy interventions

The policy discussion was followed by a discussion on strategy. Sue Bree, New Zealand College of Midwives, Nick Baker, New Zealand Paediatric Society and Ken Clark Royal Australasian College of Obstetriciams and Gynaecologists each led these smaller group discussions. Iain Potter, Health Sponsorship Council coordinated the feedback session.

Ashley Bloomfield, Ministry of Health, summarised the collective thinking on policy and presented it to the group for their agreement of the main themes. The last activity of the forum was an individual assessment of key areas for deciding strategy that related to the briefing papers. This was an opportunity for every participant to have their say. Three of twenty five people did not pass in their assessments and four Education for Change participants did not complete one. Feedback is summarised for the 22 people.

Next step working group

At the end of the day it was proposed that a small group join the project team as a next step to decide "where to from here?" and the following five people accepted: Sue Bree (midwife), Nick Baker (paediatrician), Ken Clark (obstetrician), Margaret Shanks (general practitioner), Michelle Mako (public health professional). The forum ended promptly at 4:00 p.m. as scheduled.

[4] Neiburg et al. The fetal tobacco syndrome. *JAMA* 1985;253(20):2998-9

[5] Perry BD Biological relativity: Time and the developing child (1998, November 30). Gray Matter. Forbes ASAP, 3rd Annual Big Issue. (http://www.childtrauma.org/ctamaterials/biolo_relativity.asp)

Forum discussion outcomes

Below is a report of the summary statements, group discussion feedback and individual assessments gathered on the day, that identify areas of agreement. No attempt has been made to summarise discussions beyond this as many discussions were informal and some were not able to develop due to time constraints. In particular, the discussion about a descriptive term for the consequences of maternal smoking on the unborn baby, described as fetal tobacco syndrome[6], needed more discussion and another forum as did the document introduced by Marewa Glover describing a US model of national partnership to promote smokefree pregnancies[7].

Understandings

From the collective policy discussion, forum participants supported these understandings and policy perspectives:

- The impact of time is greatest during rapid development, magnifying the need to provide an optimal place for a child to grow during the nine months of pregnancy.
- Smoking in pregnancy is the biggest single preventable cause of adverse pregnancy outcomes, affecting an estimated 18 000[8] pregnant women and unborn babies each year.
- Achieving smokefree pregnancies provides the single best protection against pregnancy complications, including pre-term birth, miscarriage and stillbirth, in the population at large.
- Smokefree pregnancies have major benefits for the health of the mother and wider family, and lifelong benefits for the child.
- Achieving smokefree pregnancies must be a high priority for the wider health sector and community as well as those directly involved in the care of pregnant women.
- There is considerable evidence[9] of effective ways to assist pregnant women who smoke to become smokefree.

Policy

- Achieving smokefree pregnancies and parenting is a high priority for improving the health of New Zealanders
- Achieving smokefree pregnancies needs to be a key driver for tobacco control and maternity care policies.

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[6] Neiburg P et al. The fetal tobacco syndrome. *JAMA*. 1985 May 24-31;253(20):2998-9.

[7] Melvin CL Chair, Steering Committee, The National Partnership To Help Pregnant Smokers Quit (2002) University of North Carolina

[8] Borman B, Wilson N, Mailing C. Socio-demographic characteristics of New Zealand smokers: results from the 1996 census. NZ Med J 1999;112:460–3 Borman

[9] Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

- Pregnancy presents an important opportunity for health professionals to identify smokefree status and support parents to become and stay smokefree.
- All pregnant women should have equitable access to effective interventions to help them be smokefree.
- Three action priorities are; Increasing public awareness, education of health professionals and the development of systems to support health professionals to intervene in an effective and consistent way.

Strategies

From group discussions, forum participants identified these strategy areas as important:

Develop supportive systems

- Systems that are planned and collaboratively designed
- Systems for early smokefree identification of pregnant women and their partners
- Systems for standardised intervention schedules (e.g. the five A's)
- Systems and protocols for using nicotine replacement products
- Systems for cotinine screening
- Systems to monitor and audit smokefree status and interventions
- Systems to improve data collection and monitoring (to enable a case for better resources)
- Systems to track and evaluate data collected
- Systems for handover to well child providers
- Systems for health professional accountability and mandatory reporting

Provide smokefree education for health professionals

- Funded and facilitated education programmes at all levels to:
    - raise the priority of achieving smokefree pregnancies
    - empower health professionals to understand that interventions are effective
    - increase confidence and competence of health professionals to understand care pathways and intervention opportunities
    - inform about available services and help
- Funded time to attend

Support pregnant women to become and stay smokefree

- Early intervention opportunities e.g. linked to pregnancy tests
- High quality intensive programmes available to across New Zealand
- Simple tools for everyday practice (e.g. Kits, Talk Cards, and solution focused language)

- Appropriate resources available at the different phases of pregnancy
- 0800 smokefree pregnancy telephone line

Increase public awareness

- Pregnancy specific mass media campaign that follows education of health professionals
- Key campaign message "something can be done"

Smokefree pregnancy service standard

Participants ended the day by making an individual assessment of a previously prepared checklist of items that related to the main themes of the forum as presented in the briefing paper. This was to enable individual feedback as well as collective and to strengthen feedback on areas of agreement. These items followed the framework of the "Systems First" five step standard for smokefree leadership in hospitals[10]: strong policy, clear systems, frequent and brief intervention and dedicated responsibilities. Collated responses are presented here as another way to represent the degree of agreement achieved by forum participants.

Summary of feedback

Responses n=22 %	We agree to this standard for best practice care in promoting smokefree pregnancies and parenting
	Supportive systems
	We agree that systems for the following are essential to support policy:
100	☐ Promotion - of this smokefree pregnancy and parenting policy
86	☐ Screening - of smokefree status (pre-pregnancy, in pregnancy and of the child)
100	☐ Documentation - of smokefree status and any interventions provided
86	☐ Intervention - care plans for smokefree intervention, NRT, and referral
100	☐ Professional education - to new and current LMCs and health professionals
100	☐ Monitoring and feedback - on smokefree prevalence and intervention rates
	Education of health professionals
	We agree that ongoing staff education is needed that includes these core topics
100	☐ Evidence of smoking effects on pregnancy for the woman and her child
100	☐ Intervention effectiveness for brief, intensive and public health strategies
91	☐ Behaviour change principles
95	☐ Brief intervention (5A's) skills for brief motivational interventions (BMI)
100	☐ Pharmacotherapy in pregnancy e.g. nicotine replacement therapy (NRT)
91	☐ Knowledge of smokefree roles, responsibilities, systems, accountabilities

[10] Cowan S ad Smith D. Systems First Guidelines for smokefree leadership in hospitals. Education for Change, revised August, 2005

	Interventions
	We agree that interventions with families need to include a mix of:
100	☐ Brief (the 5 A's of usual care—ask, assess, advise, assist, arrange)
95	☐ Intensive (specialist pregnancy/parenting referral services)
100	☐ Publicity (multi-media campaigns and community education)
100	☐ Pharmacotherapy options with the highest efficacy and acceptance
100	☐ Positive smokefree language and the promotion of smokefree benefits
100	☐ Early alert of risk status from smoking in pregnancy and appropriate referral
	Dedicated responsibilities and services
	We agree there needs to be:
100	☐ Dedicated responsibility for carrying this initiative forward
100	☐ Dedicated responsibilities for data collection, monitoring and feedback
95	☐ National availability of dedicated smokefree pregnancy services
91	☐ Promotion of Quitline to smoking parents wanting to become smokefree
64	☐ *Integration of FTS (or smoking in pregnancy effects) into undergraduate education
91	☐ Uptake of this policy and strategy by all (professional organizations, district health boards, health agencies, education institutions, NGOs, and community groups)

* It is likely that there was agreement about the inclusion of a topic relating to the effects of smoking in pregnancy on the unborn child, but not perhaps to the term "fetal tobacco syndrome" itself, as there were mixed views about the suitability of this term.

Comments

The following comments were written on the individual assessment sheets and are presented here verbatim.

Systems

- System around documenting smokefree status must be adequately resourced.
- As well as screening of status, recording must be included.

Education

- Educate undergraduates on smoking related pregnancy risks
- I think an understanding of tobacco dependence would be a good start.
- Develop a card on how to ask the questions, what language to use.
- Integrate fetal tobacco syndrome (FTS) education into all health care professional programmes not just undergraduates, but perhaps not with this term.
- Education must be supported by funding to enable participation in education.
- Include GP teams in professional education.
- Do not like the term fetal tobacco syndrome (FTS) (comment made by 4 people)

- Use a different word for FTS
    - fetal tobacco pathological effects
    - effects of tobacco on fetus
    - risks associated with not being smokefree
    - fetal tobacco spectrum disorder

Interventions

- Promote GP as well as Quitline as a service to become smokefree.
- Use pharmacotherapy as part of the whole package of intervention
- Like the idea of a an 0800 number for supporting smokefree pregnancy
- NRT as intervention - 'still not sure on the evidence'.
- Need to develop a 'pathway from pregnancy to post pregnancy identifying what can be done, when, by whom
- NRT in pregnancy should be extended to breastfeeding also.

Services

- Funding made available to primary health organizations and district health boards
- Strong local and national networks, central leadership, local implementation, evolution

Summary

The Smokefree Pregnancy Forum achieved its goals despite ambitious expectations for a one day meeting. As facilitators of the forum, it seemed to us the topic was like a very ripe plum ready to fall. The strength of research evidence of harm to mother and child, and of effectiveness of intervention, left little room for debate. This, and knowing that low levels of intervention are currently provided in New Zealand, aligned us all in a spirit of agreement and action.

Because of this forum, responsibility for a coordinated approach to achieving smokefree pregnancies has been shared across all of health. This report describes the outcomes of forum discussions and directs the health service towards the following standard actions:

The Butterfly Creek Smokefree Pregnancy Standard
1. Make achieving smokefree pregnancies a high priority for policy
2. Develop systems to support health professionals to intervene in a consistent way
3. Provide professional education to support effective interventions
4. Support pregnant women to be smokefree with equitable access to effective interventions
5. Increase public awareness that the issue is serious and that "something can be done"

The next steps

The next steps have begun. We have an email communiqué "Starting Smokefree" to keep forum participants connected and in the loop. We have a web based forum to continue meeting and discussing (Starting Smokefree)[11]. We have this report to share and to be an interim focus for action in our networks and we have a group of five people to help us take the initiative forward. The hope is the development of a leadership document that can be endorsed by key professional bodies and health agencies and guide New Zealand towards a smokefree start to life for all.

In working together for smokefree pregnancies, we make a stand for the value of a mother and child and a stand for health and well-being. There is so much to gain. We encourage all readers of this report to fly the flag for smokefree pregnancies whatever your circle of influence and do what you can to ensure that this strategy is taken up by all – all professionals, district health boards, primary care organisations, health professional education institutions, health agencies, NGOs, the media and community groups.

> *"When I looked around the room and saw all those important people wanting smokefree pregnancies, too, I saw that what I had done to be smokefree was much more important than I realised. There were all these people behind me, yet they were learning from my success. I saw that I didn't just become smokefree for me amd my family, but for all those people, too. I felt part of something big." Krystal Black, Forum Guest*

[11] http://efc.co.nz/forum/viewforum.php?f=17&sid=39fa1c3c73682334958c4baccada2690

Appendices

Suggested reading

1. **Effects***:* W Hofhuis, J C de Jongste and P J F M Merkus. Adverse health effects of prenatal and postnatal tobacco smoke exposure on children Archives of Disease in Childhood 2003;88:1086-1090

2. **Treatments:** Melvin CL and Gaffney CA. Treating nicotine use and dependence of pregnant and parenting smokers: An update *Nicotine & Tobacco Research Vol 6 Supplement 2 (April 2004) S107-S124*

3. **Pregnancy interventions:** Lumley J, Oliver SS, Chamberlain C, Oakley L. Interventions for promoting smoking cessation during pregnancy. *The Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD001055.pub2. DOI: 10.1002/14651858.CD001055.pub2.

4. **Infancy interventions:** Roseby R, Waters E, Polnay A, et al. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke *The Chochrane Database of systematic reviews 2002,* Issue 3. Art.No.: CD001746.

5. **Nicotine replacement:** Silagy C, Lancaster T, Stead L, Mant D, Fowler G. Nicotine replacement therapy for smoking cessation. *The Cochrane Database of Systematic Reviews* 2004, Issue 3. Art. No.: CD000146. DOI: 10.1002/14651858.CD000146.pub2

6. **Pharmacotherapy in pregnancy:** Benowitz NL and Dempsey DA. Pharmacotherapy for smoking cessation during pregnancy *Nicotine & Tobacco Research* Vol 6, Suppl 2 (2000) SA189-S202

7. **Smokechange:** Summary of the 2004 service report to the Ministry of Health report

8. **Hospital practice:** National assessment of the extend to which new Zealand hospitals assess and address the smoke-exposure of patients – 2004 report

9. **Position Statement:** Women's Hospitals of Australasia (WHA) Position Statement. Smoking Cessation in Pregnancy. Endorsed 1/09/2005.

Professional biographies

of Smokefree Pregnancy Forum delegates

Butterfly Creek, Auckland Airport
13 October 2005

Note: We acknowledge here the people who have been invited, have supported and are attending this Forum. We have edited some biographies for the purposes of space. We have also included people from whom we have not received information so that this list can be updated at the forum itself.

Name **Candace Bagnall**
Position Senior Portfolio Manager, Auckland Office, Public Health Directorate
Organisation Ministry of Health
Professional overview Operations leadership role for the tobacco control programme for the previous 5 years.
Current focus Shortly moving into a new position leading a service development team in Public Health Policy, with a continued role in overseeing the tobacco control programme, along with several other areas.
Interest in this issue am interested in this area from the perspective of a funder, in developing and strengthening effective programmes which protect women and their children from the harmful effects of environmental tobacco smoke.

Name **Nick Baker**
Position President
Organisation Paediatric Society of NZ
Current focus Preventive healthcare, child health policy and administrative structures, community involvement in health, training health professionals, developing educational resources for the general public, information technology, advocacy for children and youth, the impact of physical environments on health, paediatric infectious diseases, health service audit and strategy.

Name **Ashley Bloomfield**
Position Chief Advisor Public Health
Organisation New Zealand Ministry of Health
Professional overview Trained in medicine and public health at the University of Auckland and has worked in the health policy field for the past 8 years with the National Health Committee, National Screening Unit and Ministry of Health. .
Current focus Chair of the Interagency Committee on Drugs, the Expert Advisory Committee on Drugs and is a member of the National Screening Advisory Committee
Interest in this issue Longstanding interest in tobacco control, and oversaw the development of the NZ smoking cessation guidelines

Name **Sue Bree**
Position President
Organisation NZ College of Midwives
Professional overview Practising self-employed Midwife in rural Northland
Interest in this issue Information to be dispersed to all members of the College in order to attempt a widespread coordinated approach to this problem

Name **Kim Burgess**
Title Dr
Position GP, and Clinical Leader in population health
Organisation Pegasus Health
Professional overview I work half time in General Practice and part-time providing clinical input into Pegasus Health's population health programmes.
Current focus Planning and delivery of smoking cessation programmes in primary care, within Pegasus and Partnership Health PHO
Interest in this issue Identified as an area where General practice could look at collaborating with other providers to address gaps

Name **Kenneth Clark**
Title Dr
Position President
Organisation RANZCOG (Royal Australian and New Zealand College of Obstetricians and Gynaecologists)
Professional overview College role as above, NZ and Australian based / Consultant Obstetrician and Gynaecologist in public and private practice, Palmerston North / Medical Director MidCentral Health
Current focus Wide-ranging Women's Health issues relevant to my College and specialty
Interest in this issue Reduction of smoking in pregnancy seen as a vital issue by the RANZCOG and all its members

Name **Judith Clarke** **Position** National Projects Coordinator **Organisation** Education for Change **Professional overview** Background in corporate training and education. Recently returned from four years contracting in Europe **Current focus** Coordinating networks to promote infant health and wellbeing and implementating 'Smokefreee Children' paediatric staff education **Interest in this issue** Promoting a safe start to life for all children	**Name** **Stephanie Cowan** **Position** Director **Organisation** Education for Change **Professional overview** Education practice grew out of the high local and international concern about SIDS in the mid 1980's. Twenty years experience in the design and delivery of education programmes for addressing difficult issues, in particular re promoting infant health. Currently supports a team of 16 to provide health-funded services to address smoking in pregnancy, prevent sudden infant death and support smokefree leadership in hospitals/health services. **Current focus** Systems level change in health services to strengthen smokefree support for people who smoke **Interest in this issue** Smokefree health leadership is a gateway to supported families and protected children.
Name **Marewa Glover** (Nga Puhi) **Title** Dr **Position** Director, Auckland Tobacco Control Research Centre **Organisation** School of Population Health, University of Auckland **Professional overview** 12 years working in tobacco control and Maori health research. **Current focus** Latest projects look at Maori attitudes to Assisted Human Reproduction, a Pre-quit NRT clinical trial, young adolescents pocket money and access to tobacco, and a large 5 year intervention aimed at changing parents behaviour to reduce uptake among children aged 11-13. **Interest in this issue** Dissemination of results from study on smoking during pregnancy by Maori women. Issue is one of the key priority areas for Maori health.	**Name** **Judith Lumley** **Title** Professor **Position** Director **Organisation** Mother and Child Health Research, La Trobe University, Victoria, Australia **Professional overview** Her work, which has influenced the care of the 250,000 Australian women who give birth each year, has shown that helping women give up smoking during pregnancy reduces the risk of low birth weight and premature babies. Lumley has also influenced management of post-natal depression, highlighted inconsistencies in antenatal care, and argued for better evaluation of the effect of early discharge after birth. **Current focus** She focuses on the health of mothers and babies, "because that's where the health of society begins".
Name **David Knight** **Title** Dr **Position** Clinical Leader **Organisation** National Women's Health **Professional overview** Clinical leadership at NWH **Current focus** Neonatal Paediatrician **Interest in this issue** Development of programme at NWH	**Name** **Trish Jackson-Potter** **Position** Clinical advisor **Organisation** RNZ Plunket Soc. (Inc) **Professional overview** Clinical advisor for RNZ Plunket Soc. working with policy development and implementation, ongoing education for staff and support for operational teams. **Current focus** Child and Family health **Interest in this issue** Effects of smoking on health and economics for families.
Name **Lesley McCowan** **Title** Dr **Position** Associate Professor in Obstetrics and Gynaecology **Organisation** University of Auckland **Professional overview** I am a subspecialist in maternal fetal medicine and my clinical practice is with women with major pregnancy risk factors, many of whom have previously had preterm, growth restricted or stillborn babies **Current focus** To reduce the burden of pregnancy complications due to smoking in NZ women **Interest in this issue** To raise the awareness of health professionals about the seriousness of FTS and to encourage them to play an active role in helping women to become smokefree during pregnancy	**Name** **Deborah McLeod** **Title** Dr **Organisation** Research Director, Department of Primary Health Care and General Practice Wellington School of Medicine and Health Sciences, University of Otago **Professional overview** Experienced researcher and evaluator, particularly in the areas of health service research and implementing theory into primary care practice **Current focus** Equitable access to health services **Interest in this issue** My interets in smoking cessation in pregnancy is primarily from the perspective of implementing smoking cessation into usual maternity care. I have been involved in developing smoking education programmes and evaluatiing them through process evaluation and randomised controlled trials
Name **Michelle Mako** **Position** National Health Promotion Manager at Cancer Society **Organisation** Representing Public Health Association Executive Committee **Professional overview** Prior to starting in the Cancer Society I worked for the Ministry of Health's Public Health Directorate for eight and a half years, primarily in Maori Public Health **Interest in this issue** I have an ongoing commitment and passion to reducing inequalities for Maori and Pacific communities in particular, and to advancing public health.	**Name** **Ingrid Minett** **Position** Team Leader **Organisation** Education for Change **Current focus** Smokechange, Auckland; Midwife training days (Auckland); Systems First (Auckland City Hospital) **Interest in this issue** Very high interest to support working with women who are smoking in their pregnancy, training midwives, and supporting smokefree systems in hospitals

Name **Philip Pattemore** **Title** Dr **Position** Senior Lecturer in Paediatrics **Organisation** Christchurch School of Medicine, University of Otago **Professional overview** Hospital Paediatric Specialist (General and Respiratory), teaching undergraduate and postgraduate paediatrics, research in respiratory disorders of children **Current focus** Asthma, Cystic fibrosis, Smoking exposure in children **Interest in this issue** Smoking exposure in children	**Name** **Iain Potter** **Position** Chief Executive **Organisation** Health Sponsorship Council (HSC) **Professional overview** The HSC is a Crown Entity charged with "promoting health and encouraging healthy lifestyles". It actions this through a social marketing approach to a number of health and social issues determined by the Ministry of Health. **Current focus** Tobacco control (Smokefree, Auahi Kore), sun safety (SunSmart) and promoting walking and cycling. **Interest in this issue** Tobacco control is a major area of concern for the HSC.
Name **Dr Margaret Shanks** **Position** Fellow **Organisation** College of General Practitioners **Professional overview** GP Obstetrician **Interest in this issue** Interested because I am a GP Obstetrician and a GP with special interest in women's health Issue	**Name** **Whaea Mina Timu Timu** **Position** Kuia **Organisation** NZ College of Midwives and member of Midwifery Council **Professional overview** Nursing and midwifery **Interest in this issue** The wellbeing of hapu and iwi is of prime importance to me. The well-being of a woman ensures the well being of the child which has an impact on the family as a whole. Future generations will benefit from smokefree people and environments.
Name **Jo Waddingham** **Title** Midwife **Position** Smokechange Educator and Link Midwife **Organisation** Education for Change **Professional overview** 5 years as core and independent midwife before joining Education for Change 1 year ago **Current focus** Providing dedicated pregnancy service of education and support to change smoking, for pregnant women and their families **Interest in this issue** Strong commitment to empowerment and support to women to achieve optimal pregnancy and birth outcomes, and the highest level of health and well-being for children.	**Name** **Jane Waite** **Title** Maternity Services Manager **Position** Manager of maternity services CDHB **Organisation** Christchurch District Health Board **Professional overview** Registered nurse and Midwife have worked in a variety of positions both in the hospital and community settings. Have managed Maternity services for CDHB for three years this includes Christchurch hospital and three primary units **Current focus** Improving services for women of Canterbury **Interest in this issue** Smoking in pregnancy undermines the health of the child. I am passionate about maternal and child welfare
Name **Alistair Woodward** **Title** Professor **Position** Head of School of Population Health **Organisation** University of Auckland **Professional overview** Research, teaching, policy **Current focus** Leading the School **Interest in this issue** Developing effective interventions	**Name** **Cheryl Young** **Position** Team Leader **Organisation** Education for Change **Professional overview** Seven years of working with Change in the Criminal Justice/Psychology field; 16 months of working for EFC **Current focus** System First Support (Southland Hospital). Partners in Change Training for Midwives (Nationally). Smokechange Educator (Invercargill) and Team Leader (Southern) **Interest in this issue** For New Zealand to lead the world in the prevention and management of fetal tobacco syndrome as a means of protecting the life and well being of children. How NRT can best be used to support women during pregnancy.
Name **Joyce Croft** **Position** Midwife	**Name** **Christine Hawea** **Position** Midwife **Organisation** National Maori Midwives Caucus
Name **Hayden McRobbie** **Position** Research Fellow **Organisation** School of Population Health	**Name** **Chris Hendry** **Title** Dr **Position** Executive Director (Midwife) **Organisation** Midwifery & Maternity Provider Organisation
Name **Greg Phillipson** **Title** Dr **Position** Infertility Specialist **Organisation** Fertility Centre	**Guest participants** **Name** Krystal Black **Name** Victoria Hotene

Unable to attend

Name **Julian Finch**
Position CEO
Organisation DHBNZ

Unable to make contact

Name **Joanne Rama**
Position President
Organisation Nga Maia o Aotearoa me to Waipounamu

Sent representatives

Name **Karen Guililland**
Position CEO
Organisation NZCOM

Name **Angela Baldwin**
Position CEO
Organisation Plunket

Name **Pauline Burt**
Position General Manager
Organisation Christchurch Women's Hospital

Name **Jim Vause**
Position President
Organisation RNZCGP

Name **Gay Keating**
Position President
Organisation Public Health Association

Name **Pippa MacKay**
Position General Practioner
Organisation Ilam Medical Centre