

Reducing smoking in pregnancy

The conditions in which people are born, grow, live, work and age can lead to health inequalities – the unfair and avoidable differences in health status.

Actions to tackle health inequalities demand the efforts of government, statutory organisations, community, voluntary and private sectors. This Good Practice Guide to reducing smoking in pregnancy is one of a series designed to capture information about health inequalities and highlight evidence-based interventions and key actions for improvement across sectors.

Other Good Practice Guides in this series can be accessed at: www.publichealth.hscni.net/publications/good-practice-guides

Why do it?

Smoking during pregnancy is a major cause of ill health for both mother and baby. It increases the mother's risk of potentially serious complications, and the infant's risk of death and low birth weight.¹

Health and social context

There is a clear link between smoking in pregnancy and social disadvantage; the greater the disadvantage, the higher the smoking prevalence. There is a need to reduce smoking in pregnancy for all women, with a focus on the needs of those who experience social disadvantage.

The key factors that contribute to smoking in pregnancy are:

- caring responsibilities;
- access to material resources;
- having a partner who smokes.^{2,3}

Evidence suggests that while women know that tobacco use is damaging their health, for many smoking is a means of coping with poverty, disadvantage and lack of control over other aspects of life.²

Women who continue to smoke during pregnancy are younger and less educated; more likely to be single and in manual occupations and much less likely to perceive smoking as a risk to their baby compared with those who manage to stop.^{4,5}

- In Northern Ireland 24% of women are smokers, with the highest smoking rates recorded among younger women aged 20-24 (41%), 25-34 (31%) and 35-49 (28%) and women from semi-skilled manual (33%) and unskilled manual (31%) socioeconomic groups.⁶
- In Northern Ireland, 43% of women give up smoking before or during their pregnancy, while 18% of mothers continue to smoke during their pregnancy.⁷
- More than half of women who quit in pregnancy tend to start smoking again within a month of the birth.⁷

Policy context

The *Investing for Health* strategy is a key element of the Programme for Government aimed at improving the health of all our people and reducing health inequalities.⁸

It states that smoking, more than any other identifiable factor, contributes to the gap in healthy life expectancy between those most in need, and those most advantaged.

The five year *Tobacco action plan 2003–2008* builds upon *Smoking kills – A white paper on tobacco 1998*.⁹

It provides a framework for collaborative working across government departments, the statutory, voluntary and business sectors, and local communities. It identifies pregnant women as a key target group.

What works?

For individuals/families

- brief interventions (5–10 minute focused conversation with a trained person);
- individual behavioural counselling with a cessation specialist;
- group cessation programmes;
- smoking cessation products, for example, nicotine replacement therapy (NRT), with support, once a person is ready to quit;
- self-help materials;
- telephone counselling and quit lines.¹²

The greatest impact occurs when several methods are used together.^{13,14}

However, group sessions are very poorly attended by pregnant smokers and therefore are considered less effective.

Provision of a reward or incentive can be an effective way of helping women quit smoking during pregnancy compared to usual care alone. (Incentives include cash, vouchers, lottery tickets, prize draws.) This abstinence does not continue into the long term post-pregnancy.¹⁵

Tailoring intervention methods and addressing barriers to behavioural change and the concerns of pregnant women can lead to greater acceptance of interventions.¹⁶

NRT is recommended for pregnant women who smoke heavily and who have not succeeded in quitting by behaviour change alone.¹ Although NRT is not risk free, it is considered that it poses less risk than continuing to smoke heavily.¹⁴

It is important to advertise cessation services and make support materials readily available.¹⁵ Drama has been used successfully to connect with pregnant smokers.

For communities/settings

A case study Newcastle Community Midwifery Care project provided enhanced midwifery care to expectant mothers at home and increased access

to other welfare services. The ethos was of support and encouraging a sense of achievement. One in two mothers in the project quit or reduced their smoking as compared with one in four in the control group.¹

Further information is available at www.ncl.ac.uk/medev/assets/documents/casestudyprn.pdf

No evidence is available at present for **schools or workplaces**.

At policy level

- increasing the unit price for cigarettes;
- mass media campaigns can be effective alone, but are better when combined with other interventions;¹¹
- health promotion and behavioural support;
- counselling and self-help strategies;
- reducing out of pocket expenses for costs of effective cessation therapies;⁹
- smoking behaviour is linked more to how women live than to their knowledge about smoking. Messages should be relevant and appropriate to their circumstances.⁵

Measures for which evidence is lacking or unclear

- There are very few effective smoking cessation interventions for pregnant/postpartum women that include partners or target partner smoking behaviours.
- There is limited evidence on the success of interventions to reduce environmental tobacco smoke such as smoke-free homes.¹⁹

While existing research targets people in low socioeconomic groups, very little evidence exists on interventions that are effective specifically for these groups.²

What can we do?

Key actions for health improvement

Prioritise

- Recognise that because the health gains are so large, even small successes with pregnant smokers are worth higher levels of investment.¹⁷

Provide cessation services

- Train all those who work with pregnant women in brief intervention skills.
- Offer interventions throughout pregnancy.¹⁷
- Focus on key stages, pre-pregnancy and the first three months for cessation and month eight for support to prevent relapse following the birth.^{1,3}
- Possible intervention points include initial GP/ midwife consultation, booking visit, at home, hospital or community antenatal clinic, antenatal care visits and postnatal home visits.¹⁸
- Build cessation programmes around the context of pregnant women's lives.⁵

Connect existing services with cessation services

- Establish links with contraceptive services, fertility services, antenatal and postnatal services to ensure that women who are ready to quit are signposted to appropriate services.¹⁸
- Target cessation programmes at both pregnant women and their partners.³
- Offer intensive interventions from a trained cessation specialist to all women early in their pregnancy.³
- Promote the use of NRT for pregnant women who smoke heavily and have been unable to stop using behavioural methods only.¹

Reduce poverty

- Given the strong association between social inequalities and continued smoking in pregnancy, health professionals need to support strategies in the wider community to reduce inequalities. For example, providing support for accessing benefits.²

Use available information

- Use data for the local area to focus and plan

cessation services for pregnant women. For example, of the number of women who are pregnant at any one time, how many of them smoke? Which areas have the highest rates of smoking, birth weight and infant mortality?

- Ensure that all staff are aware of the location of local services in GP practices, pharmacies and in community settings such as healthy living centres and the type of support they offer.

References

A full list of references is available at www.publichealth.hscni.net/publications/good-practice-guides

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