Tobacco Cessation among Pregnant Women and New Mothers: A Qualitative Look at the Challenges
Louisville Metro Healthy Start

Qualitative Data

Reducing the rate of infant mortality in targeted areas of Louisville Metro

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Introduction

Aware that prenatal exposure to tobacco significantly increases the risk of physical, emotional, and developmental problems for infants, Healthy Start administrators and members of the Healthy Start Advocacy Group asked evaluators to analyze the data for the link between smoking and infant health. The analysis of birth outcomes completed in early 2012 found that:

- **Smoking Prevalence:** Overall, 22.1% (n=1,053) of mothers self-reported smoking during pregnancy. Between 2007 and 2010, the smoking prevalence among pregnant mothers increased from 20.7% to 23.3%.

- **Low Birth Weight:** Among Healthy Start mothers who smoked during pregnancy, 20% had a LBW baby compared to 13.6% of Healthy Start mothers who did not smoke during pregnancy (p<0.001).

- **Prematurity:** Approximately 17.2% of Healthy Start mothers who smoked during pregnancy gave birth to a premature infant compared to 13.7% among mothers who did not smoke (p<0.01).

Data Source: Healthy Start Database and Kentucky Vital Statistics birth records, 2007-2010

The high prevalence of self-reported smoking during pregnancy, coupled with the absence of a downward trend in this behavior, generated concern among the Healthy Start Advocates and staff. They were interested in knowing more about why women were not responding to smoking cessation efforts, from the women who reported a history of smoking during pregnancy and from the staff who were working with them.

Staff made several attempts to convene a focus group of women, currently in the Healthy Start program, who smoked during pregnancy. However, the women were reluctant to share their experience and to talk about the difficulties of quitting in the context of a focus group. Unable to gather a group of Healthy Start participants for this purpose, evaluators decided to meet with the staff who had the greatest degree of contact with these women: the Healthy Start nurses and resource workers. Three meetings were held with these members of the Healthy Start team. They described the challenge for the women who are dealing with multiple stressors and the challenge for staff who do not want to push so hard on the issue of smoking that women leave the program. They also presented recommendations.
REACH evaluators met with three groups of Healthy Start nurses and resource workers (11 participants) to get their thoughts on the reasons the rate of smoking during pregnancy remains high for women in the Healthy Start program (20.7% to 23.3% between 2007 and 2010).

The ideas from all three groups were similar. The themes are summarized below.

**Reasons women in the Healthy Start program continue to smoke:**

- Women have a genuine desire to quit smoking during pregnancy; however, other stressors in their lives consume their focus and energy.

- Things like paying the rent, getting enough food, and getting (or keeping) a job take priority.

- Smoking is a (short term) stress reliever, and when the stress gets too great, women relapse.

- Many smoking cessation programs include a nicotine replacement component, and many questions remain about the safety of these drugs during pregnancy.
• Women with hypertension or diabetes are at greater risk for adverse side effects from the use of nicotine replacement therapy.

• The most effective strategy for the women in the Healthy Start program is to help them reduce the stressors in their lives and provide them with support and education.

• Women who smoked during a prior pregnancy that resulted in a healthy baby, or women who have known friends who smoked and had a healthy baby tell themselves that smoking ‘really isn’t that bad’ for their baby.

• Resource workers are reluctant to push the issue too much, for fear that the woman will drop out of the Healthy Start program entirely. Instead, they rely on sharing educational materials and being a source of encouragement and support.

• Some women who cut down their nicotine intake or quit entirely, resume smoking once the baby is born. For some of these women, a component of the motivation is weight loss.

**Strategies/approaches in use in helping Healthy Start women quit include:**

Instead of directly focusing on the smoking, some resource workers focus on the stressors and ways to eliminate the things that might be getting in the way of a quit attempt.

Resource workers try to work with mothers without pressuring them. There is a strong focus on educational materials; leaving them with the woman to consider and possibly discuss at the next visit.

Support rather than pressure is seen as an important strategy for receiving honest responses to questions about continued smoking and for maintaining the woman in the Healthy Start program.

Goal setting includes cutting back, the identification of stressors that may trigger a relapse, and the identification of other ways to relieve stress and anxiety.

Instead of directly focusing on the smoking, some resource workers focus on the stressors and ways to eliminate the things that might be getting in the way of a quit attempt.
IV. Suggestions/recommendations:

If a smoking cessation program becomes a part of the Healthy Start program, then it should be handled by a separate nurse (one without an existing caseload). The home visits associated with this specialty service would be in addition to (and separate from) the current home-visit protocol.

Because pregnancy complicates the use of nicotine replacement therapy, smoking cessation efforts need to begin before pregnancy. Staff suggested working with the Family Health Centers and other primary care locations where women receive family planning services to ensure that women are screened, receive educational materials, and have access to smoking cessation programs.

Some women who cut down their nicotine intake or quit entirely, resume smoking once the baby is born. To the extent that one motivator for resuming smoking is linked to a desire to lose weight, alternative weight loss strategies should be emphasized.

Identify women who have been successful in quitting and convene them for a focus group on what it was that “worked.”

Work with the partner or others in the home to address issues of second hand smoke and support for the person wanting to quit. Partners and others in the home should be included in the discussion of cessation, and encouraged to consider quitting, as well.

Incentives are important if women are to make time for a smoking class or other out-of-home smoking cessation program. Otherwise, the other demands and stresses in their lives consume their time and energy. As an example, Healthy Journey for Two smoking cessation program uses refreshments and points for baby supplies as a means of attracting participants.

Any smoking cessation service needs to be located in the woman’s neighborhood, as transportation is a significant barrier for many women.

Focus needs to be on stress reduction with alternative techniques for reducing stress taught and made available.
Focus Group:
The challenge of smoking cessation as perceived by women faced with the stresses of single parenthood and a history of poverty

REACH evaluators conducted a focus group with eight women, all of whom were low-income single parents. Participants were recruited based upon their history of having smoked prior to or during pregnancy. Seven of the eight met this criterion. Although one woman had never smoked, she was allowed to remain in the group.

Evaluators began by asking the women about their understanding of the risks and benefits of smoking. They identified several risks, including respiratory problems, cardiovascular disease, and addiction. The majority of the identified benefits related to the act of smoking a cigarette being a source of stress reduction. They described smoking as “calming” and “soothing to the nerves”. One participant said that she smokes when she is “edgy”; another participant said she smokes “to be nice”. One participant described the feeling of “release” she gets through the physical act of exhaling, saying it is “like you are letting stuff go”. Another spoke of the link between drinking (alcohol) and smoking, indicating that she particularly enjoyed a cigarette at times when she was drinking. In addition stress reduction, participants cited weight control as a benefit to smoking; particularly as a means of getting back to their pre-pregnancy weight and then maintaining that weight. One participant mentioned that she perceived smoking to be glamorous, and recalled images in old movies. Other participants disagreed, and indicated that, while that was once the case, the image had changed from glamorous and cool to unhealthy and offensive.

The majority of the discussion centered on what had worked for them, in terms of quitting or reducing their use of cigarettes, and what they would suggest in terms of programs that would lead to a reduction in smoking among pregnant women and parents of young children. The overall consensus was that no single strategy works for everyone and that a comprehensive approach involving multiple strategies had the best opportunity for success. One participant commented: “you need to come at them however you can come at them” because people respond differently at different times in their lives. Below is a summary of their ideas about what had contributed to their ability to quit or reduce their use.
The primary role of education (of women, their partners and their children)

Many of the comments related, in some form, to the primary role of education in providing the incentive to quit and the motivation to resist the desire to start smoking again.

• Public awareness campaigns: Recent, hard-hitting, public awareness spots produced by the Centers for Disease Control (CDC) were mentioned by several participants as being very persuasive in describing the risks associated with smoking. [http://www.cdc.gov/tobacco/campaign/tips/stories/]

• Concern expressed by their child: Several participants mentioned that comments made by their children were key to their decision to quit smoking. Even very young children are getting the message that smoking is harmful, both to the adults in their world who smoke and to themselves through second hand smoke. Participants noted the power of education, whether the focus of the education is the child or the parent.

• Educate the partner: Participants stated that the need to educate male partners about the risk of smoking should not be underestimated. They indicated that the partner could be a huge source of encouragement (when they supported the woman’s desire to quit); or they could create significant barriers to her efforts to quit.

Support of a partner/social group

One participant attributed her success in quitting to her partner holding her accountable. She said that her partner was concerned about the impact of her smoking on the health of their baby and was adamant that she quit. Other participants agreed that their partner, as well as others adults in their social circle, play a significant role in making it easier (or more difficult) to quit. When a partner does not smoke, or when the woman’s family/friendship network consists primarily of non-smokers, then it is easier to quit and not re-start. However, when the woman lives with (or spends considerable time with) people who smoke, then there is little support for quitting and considerable temptation to continue. One participant, in confirming the power of the social group and the need to surround yourself with people who act in healthy, responsible ways, said that her strategy involved the axiom: “if you can't change the people around you, change the people around you”.

Participants stated that the need to educate male partners about the risk of smoking should not be underestimated.
Access to a replacement therapy
One participant mentioned that the thing that worked for her was having access to an intermediary step, between smoking and “cold turkey”. She used an electronic cigarette as a transition from tobacco to smoke-free.

Personal knowledge of health consequences affecting a loved one or an infant
Several participants acknowledged the impact of knowing that a relative had died of lung cancer and that the cancer was a result of smoking; another mentioned the impact of stories of babies who have been affected by the mother’s smoking during pregnancy. These real-life stories, like the CDC ads, made them reluctant to pick up a cigarette and motivated them to quit.

The importance of the woman’s sense of self-efficacy
Several comments were made about the importance of the woman believing that she can not only make good decisions but can also perform in competent ways. One participant suggested teaching assertiveness, so that the woman would feel comfortable in saying “no” to pressure that she smoke or permit her child to be in a smoke-filled environment. Another participant recommended that women be taught ways to get temporary relief from the stress in their lives without resorting to cigarettes. One participant recommended exercise as a means for reducing stress and gaining energy. One woman stated that her history of having successfully quit smoking in the past (for a while) made her more confident that she could do it again.

The impact of policies that support smoking cessation
In addition to educating the pregnant woman and mother about the dangers of smoking to her and her child, educating partners and children on the risks of smoking and second-hand smoke, providing access to replacement therapies, and strengthening the woman’s confidence in her own ability to quit, participants mentioned the value of changes at a policy level. The two policy strategies identified by participants as making a positive difference in their efforts to quit were:

- Creating/expanding smoke free environments (campuses, restaurants, apartment buildings, workplaces), and
- Increasing the cost of a pack of cigarettes.
Both strategies make it more difficult to smoke and cut down on the use of smoking as an automatic response to a stressful day.

In summary, participants were aware of the risks of smoking and they were cognizant of the challenges associated with quitting. Even those who still smoked supported efforts to make their use of cigarettes more costly, more cumbersome, and less attractive. The overarching message was that no single tactic was going to be successful for everyone, and that a comprehensive approach with multiple strategies was needed. Of all the approaches, education was the most important. Even within education, a broad range of formats and content was suggested; as participants acknowledged that for some women the scary ads of the recent CDC campaign were most compelling; while for others, it was messages carried through information given to their children that made the difference. Repeating the words of one participant, “you need to come at them however you can come at them”.

**Conclusion**

Quitting smoking is a challenge for many people, but the stressors in the lives of Healthy Start participants make it particularly difficult to quit. The women in the focus group had many words for it, but smoking helped them get a brief respite from the stress in their lives. However, because of their concern for the health of their baby, and for their own health, they expressed a genuine desire to quit.

The overarching recommendation of staff was that the focus should be on reducing the stressors, as that needed to happen before some women would be able to give up cigarettes. For the women with a history of smoking and of living in poverty, the key message was that no single solution/approach will work. Multiple strategies, from education to alternative forms of stress reduction, and multiple messengers, from the media to a partner to a child to a health care professional, are needed.

Their recommendations related to providing a comprehensive approach to the problem of smoking during pregnancy and around young children are repeated below:

- Educate the partners: Partners can be a huge source of encouragement (when they support the woman’s desire to quit); or they can create significant barriers to her efforts to quit.
• Educate women to the health hazards of smoking, by using the stories of people who have been disabled by their addiction. Recent, hard-hitting, public awareness spots produced by the Centers for Disease Control were mentioned by several participants as being very persuasive in describing the risks associated with smoking.

• Teach assertiveness, so that women feel comfortable in saying “no” to pressure that she smoke or permit her child to be in a smoke-filled environment.

• Focus on stress reduction with alternative techniques for reducing stress taught and made available. Teach ways to get temporary relief from the stress in their lives without resorting to cigarettes. Use exercise as a means for reducing stress and gaining energy.

• Provide access to an intermediary step, between smoking and “cold turkey”, such as an electronic cigarette.

• Create/expand smoke free environments (campuses, restaurants, apartment buildings, workplaces), and

• Increase the cost of a pack of cigarettes.

• Work with the Family Health Centers and other primary care locations where women receive family planning services to ensure that women are screened, receive educational materials, and have access to smoking cessation programs prior to pregnancy.

• Emphasize alternative weight loss strategies, so that women do not resume smoking after their baby is born as a way to lose weight.

• Provide incentives to women who make time for a smoking class or other out-of-home smoking cessation program. Otherwise, the other demands and stresses in their lives consume their time and energy.

• Locate smoking cessation services in the neighborhood, as transportation is a significant barrier for many women.

Multiple strategies, from education to alternative forms of stress reduction, and multiple messengers, from the media to a partner to a child to a health care professional, are needed.
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