NJ-PRAMS is a joint project of the New Jersey Department of Health and Senior Services and the Centers for Disease Control and Prevention (CDC). Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants—such as improving access to high quality prenatal care, reducing smoking, and encouraging breastfeeding. • One out of every 50 mothers are sampled each month, when newborns are 2-6 months old. Survey questions address their feelings and experiences before, during and after their pregnancy. • From 2002 to 2011, over 17,000 mothers were interviewed with a 72% response rate.
More detailed data tables and charts for New Jersey (and all other PRAMS states) are available from the CPONDER automated data query system maintained by CDC (www.cdc.gov/prams/CPONDER.htm). The site also provides information on the general background of PRAMS, methodology and publications.

In addition, the NJ-PRAMS website (www.nj.gov/health/fhs/professional/prams.shtml) posts Data Briefs on individual topics such as access to health insurance, smoking during pregnancy and breastfeeding. The Briefs offer more detailed analysis, priorities for action and resources for service providers.

The PRAMS sample design oversamples smokers and minorities, and details vary by year. Data are weighted to give representative estimates of proportions in specific categories and of actual persons (such as uninsured mothers). The survey began with births from the second half of 2002, and population estimates for 2002 only represent half a year.

Tables with demographic breakdowns use only the five most recent years of data. The population count estimates (labelled pop est) are annual averages. Records with missing data on any sociodemographic factor are ignored in all calculations.

The PRAMS questionnaire changes every three to five years, although the core content has remained consistent—but not constant—over time. New Jersey joined PRAMS during the Phase 4 questionnaire. The most recently used Phase 6 questionnaire was implemented in 2009, and is available on the NJ-PRAMS website. Prior questionnaires are available on request, but in general data from earlier years have been reformatted to match the latest response structures. Changes that potentially affect interpretation or trends are noted in the overview that follows.
Access to Care

Timely access to prenatal care is critical for identifying and managing complications of pregnancy and reducing risk of adverse outcomes. In New Jersey, timely entrance to prenatal care is predominantly influenced by insurance status before pregnancy and whether the pregnancy was intended.

Insurance status

- Privately-funded insurance prior to pregnancy—through employment, a family member's employment, or purchase from the individual market—has steadily declined to just above 60%.
- Prior to pregnancy, more women report having no insurance than being enrolled in NJ FamilyCare (NJ’s Medicaid program). Note: a major change in question format was intended to correct underreporting of FamilyCare before 2009.
- NJ FamilyCare covered prenatal care for 30% of mothers in 2011—including more than half of those previously uninsured. Around 10% remained uninsured or skipped prenatal care.

Pregnancy intention and healthcare

- The proportion of live births that were intentional pregnancies has remained near two out of three. Mistimed pregnancies—those reported as desired at a later time—were about three times as prevalent as unwanted pregnancies.
- The proportion of women entering prenatal care in the first trimester has modestly improved to about 80%.
- Late prenatal care was twice as likely among pregnancies that were mistimed or unwanted.

Prenatal care is an opportunity for healthcare providers to educate, screen and refer patients.

- Recall of discussion of specific health behavior and healthcare topics ranged from under 50% for partner abuse up to 80% or more for medication safety and HIV testing.
- Among recent public health priorities, breastfeeding education was reported by 75%. How to recognize and react to preterm labor was reported covered by 78% of women with private insurance and by 80% under FamilyCare.
- Discussion of partner abuse (which can be interpreted as screening or preventive education) was reported by 44% of women, including 59% of unmarried and 71% of teen mothers but only 33% of privately insured and college educated mothers.
Healthy Pregnancy

Healthy behaviors before and during pregnancy also reduce risk of adverse outcomes. Prenatal screening for behavioral risk factors is far from universal, even though PRAMS and other data confirm broad prevalence of risky behaviors across sociodemographic gradients. Intervention strategies to promote healthier lifestyles are more effective before pregnancy, since adverse effects often occur before the pregnancy is known.

Health behaviors during pregnancy

- In 2011, smoking declined slightly. Three patterns are identified in PRAMS: smoking three months before pregnancy but quitting before the pregnancy is recognized (2%), quitting later during pregnancy (10%), and smoking throughout pregnancy (6%). The trend since 2007 has been inconsistent.
- The proportion of mothers who report they were weekly drinkers of alcohol before they became pregnant has been trending upward, as has the proportion who admitted to at least one binge-drinking episode in the three months prior to pregnancy. (Changes were made in the binge question starting in 2009 that increase reported incidence.)
- Maternal body mass index over 25 (overweight and obese combined) increased modestly over the decade, to 41% in 2011.
- Rates of reported abuse, both before and during pregnancy, fluctuate around 2-3%.

Risk factors

- Among women who smoked before pregnancy, 70% of those with intended pregnancies quit, compared to 60% for mistimed pregnancies and 41% for unwanted pregnancies.
- Women enrolled in NJ FamilyCare for prenatal care had higher prevalence of prepregnancy smoking (including quitters) and slightly lower success quitting.
- Weekly drinking before pregnancy is associated generally with higher socioeconomic status (White, insured, college, married) and older age. The same is true for binge drinking before pregnancy.

Smoking relapse after pregnancy

- Just under 10% of mothers smoked after the baby’s birth. Women covered by FamilyCare did so at more than twice the rate of others.
- Among women who quit smoking during pregnancy, 39% of those with intended pregnancies relapsed, compared to 48% for mistimed pregnancies and 40% for unwanted pregnancies.
Postpartum Period

PRAMS offers a unique opportunity to assess health behaviors and healthcare utilization in the weeks after a newborn goes home. Among the highest priority items for maternal and child health in New Jersey are breastfeeding, infant sleep and postpartum depression.

- Breastfeeding initiation has increased gradually over the decade, reaching 80% in 2010.
- However, *persistence* as measured by exclusive breastfeeding though eight weeks has remained stable, at 25% in 2010.
- Routine back (supine) sleep, the best practice for preventing SIDS, has gradually increased, to 67% in 2010.
- Routine back sleep was much less prevalent for non-Hispanic Black (42%) and Hispanic (56%) mothers, women with high school or less education (<54%) and for FamilyCare participants (51%).
- Items measuring depression symptoms were introduced to PRAMS in 2009. A composite score indicating positive risk has averaged 8.7% for two years.
Alcohol use
A screening/skip question asks, “Have you had any alcoholic drink in the past two years?” Drinking behavior is queried “in the three months before” and “during” pregnancy (see Smoking/Tobacco). Reports during pregnancy are quite low, and not reported here. Responses to indicate quantity have evolved over questionnaire phases. Weekly drinking is defined as at least one drink “in an average week.” Binge drinking is defined as 5 drinks in one sitting until it was changed to 4 drinks in 2009.

Body mass index (BMI)
Mothers are asked their pre-pregnancy weight and height; BMI is calculated later. BMI over 25 is considered overweight.

Breastfeeding
Defined as feeding by breast or using pumped breast milk. For interviews through 2011, exclusive postpartum breastfeeding is reported as of the eighth week of life (the earliest date of interview). Infants who have not been fed any other liquids or solid food are considered exclusive breastfeeders. There is a separate question asking whether the infant was fed anything besides breast milk before hospital discharge, which is not considered in the eight-week indicator.

Health insurance
Health insurance questions were revised for 2009 (Phase 6) to more accurately identify participants in Medicaid and the State Children’s Health Insurance Program (jointly branded as NJ FamilyCare), private employer-based and individual plans, and non-insurance (including indigent or “charity” care). This change may be the cause of greater reporting of FamilyCare, which may also be coincident with a decline in private coverage.

Partner violence
“Did your husband or partner push, hit, slap, kick, choke or physically hurt you in any way?” This is asked for the twelve months before, and again during, pregnancy. Earlier questionnaire phases asked about non-partner violence; Phase 6 did not. Phase 7 will ask about ex-partners.

Postpartum depression symptoms
New Jersey requires that hospitals screen mothers for post-partum depression before discharge, using a validated screening tool. PRAMS attempts to extend the time frame of surveillance, but only has room for three standardized mood questions: “How often do you feel... down or sad; hopeless; slowed down.”

Pregnancy intention
Intention is asked in a number of different ways, including, “Were you trying to become pregnant?” and “Were you doing anything to keep from becoming pregnant?” The consensus within the national PRAMS project has been to recode a third question, “How did you feel about becoming pregnant?” into three categories: intended to become pregnant, mistimed (wanted to
be pregnant later), and unwanted (did not want to be pregnant then or in the future). This question is asked before the other two, hoping to minimize contamination.

**Prenatal care**

Defined in the questionnaire as “Visits to a doctor, nurse or other health care worker [HCW] before your baby was born to get checkups and advice about pregnancy ... not including a visit only for a pregnancy test or only for WIC.” Initiation is dated in terms of weeks or months since pregnancy began. The mother was also asked to date when she became sure she was pregnant. A multiyear calendar is provided in the questionnaire. Mother is asked what insurance specifically paid for prenatal care.

**Screening/education content** is probed in twelve yes/no items, “During any of your prenatal visits, did a doctor, nurse or HCW talk with you about ...” as listed in the tables.

**Race and Hispanic origin**

The NJ-PRAMS sampling plan calls for oversampling to more accurately address important social disparities in health. As with all Federally-sponsored surveys, Hispanics or any race are counted as a separate group; non-Hispanic Blacks and non-Hispanic Asians are also distinguished from non-Hispanic Whites. New Jersey is the only PRAMS state to oversample Asians. Classification is based on the birth record—there are no questions on this topic in the PRAMS questionnaire.

**Questionnaire phase**

The PRAMS questionnaire changes every three to five years, although the core content has remained consistent—but not constant—over time. New Jersey joined PRAMS in 2002, using the Phase 4 questionnaire. The Phase 7 questionnaire was implemented for births in 2012.

**Sampling plan, stratification**

PRAMS starts with a stratified systematic sample of birth certificates (unduplicated for multiple live births). Infants must be at least two months old before mothers are contacted; occasionally the infant is three months old at sampling, due to late submission of birth record. The fraction of all NJ-resident mothers sampled has ranged from 1:33 to the current 1:50.

There are six sampling strata based on birth certificate variables: Whites who reported smoked during pregnancy; any minority (Black, Hispanic, Asian) who also smoked; non-smoking Whites, Blacks, Hispanics, and Asians. Compared to non-smoking Whites, all other groups are oversampled to permit their effective analysis. Weights are used in analysis to [a] adjust estimates to represent the underlying population, and [b] project the annual number of mothers in any category or outcome. This requires special software, such as SAS Survey Analysis procedures or the specialty package SUDAAN.

PRAMS self-report responses suggest that tobacco-exposed pregnancies are underestimated in the official birth record (11.4% versus 8.2%).
Tobacco exposure during pregnancy (Cigarette smoking)
A screening/skip question asks, “Have you smoked any cigarettes in the past two years?” Smoking behavior is queried “in the three months before” and “during” pregnancy. Responses to indicate quantity have evolved over questionnaire phases. New Jersey was the first PRAMS state to ask women who smoked before pregnancy and quit whether it was before or after the found out they were pregnant; quitting after still represents a tobacco-exposed fetus.

Mothers are also asked whether they smoke at the time of interview, which addresses both postpartum relapse and infant environmental exposure. Smoking rules in the house—allow, restricted or prohibited—also address environmental exposure.

Weighting, population estimates
Most PRAMS states use stratified sampling plans to oversample groups of special interest. New Jersey oversamples smokers as reported by the birth record, and Blacks, Hispanics and Asians. Analysis as a simple random sample will yield biased estimates. Sampling weights are used to correct for oversampling, and an additional round of non-response adjustments further improve the representativeness of the final, interviewed sample. Weighted samples also require special analysis techniques to accurately estimate sampling error, such as implemented in SAS Survey Analysis procedures or the specialty package SUDAAN (but not SPSS).
PREGNANCY RISK ASSESSMENT MONITORING SYSTEM
A survey for healthier babies in New Jersey

STATE AND LOCAL RESOURCES

NJ211 - A place to turn to when you need to find state or local health and human service information.
Within NJ Dial: 2-1-1  Outside NJ: 1-877-652-1148  Website: http://www.nj211.org/

NJ Parent Link - New Jersey’s Early Childhood, Parenting and Professional Resource Center.
Website: http://www.njparentlink.nj.gov/

HealthLink - New Jersey’s comprehensive healthcare consumer information website providing instant access to healthcare information for families, children, seniors and healthcare professionals.
Website: http://www.nj.gov/njhealthlink/

Family Health Line Operational 24/7 and is available anywhere in New Jersey. Trained phone counselors provide information and referrals for health screening and treatment.
1-800-328-3838  Website: http://www.nj.gov/health/fhs/primarycare/health_line.shtml

Speak Up When You Are Down - Perinatal mood disorders (PMD) can affect any woman of any age, race or economic background who is pregnant or who has recently had a baby, stopped breastfeeding, or ended a pregnancy or miscarried. PMD are treatable, but many people do not know the facts.
1-800-328-3838 (24/7) Website: http://www.nj.gov/health/fhs/postpartumdepression/index.shtml

Special Child Health and Early Intervention Services has information and resources for infants, children, youth and young adults with special health care needs and for infants and toddlers with developmental delays/disabilities. Newborn screening information and resources are also available.
1-609-984-0755  Website: http://www.nj.gov/health/fhs/ch/index.shtml

Women’s Referral Central is the primary source of information about programs of interest to women in New Jersey. Available 24 hours a day, it assists women in areas as diverse as sexual harassment, child support, and custody, consumer law and safety, to personal growth and development, education, medical referrals, homelessness, personal safety and domestic violence.
1-800-322-8092  Website: http://www.state.nj.us/dcf/women/programs/wrch.html

Phone numbers for additional information and assistance

Family Helpline 24/7 - If you’re feeling stressed out, call the Family Helpline and work through your frustrations before a crisis occurs. You’ll speak to sensitive, trained volunteers of Parents Anonymous who will provide empathic listening about parenting and refer you to resources in your community.
1-800-THE-KIDS (843-5437)

Addictions Hotline of NJ provides trained clinically supervised telephone specialists who are available 24/7 to educate, assist, interview and/or refer individuals and families battling addictions.
1-800-238-2333

Quit Smoking: 1-866-NJSTOPS; 1-866-657-8677

NJ Women, Infant, and Children Services (WIC): 1-866-44-NJWIC; 1-800-328-3838

NJ Health
New Jersey Department of Health
RECURSOS ESTATALES Y LOCALES

NJ211- Un lugar al que puede recurrir para encontrar información estatal y local sobre servicios de salud y humanos.
   Dentro de NJ marque: **2-1-1**   Fuera de NJ: **1- 877- 652-1148**   Página Web: [http://www.nj211.org/](http://www.nj211.org/)

NJ Parent Link- Infancia Temprana de Nueva Jersey, El Centro de Recursos de Crianza de los Hijos y Profesionales.

HealthLink- El sitio web de asistencia de Nueva Jersey que ofrece acceso instantáneo a información sobre el cuidado de salud para familias, niños, personas de la tercera edad, y profesionales de salud.
   Página Web: [http://www.nj.gov/njhealthlink/](http://www.nj.gov/njhealthlink/)

Family Health Line Opera las 24 horas/ 7 días a la semana y es accesible en cualquier lugar de Nueva Jersey. Consejeros calificados proveen información y referidos para servicios de exámenes médicos y tratamiento.
   **1- 800-328-3838**   Página Web: [http://www.nj.gov/health/fhs/primarycare/health_line.shtml](http://www.nj.gov/health/fhs/primarycare/health_line.shtml)

Speak Up When You Are Down – Trastornos de humor perinatales (Conocido como PMD por sus siglas en inglés) pueden afectar a mujeres de cualquier edad, raza o origen económico que están embarazadas o quien recientemente dieron a luz, dejaron de amamantar, o tuvieron un aborto provocado espontáneo. Trastornos de humor perinatales pueden ser tratados, pero mucha gente no sabe de los datos concretos.

Special Child Health and Early Intervention Services tiene información y recursos para bebés, niños, la juventud, y adultos jóvenes con necesidades especiales de salud y para bebés y niños con discapacidades del desarrollo. Información y recursos sobre revisiones para los recién nacidos disponible.

Women’s Referral Central es la fuente de información sobre los programas de interés a las mujeres en Nueva Jersey. Accesible 24 horas al día, ayuda a mujeres en una variedad de temas desde el acoso sexual, pensión alimenticia y custodia, derechos del consumidor y seguridad, hasta crecimiento y desarrollo personal, educación, referidos médicos, la falta de vivienda, seguridad personal y la violencia doméstica.
   **1-800-322-8092**   Página Web: [http://www.state.nj.us/dcf/women/programs/wrch.html](http://www.state.nj.us/dcf/women/programs/wrch.html)

Números de teléfono para más información y asistencia

Family Helpline 24/7 - Si se siente estresada, llame al **Family Helpline** y le pueden ayudar con sus frustraciones antes de que ocurra una crisis. Hablara con voluntarios sensitivos y entrenados de Parents Anonymous (Padres Anónimos) que escucharan y lo puede referir a recursos que hayan en su comunidad.
   **1-800-THE-KIDS (1-800-843-5437)**

Addictions Hotline of NJ prove especialistas clínicamente entrenados y bajo supervisión quienes son accessible 24/7 para educar, ayudar, y entrevistar y referir individuales y familias luchando contra adicciones.
   **1-800-238-2333**

Para De Fumar: **1-866-NJSTOPS; 1-866-657-8677**

NJ Women, Infant, and Children Services (WIC): **1-866-44-NJWIC; 1-800-328-3838**