

**Peterborough County-City Health Unit
Perinatal Tobacco Cessation Project**

Needs Assessment Summary and Program Recommendations

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... because health matters!

Introduction

There is a growing body of evidence that calls for action to address smoking during the perinatal period (Greaves, et al., 2003). Prenatal cigarette smoking is associated with significant adverse health effects such as fetal and maternal health problems including low birth weight, preterm birth, bleeding, and stillbirth (Child Health Network for the Greater Toronto Area (CHNGTA), 2004; Pregnets, 2003). Furthermore, smoking during pregnancy also “increases the risk of sudden infant death syndrome and has been associated with impaired physical and intellectual development of the child” (CHNGTA, 2004, p. 17).

When a pregnant woman quits smoking, there are numerous health benefits to herself, her fetus, and other members of the household, especially infants and children (Program Training and Consultation Centre (PTCC), 1995). When planning to become pregnant or upon finding out they are pregnant, many women try to quit smoking, however, postpartum relapse rates are high – 60% of women who quit during pregnancy experience a relapse and resume smoking within six months postpartum, (Greaves, et al., 2003).

In 2005, the Ontario government introduced the Smoke-free Ontario Strategy with the focus of preventing children and youth from starting to smoke, helping Ontarians quit smoking, and protecting Ontarians from second-hand smoke exposure (Ministry of Health Promotion (MHP), 2006). As part of the \$60 Million dollar strategy, Public Health Units applied for competitive funding to support innovative tobacco control strategies. The Peterborough County-City Health Unit (PCCHU) applied and was successful in receiving funding to investigate perinatal tobacco use in Peterborough County and City.

To gain greater insight into the issue, the PCCHU conducted a review of perinatal tobacco cessation literature as well as an assessment of current and historical perinatal tobacco use rates in Peterborough County and City. Furthermore, the PCCHU conducted a needs assessment with key informants to collect information about programs and services that are offered to pregnant and post partum women in the Peterborough area. The needs assessment and information collected through the key informant interviews are crucial to understanding the extent of perinatal tobacco use in Peterborough County and City. Findings from the literature review as well as results from the needs assessment will be discussed, and recommendations for future perinatal tobacco cessation programming proposed.

Literature Review

According to Health Canada (1997) “women who smoke are at risk for a variety of adverse health effects, such as lung cancer – now the leading cause of death among Canadian women” (p.9). Additionally, women exposed to second-hand smoke during their pregnancy or women that smoke during their pregnancy are not only risking their own health but the health of their fetus. Nicotine and carbon monoxide are two compounds that are found in tobacco smoke that have a specific, identifiable impact on fetal health and development. Nicotine can impair circulation and carbon monoxide crosses the placental membrane to bind with fetal hemoglobin reducing the amount of oxygen carried by the blood (Edwards, Sims-Jones, Hotz, 1996, Greaves, et al., 2003). Women that smoke or women that are exposed to second-hand smoke during their pregnancy are at an increased risk of ectopic pregnancy, spontaneous abortion, placenta previa, abruptio placenta, premature rupture of the membranes, premature birth, and delivering a low birth weight baby (Edwards, et al., 1996; Health Canada 1997; Pletsch, Morgan & Freeman, 2003; Pregnets, 2003; Wisborg, 2001). After delivery, infants and children exposed to second-hand smoke have been known to experience bronchial hyperresponsiveness, atopy, acute respiratory illness, asthma, chronic cough, ear problems, sudden infant death syndrome (SIDS), and future smoking behaviour (Edwards, et al., 1996; Health Canada 1997; Myron, 2003).

Clearly, maternal smoking has a detrimental effect on fetal growth and development, and second-hand smoke has adverse effects on infants and children. Supporting women to quit smoking before pregnancy or even early in their pregnancy will reduce the likelihood of complications occurring during pregnancy and delivery. Supporting women to remain smoke-free after delivery will prevent significant health problems for the woman as well as for the child later in life (DiClemente, Dolan-Mullen & Windsor, 2000; Edwards, et al., 1996; Greaves, et al., 2003). However, despite evidence that demonstrates the benefit of smoke-free pregnancies, “the reasons underlying women’s smoking patterns are complex, reflecting multiple and interacting social, cultural, economic, and biological influences” (Greaves, et al., 2003, p. 9). Women who are most likely to smoke during and after their pregnancy are younger, less educated, have less income, have low occupational status, and fewer social support networks (Greaves, et al., 2003; Millar & Hill, 2004; Paterson, Neimanic & Bain, 2003).

Past public health interventions to reduce smoking during pregnancy have not been overly successful and have typically been motivated by the desire to lessen the effects on fetal health, “which means that addressing the impact of social context on smoking within pregnant women’s lives has largely been avoided” (Greaves, et al., 2003, p. 10). Interventions focused solely on fetal health outcomes may increase the woman’s motivation to quit smoking for the health of the fetus, but miss the benefits of quitting for her own health. Women who quit for reasons other than their own health outcomes (i.e., quit only for the fetus) are at high risk of returning to smoking after the baby is born. Even after a five to seven month abstinence from smoking, 70% of women who quit during pregnancy return to smoking within 6 months postpartum (DiClemente, et al., 2000; Greaves, et al., 2003; Stotts, Carbonari, DiClemente & Mullen, 2000). The period immediately following delivery is particularly difficult for the mother and the return to smoking is usually facilitated by lack of sleep, stress, concerns about weight loss, and the ability to protect the baby from smoke in other ways (DiClemente, et al., 2000). “Variability in postpartum relapse rates among pregnant quitters along with the contextual factors surrounding pregnancy smoking cessation (i.e., heavy external pressures to quit smoking) suggests that intention, motivation, and commitment to sustain cessation postpartum may differ considerably among women” (Stotts, et al., 2000, p. iii19).

Previous interventions that addressed tobacco use during and after pregnancy have not been helpful to planning future interventions as many have gone unevaluated, used inconsistent terminology, or did not define tailored components of the intervention (Greaves et al., 2003). There has been limited research conducted on population health approaches to addressing perinatal tobacco use, with more research being done to assess the effectiveness of one-to-one interventions. Health Canada (1997) highlights the effectiveness of one-to-one interventions as being good for heavy smokers, easy to tailor depending on the needs and circumstances of the particular smoker, and historically associated with higher cessation rates. Brief, one-to-one interventions offered by health practitioners have been highlighted in the literature as critical to a comprehensive tobacco cessation initiative. Even minimal contact interventions produced cessation rates 2.3% higher than the control group (Becker, 1998, Registered Nurses Association of Ontario, 2003). More intensive interventions lasting 5 to 20 minutes, when coupled with pregnancy-specific self-help materials can double usual pregnancy-related quit rates, even among high-risk groups (Becker, 1998; Paterson, et al., 2003). The effectiveness of smoking cessation

materials or self-help resources tailored to pregnant women have been evaluated in several randomized trials and have out-performed standard materials in short-term evaluations of quit-rates (Naylor, Adams & McNeil, 2002).

One-to-one interventions and self-help resources are two common interventions used to address perinatal tobacco use; however rates of smoking during pregnancy have only decreased slightly. Research in this field calls for new comprehensive methods that assist pregnant women to quit smoking and, in turn, prevent the return to smoking after pregnancy (Paterson et al., 2003; Stotts, et al., 2000). Greaves and colleagues (2003) identify seven best practice approaches for tobacco cessation interventions with pregnant and postpartum women that call for tailored approaches that reduce stigma, integrate social issues, are women focused, and include relapse prevention, harm reduction, and social support.

Peterborough Statistics

According to the 2001 Statistics Canada report (2006) the population for the PCCHU area was 125,859 with 20% being females of childbearing age¹. In 2004, the Peterborough Social Planning Council (PSPC) conducted a profile of indicators for Peterborough (2004) and found that residents fell below Ontario's average income. Couple families in Peterborough earn an average of \$55,711 per year, where as female lone-parent families only earn \$24,700 per year (PSPC, 2004). In 2001, 13.5% of Peterborough's population was living below the low-income cut off in addition to an average of 150 people for every 1000 receiving either general welfare assistance (GWA) or family benefits allowance (FBA).

Peterborough Regional Health Centre (PRHC) is the only hospital that offers labour and delivery services in Peterborough County and City. Women in Peterborough can choose to deliver their baby at PRHC or at their home with a midwife. All births, including those that take place in private dwellings, are monitored by the Perinatal Partnership Program for Eastern and Southwestern Ontario (PPESO). PPESO tabulates statistics on each birth in order to track perinatal health of mothers and the health of newborns (PPESO, 2006b).

To establish a need for programming, the PCCHU analyzed perinatal tobacco use rates from 2003, 2004, 2005, and for the first six months of 2006. The total number of births in

¹ According to Statistics Canada (2005) a woman of childbearing age is described as any woman between the ages of 15 and 44 years.

Peterborough remained consistent throughout from 2003 to 2005, with approximately 1100 births per year. Roughly 64% of these births are by City residents and 36% by County residents (see Appendix A for graphical image of PPPEO statistics) (PPPEO, 2004; 2005a; 2006a).

PPPEO statistics from 2003, 2004, and 2005 demonstrated that a consistent 21% of women delivering at Peterborough Regional Health Centre or in their own home under the care of a midwife smoked cigarettes after 20 weeks of pregnancy (PPPEO, 2004; 2005a; 2006a). This rate is approximately 11% higher than the provincial average (PPPEO, 2005b). Moreover, for all three years approximately 50% of pregnant women in Peterborough less than 20 years of age, and 35% of pregnant women between 20 and 24 years of age smoked (PPPEO, 2004; 2005a; 2006a).

The PPPEO statistics were further assessed to understand the dynamics of perinatal tobacco use in Peterborough County versus the City of Peterborough. In some years, a few townships in Peterborough County showed a higher than average perinatal tobacco use rate (PPPEO, 2004; 2005a; 2006a). However, a high rate in these townships was not consistent from one year to the next resulting in inconclusive evidence supporting this finding. Moreover, some townships have a very small number of live births every year. Therefore, it is difficult to conclude if any township requires a specific perinatal tobacco cessation focus.

Although, when all townships are grouped together into the Peterborough County category, perinatal tobacco use rates fluctuated anywhere between 15% and 22% of women giving birth from 2003 to 2005. Consistently, the perinatal tobacco use rate for women from the City of Peterborough was 22% (PPPEO, 2004; 2005a; 2006a). Therefore, if any conclusion can be made, perinatal tobacco use rates are slightly higher for City residents than County residents. Although, it must be noted that the difference is very small, therefore a perinatal tobacco cessation intervention should be applied equally to women living in the City and County of Peterborough (see appendix A for graphical images of PPPEO statistics).

In summary, there is no significant evidence that suggests perinatal tobacco use rates varying from City to County residents; however an alarming number of women under the age of 25 are using tobacco during their pregnancy.

Findings from needs assessment

As part of a comprehensive process to understand the issues associated with Peterborough's high perinatal tobacco use rate, the PCCHU conducted a needs assessment with key informants in order to collect information about programs and services that are offered to pregnant and post partum women in the Peterborough area.

In consultation with the reproductive health program at the PCCHU, a total of 30 individuals, organizations, or coalitions were identified as critical key informants for the purpose of this needs assessment. The identified key informants provide a range of practitioners that work with women in preconception, prenatal, and postpartum stages (see appendix B for a complete list of key informants). Organizations that work with women in the preconception phase are crucial to the prevention of tobacco use by women in childbearing years. Organizations in the pregnancy phase play an important role in supporting women to quit and/or remain smoke-free during their pregnancy, and organizations that provide services to women in the postpartum phase are critical to the reduction of second-hand smoke exposure, but also a key component to relapse prevention.

Between February and August 2006, a total of 22 interviews were conducted with 49 practitioners (due to time restraints or inability to contact a key informant, 8 key informants were not interviewed). Questions for each interview were structured under the following categories: environmental scan of services, assessment of current tobacco cessation strategies, assessment of new tobacco cessation strategies (see appendix C for a complete list of needs assessment questions).

The environmental scan of services revealed that there are many services a woman living in the City of Peterborough can access before, during, and after pregnancy. There are however, much fewer services in the County of Peterborough that women can access without the use of transportation. Using the practitioners that were interviewed, a flow chart of perinatal services was created (see appendix D for a copy of flow chart). According to the flow chart, women living in Peterborough County and City can access approximately 10 different programs or services before pregnancy, 19 programs or services from the beginning of pregnancy and up to and including 24 weeks gestation, 18 programs or services from 25 weeks gestation to delivery, and 21 programs or services following delivery.

Each practitioner interviewed was asked about their approach to tobacco cessation with clients. The majority of key informants revealed that most clients are asked about their tobacco use either by intake questionnaire or through direct discussion. Most commonly the questions used to assess for tobacco use were “Do you smoke?” and “How many cigarettes do you smoke each day?”. No key informant identified using assessment strategies for “spontaneous quitters”.

Key informants were asked about their approach to providing cessation support. Many stated that their approach to cessation was reactive, meaning that it was provided only if the client identified tobacco use as an issue. The few key informants that provided proactive tobacco cessation support typically referred clients to the PCCHU for more information. Only programs housed within PCCHU and one Nurse Practitioner, who consequently was a former PCCHU employee, referred tobacco users to other cessation services (i.e., self-help resource, Smoker’s Helpline, Motherisk Helpline).

Of the 22 individuals and organizations that were interviewed, 17 stated that they would like to augment their current approach to tobacco cessation by either training staff to be more conscious of tobacco cessation methods, including appropriate tobacco use screening questions on intake forms, offering perinatal tobacco cessation information to their clients, or by incorporating relapse prevention strategies into their practices.

Recommendations for service delivery

Smoking remains one of the few potentially preventable factors associated with low birth weight, preterm birth, and perinatal death. Additionally, smoking is a significant *preventable* cause of lung cancer and breast cancer (Oliver, Chamberlain & Oakley, 2006). These two factors alone demonstrate why perinatal tobacco cessation strategies must be included as part of women and child health programming. Given the significant physical and social factors women experience before, during, and after pregnancy, perinatal tobacco cessation interventions must be comprehensive. Literature about perinatal tobacco use calls for programming to be tailored to that of the target population, recognize a woman’s social, psychological, and economic context, and incorporate a mechanism for support (Greaves, et al., 2003; Ussher, Etter & West, 2006; Wayne & Hill, 2004). Based on suggestions from the literature and findings from the needs assessment, the following recommendations should be considered for future PCCHU programming.

Recommendation 1

Incorporate a process for screening tobacco users and spontaneous quitters, as well as a protocol for providing cessation support into all PCCHU clinical programs.

Rational

The document “Expecting to quit: A best practice review of smoking cessation interventions for pregnant and postpartum women and girls” calls for screening of all women and girls of childbearing age for tobacco use and an increase in tracking of smoking patterns, including women who quit spontaneously during pregnancy, and postpartum (Greave, et al., 2003). Currently in Peterborough, organizations that work with pregnant or postpartum women only screen for tobacco use via intake questionnaires, and do not screen for spontaneous quitters. Furthermore, organizations are not conducting brief minimal contact interventions, which have been shown as effective in decreasing tobacco use (Becker, 1998; RNAO, 2003). Therefore, the PCCHU should incorporate standardized screening and cessation services into their clinical setting by following Greaves et al. (2003) best practice recommendations. The standardized screening should be tailored to each stage of pregnancy including preconception (a focus on cessation), prenatal (a focus on cessation and relapse prevention), and postpartum (a focus on cessation and relapse prevention). By doing this, the PCCHU will be in a better position to promote the standardized screening and cessation method to other agencies in Peterborough. Ideally, the ultimate goal is that every organization in Peterborough that works with women before, during, or after pregnancy screens for current or recent tobacco use, and provides one to two minutes of cessation support.

Recommendation 2

Support those that work with pregnant and postpartum women by increasing their confidence in addressing perinatal tobacco use with clients.

Rational

Health practitioners and other individuals working with pregnant women play an important role in motivating women to stop smoking (Health Canada, 1997). However, many health care providers are not confident about their ability to provide tobacco cessation services, which is the case for many key informants that were interviewed. Anyone working with pregnant and post partum women in Peterborough should have sufficient confidence and abilities to address tobacco

use with their clients in order to provide individual intervention, emotional support, counseling, and self-help materials. Therefore, the PCCHU should facilitate training opportunities for health professionals and other individuals working with pregnant women with the goal of increasing their confidence in addressing tobacco use with clients.

Recommendation 3

Strengthen partnerships and foster inter-sectoral collaboration with programs and agencies that work with pregnant or postpartum women and girls under the age of 25 years.

Rational

PPESO statistics demonstrated an alarming number of women in Peterborough under the age of 25 years smoking during pregnancy. Pregnant teens and young women are often categorized as high risk populations as they are less likely to complete their education and are more likely to have limited career and economic opportunities (Public Health Agency of Canada, 2006). The biological and psychological immaturity of young mothers and limited life experiences make this population extremely vulnerable to adverse outcomes (Best Start, 2005; PPESO, 2005b). The creation of networks and partnerships offer an effective and practical approach to solving problems, seizing opportunities and planning results (Frank and Smith, 1997). Therefore, by having all agencies that work with young pregnant women and teens come together to learn more about this health issue, a network of support will be created, thereby enhancing the perinatal tobacco cessation effort. Many of the existing programs such as Babies First, Teen Prenatal Support Club, School for Young Moms, and Healthy Babies Healthy Children already work closely with one another. Therefore, it seems natural that these programs collaborate to address the high rate of perinatal tobacco use among young women and teens living in Peterborough.

Recommendation 4

The PCCHU develop, in partnership with pregnant women, appropriate tobacco cessation resources for use by agencies in the Peterborough community.

Rational

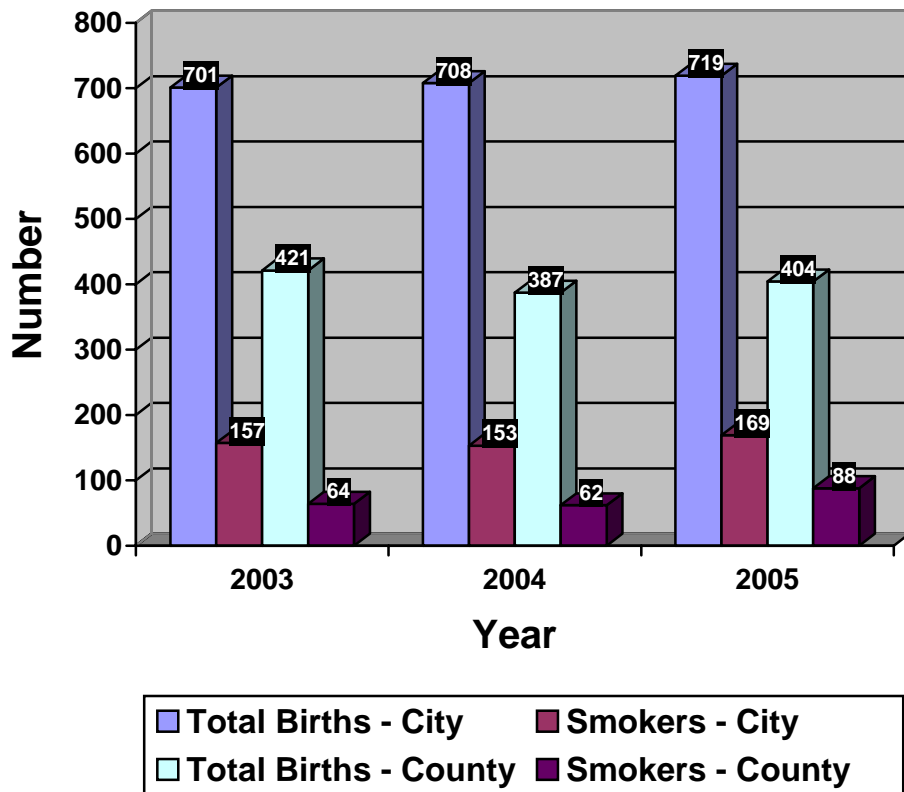
The document “Expecting to quit: A best practice review of smoking cessation interventions for pregnant and postpartum women and girls” calls for public health messages to be framed in a sensitive, non-judgmental way that is relevant to the social and economic circumstances of

women's daily lives (Greave, et al., 2003). Furthermore, Greaves at al. (2003) call for perinatal tobacco cessation interventions to be tailored to the characteristics of the target population. Therefore, the PCCHU should foster the development or modification of perinatal tobacco cessation resources that could be used by agencies that work with women with low literacy skills, agencies that work with teens, and agencies that work with pregnant and post partum women in general. The creation of all three specific resources should, at a minimum, include consultations with the intended target population, as well as the agencies that will be using the resources.

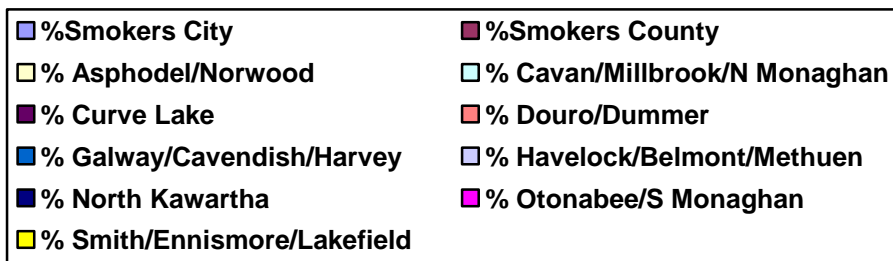
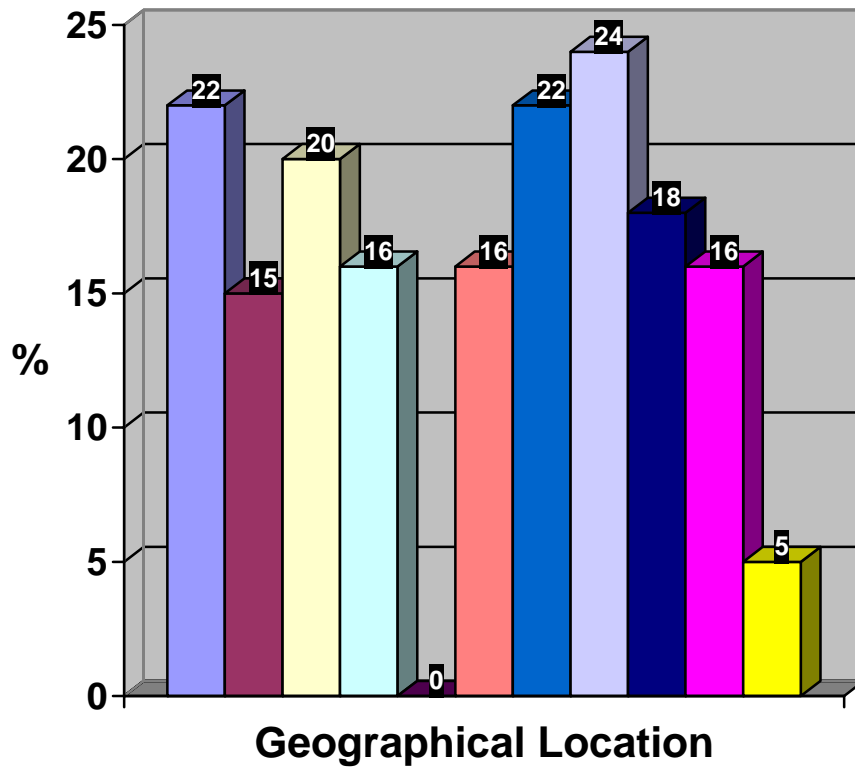
Appendices

Appendix A

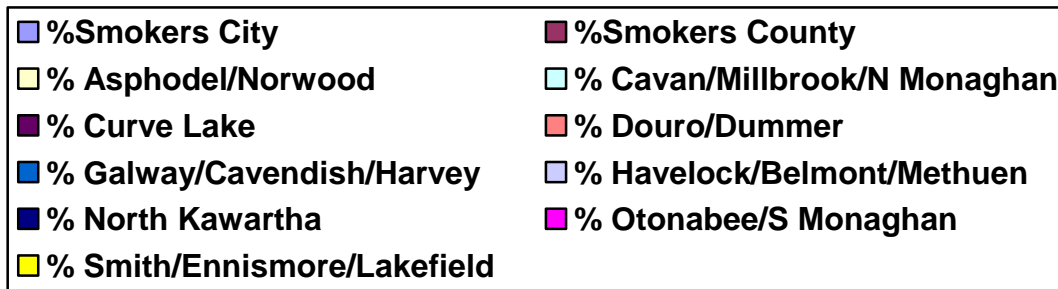
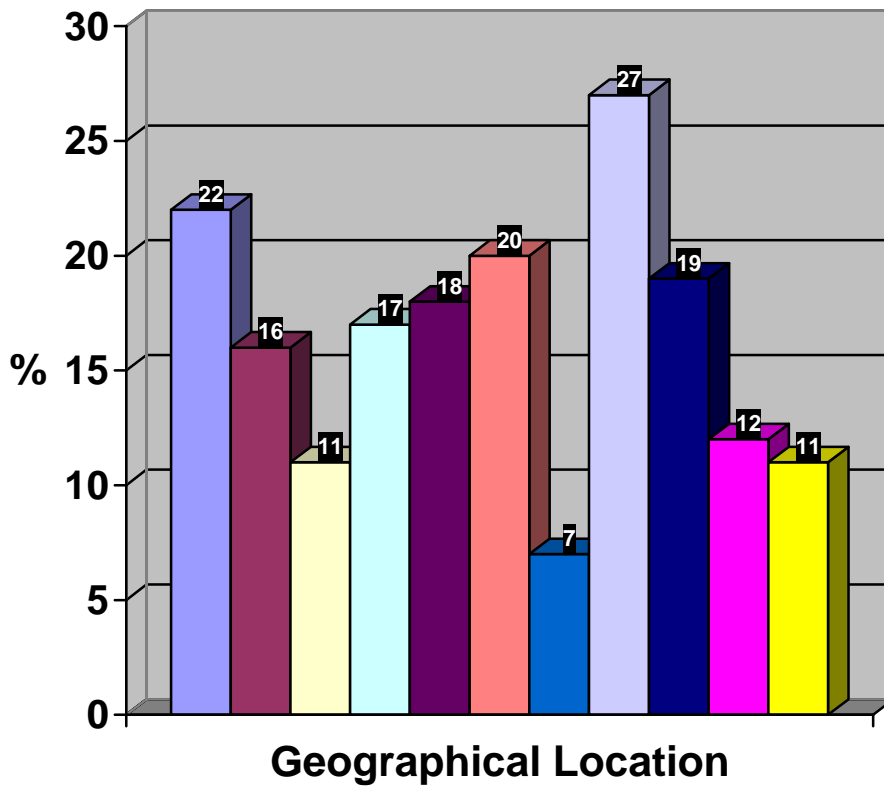
Number of Births vs. Number of Pregnant Smokers, Peterborough County & City, 2003-2005



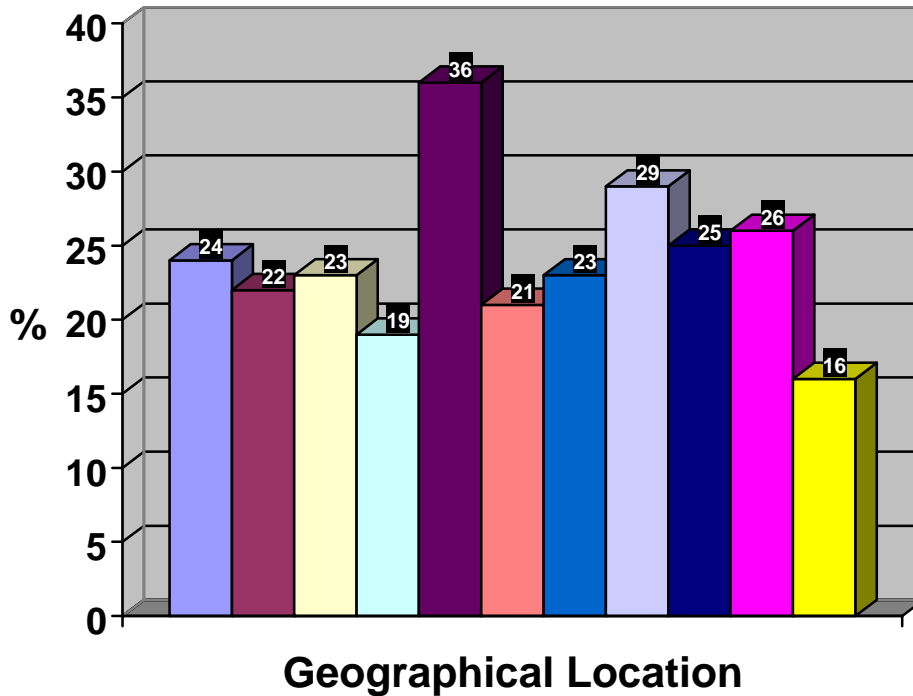
Percentage of Women Smoking During Pregnancy by Geographical Area - 2003



Percentage of Women Smoking During Pregnancy by Geographical Area - 2004

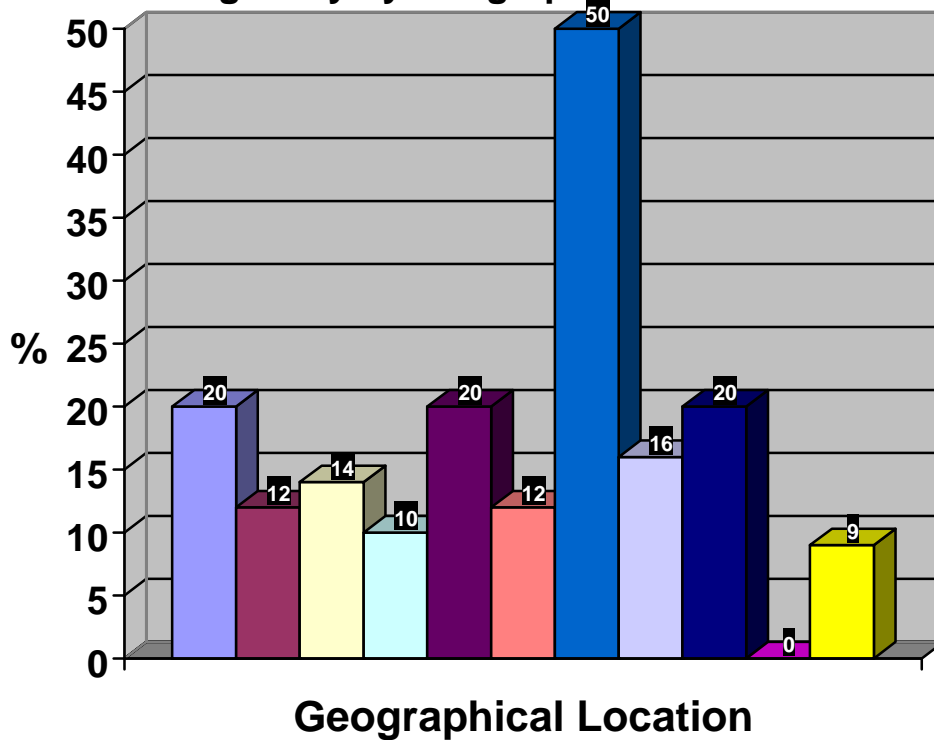


Percentage of Women Smoking During Pregnancy by Geographical Area - 2005



■ %Smokers City	■ %Smokers County
■ % Asphodel/Norwood	■ % Cavan/Millbrook/N Monaghan
■ % Curve Lake	■ % Douro/Dummer
■ % Galway/Cavendish/Harvey	■ % Havelock/Belmont/Methuen
■ % North Kawartha	■ % Otonabee/S Monaghan
■ % Smith/Ennismore/Lakefield	

Percentage of Women Smoking During Pregnancy by Geographical Area - 2006



■ %Smokers City	■ %Smokers County
■ %Asphodel/Norwood	■ %Cavan/Millbrook/N Monaghan
■ %Curve Lake	■ %Douro/Dummer
■ %Galway/Cavendish/Harvey	■ %Havelock/Belmont/Methuen
■ %North Kawartha	■ %Otonabee/S Monaghan
■ %Smith/Ennismore/Lakefield	

Appendix B

Key Informants for Needs Assessment

1. Ontario Early Years Centre / Babies First / Brighter Futures
2. Lovesick Lake Native Women Assoc
3. Curve Lake First Nation Health Centre
4. Kawartha Community Midwives
5. Women's Health Centre
6. Birthright
7. Peterborough Pregnancy Support Services
8. School for Young Moms
9. Teen Supper Club
10. Social Services – Ontario Works
11. Peterborough and District Childbirth Assoc.
12. Fourcast
13. Peterborough Regional Health Centre, Women & Children Services Working Group
14. Peterborough Regional Health Centre, Women & Children Services – Nurse Educator
15. Breastfeeding Clinic
16. Perinatal Managers
17. General Practitioners
18. Pediatrician's
19. Obstetricians & Gynecologists
20. Nurse Practitioners
21. Healthy Babies Healthy Children
22. Reproductive Health
23. Sexual Health
24. Private Prenatal Educators
25. YWCA
26. Cameron House
27. Youth Emergency Shelter
28. Bridge Youth Drop-in Centre
29. Anishnaabe Regional Shelter
30. The Rural Outreach Centre

Appendix C

Needs Assessment Questions

Environmental Scan of Services

Specific variables that will be monitored: Population organizations serve, age of clients, income level of clients.

1. What programs and services does your agency provide for pregnant women?
2. What programs and services does your agency provide for postpartum women?
3. What kinds programs and services does your agency provide for partners of pregnant and postpartum women?
4. Do you use an underlying theoretical or defined goals and objectives that drive your services?
5. What factors do you perceive contribute to Peterborough's higher than average perinatal tobacco rates?

Assessment of current tobacco cessation strategies

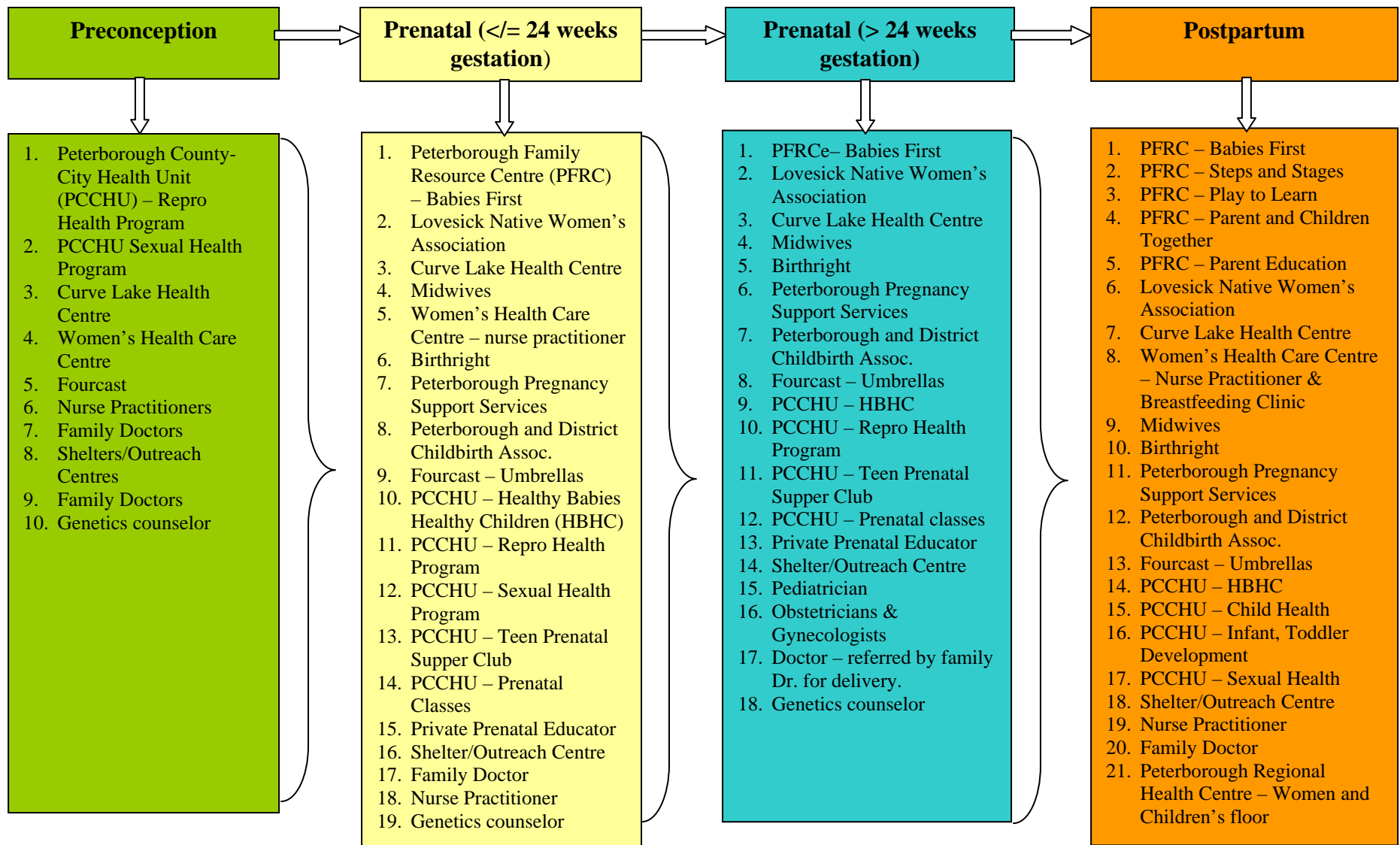
6. How does your agency provide tobacco cessation support to pregnant and postpartum women (i.e., quit guides, counseling, buddy support, partner counseling/social context, information, NRT, human follow-up, other follow-up, incentives, feedback about biological changes, and groups – this list is based on the 11 interventions as defined by Greaves et al.)?
7. Does your agency assess pregnant and postpartum women for “spontaneous quitters”? (definition of a spontaneous quitter will be provided)
8. Does your agency assess the social context of the pregnant women? (i.e., provide any support to partners, family or friends)
9. Have any of your staff taken perinatal tobacco cessation training? If yes, when was the training taken, what kind of training, how many staff have been trained, is the training used?

Assessment for new tobacco cessation strategies

10. Does your agency have any plans to include, add, or change tobacco cessation strategies in your programming?
11. Would your agency be willing to implement, augment, or change tobacco cessation strategies in your programming? If yes, to what extent?
12. Would your organization be interested in training on preinatal cessation strategies?
13. If you could advocate for other perinatal tobacco cessation resources and programs, what would you advocate for? Why?

Appendix D - Flow chart of services for women in Peterborough County and City

This flow chart represents the services that a woman may access during a “normal” pregnancy and is based on information gathered during the key informant interviews. A normal pregnancy refers to any pregnancy that follows a typical model with regular health care visits. The services shown in the flow chart are those specific to Peterborough County and City.



References

Becker, L. A. (1998). Helping patients quit smoking. Journal of Family Practice, March, p. 1-3.

Best Start. (2005, October 22). Reducing the impact: Working with pregnant women who live in difficult life situations [On-line]. Available:

http://www.beststart.org/resources/anti_poverty/pdf/REDUCE.pdf

Child Health Network for the Greater Toronto Area. (2004). Niday Perinatal Database for the Greater Toronto Area: 1st annual statistical report 2003-2004. Toronto, ON: Author.

DiClemente, C., Dolan-Mullen, Windsor, A. (2000). The process of pregnancy smoking cessation: Implications for interventions. Tobacco Control, 9 (Supplement 3), p. iii16-iii21.

Edwards, N., Sims-Jones, N. & Hotz, S. (1996). Pre- and postnatal smoking: A review of the literature. Publication # M96-2. Ottawa, ON: University of Ottawa.

Frank, F. & Smith, A. (1997). The partnership handbook. Hull, QC: Human Resources Development Canada.

Greaves, L., Cormier, R., Devries, K., Bottorff, J., Johnson, J., Kirkland, S. & Aboussafy, D. (2003). A best practice review of smoking cessation interventions for pregnant and postpartum girls and women. Vancouver: BC: British Columbia Centre of Excellence for Women's Health.

Child Health Network for the Greater Toronto Area. (2004). Niday Perinatal Database for the Greater Toronto Area: 1st annual statistical report 2003-2004. Toronto, ON: Author.

Edwards, N., Sims-Jones, N. & Hotz, S. (1996). Pre- and postnatal smoking: A review of the literature. Publication # M96-2. Ottawa, ON: University of Ottawa.

Health Canada. (1997). Asking to listen: Helping pregnant and postpartum women and their families to quit or reduce smoking. Ottawa, ON: Author.

Millar, W. J. & Hill, G. (2004). Pregnancy and smoking. Health Reports, 15, (4), p. 53-56.

Ministry of Health Promotion. (2006, September 8). Smoke-free Ontario strategy [On-line]. Available: http://www.mhp.gov.on.ca/english/health/smoke_free/fact_sheets/112505-sfo_strategy.pdf

Myron, K. C. (2003). Pregnant women who smoke heavily increase the risk that their children will also smoke heavily later in life. Havard School of Public Health, press release. Boston, MA.

Naylor, P., Adams, J. S. & McNeil, D. (2002). Facilitating changes in perinatal smoking. Canadian Journal of Public Health, 93 (4), p. 285-290.

Oliver, L. J., Chamberlain, C. & Oakley, L. (2006). Interventions for promoting smoking cessation during pregnancy. The Cochrane Database of Systematic Reviews, 4, p. 1-95.

Paterson, J. M., Neimanis, I. M. & Bain, E. (2003). Stopping smoking during pregnancy; Are we on the right track? Canadian Journal of Public Health, 94 (4), p. 297-301.

Pletsch., P., Morgan, S. & Pieper, A. F. (2003). Context and beliefs about smoking and smoking cessation. The American Journal of Maternal/Child Nursing, 28 (5), p. 320-325.

Perinatal Partnership Program of Eastern and Southeastern Ontario. (2004). Peterborough County-City Health Unit perinatal statistics January – December 2003. Ottawa, ON: Author.

Perinatal Partnership Program of Eastern and Southeastern Ontario. (2005a). Peterborough County-City Health Unit perinatal statistics January – December 2004. Ottawa, ON: Author.

Perinatal Partnership Program of Eastern and Southeastern Ontario. (2005b). Perinatal Services in Ontario: How are we doing? Ottawa, ON: Author.

Perinatal Partnership Program of Eastern and Southeastern Ontario. (2006a). Peterborough County-City Health Unit perinatal statistics January – December 2005. Ottawa, ON: Author.

Perinatal Partnership Program of Eastern and Southeastern Ontario. (2006, September 8b). Perinatal Partnership Program of Eastern and Southeastern Ontario: About us [On-line]. Available: <http://www.pppeso.on.ca/english/aboutus.html>

Peterborough Social Planning Council. (2004). Peterborough Profile 2004. Peterborough, ON: Author.

Pregnets. (2003). Smoking cessation for pregnant and post-partum women: A toolkit for health professionals. Toronto, ON: Author.

Program Training and Consultation Centre. (1995). Smoking cessation in pregnancy. Ottawa, ON: Author.

Public Health Agency of Canada. (2006, October 11). Renewal 2000: Taking stock, celebrating successes, building for the future [On-line]. Available: http://www.phac-aspc.gc.ca/dca-dea/programs-mes/capc-cpnp_renewal_e.html

Registered Nurses Association of Ontario. (2003). Integrating smoking cessation into daily nursing practice. Toronto, ON: Author.

Statistics Canada. (2006, Oct 16). Community highlights for Peterborough [On-line]. Available:

<http://www12.statcan.ca/english/profil01/CP01/Details/Page.cfm?Lang=E&Geo1=CSD&Code1=3515014&Geo2=PR&Code2=35&Data=Count&SearchText=Peterborough&SearchType=Begins&SearchPR=01&B1=All&Custom=>

Stotts, A. L., Carbonari, J. P., DiClemente, C. C. & Mullen, P. D. (2000). Postpartum return to smoking: Staging a “suspended” behavior. Health Psychology, 19 (4), p. 324-332.

Ussher, M., West, R. & Hibbs, N. (2004). A survey of pregnant smokers’ interest in different types of smoking cessation support. Patient Education and Counseling, 54 (1), p. 67-72.

Wayne, M. & Hill, G (2004). Pregnancy and smoking. Health Reports, 15 (4), p. 53-59.

Wisborg, K., Kesmodel, U., Henriksen, T. B., Olsen, S. F. & Secher, N. J., (2001). Tobacco smoke in utero and risk of stillbirth and death. American Journal of Epidemiology, 154 (4), p. 322-327.