Smoking Cessation in Pregnancy

Engagement Report for Bradford District & Craven NHS CCGs

The engagement for this project was carried out by Bradford & District Community Empowerment Network, as part of the Engaging People Project. The report was written jointly by Bradford & District Community Empowerment Network and Healthwatch Bradford & District.

Engaging People is a voluntary and community sector (VCS) partnership project, set up and funded by Airedale, Wharfedale and Craven, Bradford City, and Bradford Districts Clinical Commissioning Groups (CCGs) to carry out public and patient engagement on our behalf.

The partnership includes local organisations CNET, HALE, BTM and Healthwatch.

Engaging People carry out work that links to CCG priorities and work streams, helping us reach out to hear the voices and views of particular groups or communities.

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Background

The Clinical Commissioning Group (CCG) Improvement and Assessment Framework identified that in Bradford District, 18% of pregnant women continue to smoke during their pregnancy, compared to a national average of 12%.

Bradford City, Bradford Districts and Airedale Wharfedale CCGs asked the CNET Engaging People team to carry out a piece of work to better understand how cessation services can support women and what would encourage them to stop smoking.

The objectives for this project were to:

- Identify the key reasons pregnant women who smoke are not accessing existing services
- Identify the key barriers to stopping smoking for pregnant women
- Identify new ways to educate target groups around smoking in pregnancy and the impact of passive smoking

Target groups:

- Women of child bearing age who currently smoke
- Women who have smoked during pregnancy
- Women who are pregnant and smoking
- Women who live in communities/family surroundings where smoking is seen as part of the norm

The women we spoke to were from the following backgrounds:

- White women (including White British, White Irish and mixed/multiple ethnicities identifying as White)
- Eastern European women (most women identified as Slovakian and/or Traveler but this group also included those identifying as Czech and European)
- South Asian women (including Bangladeshi, Pakistani and mixed/multiple ethnicities)

Bradford is a city with an increasing population of people with mixed ethnic backgrounds and the way women self-identified reflected this.

The majority of those we spoke to are living in areas of multiple deprivation - high unemployment, lower educational attainment, poor housing, higher levels of crime and anti-social behavior.

Approach

National research on smoking in pregnancy identifies the difficulty in obtaining honest responses on a subject that participants can be reluctant to share their genuine feelings, for fear of being judged and deemed a “bad” person or mother.

The opening statement from the first young woman we interviewed was:

‘Would you like me to tell you how many I really smoke, or what I tell the staff?’
(5-8 cigarettes to staff, 15 – 20 actually smoked)

The approach used in gathering information was an Asset Based Community Development (ABCD) one, which recognises the value in people’s stories and experiences. Whilst the methods used to gather information were questionnaires and focus groups, the tool we used was conversation based, listening to the women’s personal insights regarding their own behaviour in a non- judgmental manner.

The aim was for women to share personal stories, journeys and feelings from their perspective and in an open manner.

At the start of each interview and focus group session, we stressed that individual responses would be treated confidentially and that no responses that could identify an individual would be shared, except in the case of a safeguarding issue.

We emphasised that there were no right or wrong answers, and that the collective responses would help shape future healthcare provision.

We spoke to women in places and venues where they had already built a relationship of trust and familiarity with staff or volunteers. Verbal consent was collected for everyone’s photographs and we explained how the photos might be used for reports and internal publications.

Women from the target groups who were on low incomes or unemployed received a £10 voucher to compensate them for their time and input.

In total, 34 women from the target groups completed the questionnaire and 35 attended focus group discussions.

The delivery of the project took place over a three month period, starting November 2017 through to early January 2018. There was a short delay to the start of the project due to the recruitment of the new Engaging People Team.

Face-to-face questionnaires

Engaging People staff completed 34 one-to-one interviews with women from the target groups in a variety of settings: community centres, a voluntary community sector health forum, a children’s centre, and maternity clinic appointments.

The questionnaires took on average 20 minutes to complete. Eight were taken away by women to complete and the remainder were completed in an interview setting.

Two members of staff were present, one talking and the other taking notes so as not to detract from the feeling of a conversational format.

A number of the interviews were audio recorded with the participants' permission, to ensure that the quotes captured were in their own words.

Focus groups

We held three focus groups, speaking to 35 women in total. One with Eastern European women, one with Pakistani women and a third with the Women's Health Network (WHN).

The WHN is a collective of women living and/or working in Bradford who have an interest in issues affecting the health and wellbeing of women and their families, particularly those from seldom-heard groups. The women who took part were a mixture of professionals and volunteers working directly with women of child-bearing age in Bradford. Some were current or ex-smokers while others had not smoked, and the group had a variety of ethnic backgrounds. A short summary of this discussion follows after the case studies.

The focus groups took place at CNET, a children's centre and a community centre. Responses were either audio recorded or collected on flip chart.

Summary

There was a real sense from our conversations with these women that it was the first time they had been asked about their feelings about smoking and smoking during pregnancy. We hope that this engagement leads to more conversations with women about how services can best support them to quit.

Key findings across the groups:

Attitudes towards smoking

- Many women expressed a desire to stop smoking. However, they perceived significant barriers to accomplishing this and often talked about the difficulty of stopping.
- A number said they did not want to stop, and explained why.
- Many individual women expressed conflicting feelings towards smoking, including how they viewed smoking in pregnancy in general, versus how they felt about themselves smoking.

Barriers to stopping

- The main reasons women gave for continuing to smoke during pregnancy were stress, anxiety and poor quality of life. Many openly spoke about their personal situations and experiences, such as financial worries, abusive relationships and having been in care. They wondered how they would cope with their lives if they were to quit smoking.

- Women across all groups identified family members and close friends smoking as a major barrier to stopping.
- Addiction and cravings were frequently mentioned too, with the majority of women fully aware that they were in this cycle. Nicotine replacement aids such as inhalators and patches generally were not deemed effective; e-cigarettes were considered more helpful for reducing cigarette smoking.
- A major barrier to accessing smoking cessation services was a fear of being judged or looked down upon.

What would help women stop?

- The women we spoke to had many suggestions about what would encourage them to stop, including reducing stress and supporting their family to quit. However, many also recognised that services have limited impact if a woman herself does not want to stop.

Whilst we did not ask whether pregnancies were planned, many of the women volunteered that their pregnancies were unplanned. For mums-to-be, this was an added stress factor and for some women, particularly those with small children, the number of cigarettes they smoked increased during pregnancy.

Though there was a lot in common in what the women we spoke to had to say, some specific themes emerged from groups with different backgrounds:

- The group of White women (excluding Eastern European women) were more likely than others to have accessed cessation support services. Some were positive about the services and what they were offering, but others explained barriers and gave reasons for not taking up referral, such as the difficulty of attending sessions with young children. They would like more in depth conversations with health professionals who are supporting them to quit. Some of the women said that family and friends had actively discouraged them from stopping.

- We heard from South Asian women that smoking is a covert habit for women in their community. They said that health professionals often assume that they do not smoke and therefore they are not always offered cessation support. There was a strong fear of judgement, both from their communities and professionals, which also discouraged some women from accessing support services. Stress was identified as a major barrier to stopping.

- The Eastern European women we spoke to considered smoking as very much part of their daily routine and of those around them. They knew that services existed – and were positive about the offer in comparison to their countries of origin – but didn't seem to have accessed them. Many did not express a

desire to stop and some said they do not know how to stop. More than the other groups, they told us that they did not want to feel pressured by professionals to stop, and that they wanted the support to be familiar and personal.

We have split the report into sections for each of these groups. This is to enable design of services that meet the needs of specific groups.

Findings

White women (excluding White Eastern European women)

'I would love to stop. My circumstances I am in mean I will be more stressed if I do stop.'

We completed the survey with 21 women who identify as White - either White British, White Irish or mixed/multiple ethnicities. Many are on a low income or income support. Virtually all of them are current smokers but had reduced the number of cigarettes they smoked during pregnancy.

The most notable theme in our conversations with these women was that they see smoking as an important tool for coping with stress.

We asked everyone we met about their feelings and thoughts around smoking in pregnancy. A lot of the women in this group have negative feelings towards smoking and expressed guilt around the health of their baby. Most of them made it clear they know they should stop.

> **'It's not good for the baby. It makes me feel guilty.'** *(Currently smoking and smoked during recent pregnancy)*

Even though the women we spoke to said the key health messages around smoking were clear, several formed ideas about smoking in pregnancy in relation to the health/ill health of their older children, particularly whether or not they have asthma.

> **'If you sat and thought about it [smoking in pregnancy] all the time, you could go crazy. All my five children are okay, only elder daughter has asthma.'** *(Currently pregnant and smoking)*

> **'I smoked more during my first pregnancy…she is seven now and is fine.'** *(Currently pregnant and smoking)*

Experiences and knowledge of support services

This group was more likely than the others to have accessed smoking cessation services, though many said they had not been offered help to quit and could not

name services. Some women acknowledged the importance of support to stop smoking, but several women felt they had just been told to stop:

> **'Important to get the support to try to stop.'** *(Currently pregnant and smoking)*

> **'I was told to stop but not offered any support like how to stop.'** *(Currently smoking and smoked during recent pregnancy)*

> **'People tell you to stop but there is no support out there to help you. Doctors are too busy with people who are ill.'** *(Has smoked in pregnancy and since given up)*

We heard about things that discouraged them from taking up referrals for support:

> **'I was offered help by my midwife, who referred me to the stop smoking clinic. There was a delay in the referral being followed up - I had already cut down on cigarettes on my own.'** *(Currently pregnant and smoking)*

> **'I don't want to know [about support services] – too stressful.'** *(Currently smoking and has smoked during recent pregnancy)*

There was also some criticism about support services, with women feeling that the support offered was not effective or did not suit them.

> **'When I've been to non-smoking clinics before, there is no relationship, no bother from workers, only lots of information is given and you are sent away.'** *(Currently pregnant and smoking)*

> **'I'm fully aware of all the support services out there. GPs and midwives are supportive, offered smoking cessation group to me, but it's not the right time for me at the moment – cigarettes are my coping strategy.'** *(Currently pregnant and smoking)*

Several women told us that free patches and inhalators had not been useful and that using e-cigarettes had been more effective in helping them to reduce the number of cigarettes they smoked. Some said that offering leaflets and web addresses was not enough and others that group settings could be off-putting. Literacy levels were also an issue for some, who had problems reading the flyers and leaflets that they had been given by services.

Most had pre-school children with them when attending sessions and complained about the difficulty in keeping them occupied whilst trying to listen to the health professional. Others highlighted the practical barriers to attending support services:

> **'[It's] yet another appointment to attend. I went while I was working and it meant taking almost a day off work, so if I was going to stop any appointment, it would have been this one.'** *(Currently smokes and has smoked during recent pregnancy)*

Women also mentioned being put off accessing support services because they feared being judged by the professionals they would be working with.

Barriers to stopping smoking

A number of common themes came up, with most citing multiple barriers to giving up tobacco. Overwhelmingly, this group of women identified stress as a key barrier.

> **'I would love to stop. My circumstances I am in mean I will be more stressed if I do stop.'** *(Currently pregnant and smoking)*

Also common was the impact of being surrounded by close friends and family members who smoke. All but one woman said that people they live with, and/or socialise with, are smokers and have smoked while pregnant. For some of the women, every woman they know has smoked during pregnancy.

> **'This is a biggie – they all smoke. Smoke is everywhere. So hard when you are trying to stop.'** *(Currently pregnant and smoking)*

> **'When I try stopping smoking, family try to rub it in my face by waving cigarettes in my face, which doesn't make me stop.'** *(Currently pregnant and smoking)*

Addiction and craving were also noted as barriers to change:

> **'It's really hard to stop once you are hooked and have done it for so long.'** *(Currently pregnant and smoking)*

> **'Whilst I know of all these [support services], it would be heard to really admit I have this addiction. My main fear is of being judged.'** *(Currently pregnant and smoking)*

A few of the women we spoke to do not want to stop and gave explanations.

> **'If I stopped smoking, I would take more substances.'** *(Currently smoking and smoked during recent pregnancy)*

What would encourage women to stop smoking?

In the same way that having close relationships with people who smoked could be a barrier, friends and family were identified as having potential influence in encouraging people to stop.

> **'Best friend, also pregnant, has stopped smoking. This encouraged me to go to the stop smoking clinic.'** *(Currently pregnant and smoking)*

> **'The message within my own circle…If my kids asked me to stop smoking, I would consider it.'** *(Currently pregnant and smoking)*

> **'Help all family to stop.'** *(Currently pregnant and smoking)*

Whilst there was an awareness of the harm that smoking causes to a baby, many thought there should be harsher and more detailed messages.

> **'Something that would frighten me would encourage me – TV adverts or video with explicit content about the damage smoking does.'** *(Currently pregnant and smoking)*

There was the sense still that the support needed to be non-judgemental. Some also felt that better conversations between women and professionals would be useful, and, ideally, one-to-one support.

> **'Talking to someone helps. Find out why women smoke, what makes it easier to stop and find out ways of stopping. [If I was in charge] I would not talk about all the dangers, I would ask women about how they would want to stop.'** *(Currently pregnant and smoking)*

> **'If midwives…asked more detailed questions about smoking rather than do you smoke/do you want to stop?**' *(Currently smoking and has smoked during previous pregnancy)*

As travelling to services was identified as a potential barrier, one woman suggested that free bus passes should be given to people needing to get to appointments. Several said that follow up telephone calls, reminder texts and WhatsApp messages for sessions would be helpful.

Women wanted help with cravings and suggested e-cigarettes should be offered free of charge to help them stop.

With all of this in mind, there was a strong sense from many of the women that you can only stop when you really want to and that services will only be able to help those who want to stop.

> **'I think services are doing the most that they can. It's down to us.'** *(Has smoked throughout previous pregnancies)*

Women with a South Asian background

'I'd say one out of three of my friends smoke in this area of Bradford [BD3] and I'd say most of the under 30 year olds smoke. It just isn't done openly.'

Face-to-face surveys were completed with seven women and we ran a focus group with four others.

Generally, we heard from them that smoking is most often a hidden or secret activity, with only close friends and trusted family members aware that they smoke. They cited cultural and religious factors as the main reasons for it being a covert habit.

Many of the women we spoke to started smoking between the ages of twelve or thirteen - their transition year to secondary school. They were introduced to cigarettes by their friendship groups. A Pakistani community worker who had been working in the Bradford Moor area for the past twenty years stated, 'If they went to school here [Bradford], I'd say just under half will be smokers. It may not be a lot but they do'.

As with the white British and Irish women, most of the South Asian women we spoke to had female friends and family members who had also smoked in pregnancy.

The women we spoke to had negative feelings about smoking in pregnancy and the fear of judgement often came up.

> **'It's a dirty habit, I don't feel good about it, just angry and depressed, also paranoid about what people think of me when they find out I smoke.'** *(Currently pregnant and smoking)*
>
> **'Not a good idea. Harmful to the baby.'** *(Currently pregnant and smoking)*
>
> **'You just get addicted to it, but I didn't want to get addicted.'** *(Comment at focus group)*

Experiences and knowledge of support services

The women we spoke to generally had not accessed support services. Someone questioned where free smoking cessation services have gone.

One mentioned receiving a stop smoking pack and a couple mentioned their GP or midwife as points of contact.

Barriers to stopping smoking

Stress was given as the main reason that women in this group continue to smoke. They also mentioned addiction and cravings.

> **'Easy to answer - it's stress and coping with bills, kids, family and men. Life's hard sometimes and you do the best you can do…. walk in my shoes and someone would do the same, if not worse.'** *(Currently pregnant and smoking)*
>
> **'Women are addicted. Hard to stop just because you are pregnant. I found being pregnant very stressful - it's how I coped.'** *(No longer smokes but has smoked in pregnancy)*
>
> **'I had cut down to one but when I found out I was pregnant, now smoke seven. It helps my anxiety. I know health people say it doesn't but it does.'** *(Currently pregnant and smoking)*
>
> **'Some women who live with their in-laws, there's more stress for them and the first thing they would do is look at a cigarette, they won't think**

it's harming their child.' *(Currently smoking and has smoked in previous pregnancies)*

Many spoke about a misconception that South Asian women do not smoke. They may not be asked if they smoke and therefore are not offered support services. Some said that GPs need to be more proactive in offering support and information.

'GPs assume we [Asian women] don't smoke, but should still ask the questions and mention support. I'd like more info on where to go and how to stop.' *(Currently smoking)*

We heard from women that embarrassment and fear of judgement was also acting as a barrier to uptake.

'The way you are looked at, as if I'm being looked up and down.' *(Currently pregnant and smoking)*

'Especially as an Asian woman, I don't smoke in public and wouldn't want to go to a smoking clinic – I might be seen.' *(Currently smoking)*

One woman told us that their family smoking was a barrier to quitting, but others' families do not know that they smoke.

What would encourage women to stop smoking?

Those we spoke to wanted to be offered support services. They generally felt that having help coping with stress would support them to stop. A couple of women suggested group discussions or awareness sessions at pregnancy clinics and highlighted the need for professionals to understand addiction. They wanted support to be non-judgemental.

'More help with stress - how to deal with it. Using real life problems would be great.' *(Currently pregnant and smoking)*

'More on other ways to deal with stress and anxiety.' *(No longer smokes)*

They would like practical help with cravings; a couple suggested vaping but wanted to know the health implications.

'Support and medical intervention to help withdrawal symptoms and cravings.' *(No longer smokes)*

There clearly needs to be more engagement with South Asian women to explore how they can access support services; the woman who said she would not want to go to a clinic for fear of being seen, also said that face-to-face support would encourage her to stop.

Eastern European Women

'It's like a hobby, it's filling time and kind of like a routine.'

We completed surveys face-to-face with six women and ran a focus group with fourteen women.

All women came from families and friendship groups where smoking, and smoking heavily, was the norm. Non- smoking family members are exceptions rather than the rule.

Many consider smoking as just part of their daily routine - several women likened it to having a coffee or having a meal. Some, however, felt they should not be smoking because of the health of their baby and expressed the desire to stop.

Several women found it hard to explain why they smoke.

> **'It's like a hobby, it's filling time and kind of like a routine. It is expensive and I know it is affecting my health.'** *(Comment at focus group)*
>
> **'I believe it's better to stop but it's really hard.'** *(Comment at focus group)*
>
> **'I don't know why I smoke.'** *(Comment at focus group)*
>
> **'I smoked and drank as normal through all my [eight] pregnancies and all my babies were fine.'** *(Comment at focus group)*

Experiences and knowledge of support services

This group were the least critical of services. The general agreement in the focus group was that there was support available compared to their place of origin, where no free support was available. However, some of the women we spoke to individually could not name any support services and most had not accessed them. Several told us they do not know *how* to stop, even when they had heard of, or accessed, services.

> **'In this country they can offer nicotine, plasters, and sprays. There's more support and it's paid for.'** *(Currently smoking)*
>
> **'I don't know how to stop even though I attended a session on how to stop.'** *(Has smoked during recent pregnancy)*

One woman said she could not understand the language on leaflets provided.

Barriers to stopping smoking

Some women told us that stopping smoking when pregnant would be so stressful to the mother that it would harm the baby, which was a reason not to try.

Many explained that feeling pressured or forced by professionals and services to stop smoking is off putting.

As with the other two groups, these women mentioned cravings, addiction, stress, quality of life, and judgement as barriers to stopping smoking. Family and close friends smoking act as a big barrier.

> **'It felt good because it helped me cope with stress.'** *(Smoked in pregnancy)*
>
> **'I had not been supported by my partner and family to stop.'** *(Smoked in pregnancy)*
>
> **'I feel addicted and because of that, [I'm] feeling nervous about stopping.'** *(Comment at focus group)*
>
> **'If life was better, I would not smoke.'** *(Currently smoking and has smoked during recent pregnancy)*

Several women we spoke to do not feel ready to stop.

> **'I feel that until I want to stop there is, and always would be, a barrier. I must be ready to stop.'** *(Currently smoking and has smoked during recent pregnancy)*
>
> **'I want to stop but I'm not ready.'** *(Comment at focus group)*

What would encourage women to stop smoking?

Amongst this group, there was an emphasis on familiarity of support and personal contact with professionals.

Suggestions included home visits, group sessions, free resources, more accessible information on leaflets - using imagery and community languages - and working with the family to help everyone stop smoking.

> **'Home visits from a familiar face or professional known to me.'** *(Has smoked during earlier pregnancy)*
>
> **'Possibly being encouraged by a familiar person who would support me with free resources and help me with my wellbeing to start first step.'** *(Currently smoking and smoked during recent pregnancy)*
>
> **'Gradually build up my strengths and hopefully stop smoking.'** *(Currently smoking and has smoked during pregnancy)*
>
> **'Encourage my partner to join and do it together.'** *(Currently smoking and has smoked during pregnancy)*
>
> **'Visual information about the effect/risks of smoking…how it affects others' health.'** *(Currently smoking and has smoked during pregnancy)*

Case Studies

Case Study One

C is 31 year old woman, from a mixed ethnic background, and is pregnant with her fourth child. She lives in the Keighley area and is in receipt of income support. *C* lives with her partner and three children.

She smokes 20/25 cigarettes per day and has smoked this amount throughout her pregnancy. Her baby is due in the next few weeks. *C* is using an inhalator but not the patches she's been given.

The one thing that encouraged *C* to access the stop smoking clinics initially was her best friend, who is also pregnant and has stopped smoking. *C* viewed her as a great role model and an inspiration.

C's mother passed away at the age of 53 due to lung cancer. Her mother smoked throughout her five pregnancies. She feels very strongly about stopping smoking after her mother's death and feels she needs the willpower to stop. *C* finds that stress is a barrier to quitting.

'I think that I need to stop for myself, not just because I am pregnant. I want to be around for my kids.

'I feel ashamed and judged because it is harming my baby. That's the reason I don't tell them [health professional] *the real figure I am smoking, but I do want to stop.'*

Case Study Two

A is a 33 year old Slovakian woman and is Catholic. She lives in in the Girlington area of Bradford and receives income support. *A* has a long-term condition and has recently given birth to her third child.

A smoked just over 20 cigarettes per day before finding out she was pregnant, cutting down to around 10 a day during her pregnancy.

A's mother, sisters, close friends and sisters-in-law all smoked when pregnant.

'*I am aware that my smoking when I was pregnant could affect my baby but I still carried on smoking. It helps me calm down when I am stressed. And I lack the power to say to myself "I want to stop."'*

A received no support from husband, family and friends in stopping and saw their influence and lack of support as a determining factor in continuing to smoke.

She was aware of places of support - GP clinics and midwives - but the fear of pressure being put on her to stop smoking and of being judged as a bad mum discouraged her from asking for help.

We asked what would help her to quit:

'Encourage my husband and family and do it together. I need to slowly build up my strengths and then I will hopefully stop smoking. At the moment I can't deal with my anger and stress and begin to argue with partner.'

Case Study Three

B is a 29 year old Pakistani, Muslim woman living in Bradford Moor area. *B* grew up in Bradford, is married and has two children, and works on a part-time basis.

She currently smokes between eight and ten cigarettes a day. Throughout both pregnancies, she smoked around five cigarettes per day. Her sister and best friends have also smoked during pregnancy.

'I started early, aged 12 at school, and so did a lot of my friends. We've had pregnancies and carried on smoking...It's so hard to stop.'

B is aware of the harm caused to an unborn baby. She said that addiction and cravings, and the fact that family and close friends smoke, made it hard to stop.

She also identified her ethnicity as a barrier to accessing and taking up support.

'GPs and health people just assume we [Asian women] *don't smoke. I never get asked if I am a smoker.*

'Especially as an Asian woman, I would never ever smoke in public - you would just get abuse - and I can't go to a smoking clinic because I might be seen.'

Women's Health Network focus group

This group contained women of different ethnicities and included current smokers, ex-smokers and some who had never smoked.

Some women's feelings towards smoking during pregnancy in the group were very negative, but there was also an understanding that smoking becomes a habit and a way of dealing with stress. Some suggested that mums-to-be could feel stigmatised and pressured to stop. Being around family members and friends who smoke was, again, recognised as a barrier.

The general feeling was that health professionals should be having conversations with women about smoking in pregnancy at every opportunity, but also about women's health in general. Health messages should be consistent across the board – one woman felt that they often contradict each other and become confusing. Several thought that the effects of smoking in pregnancy on the baby should be discussed more with pregnant women.

There were mixed feelings about services providing incentives to encourage women to stop smoking during pregnancy - some thought it was a good idea while others thought it gave the wrong message.

Conclusion

There can be no doubt that smoking in pregnancy evokes strong feelings and value judgements.

We believe that understanding the reasons why women smoke and struggle to give up - for example stress, and the impact of friends and family - is vital to designing effective support for women.

It was striking how, for many of the women, this seemed to be the first time anyone had asked them about their own views and feelings about smoking in pregnancy. We found that they responded to the opportunity to be heard without judgement, and this opened up the possibility for a wider conversation about smoking in pregnancy. We hope that a similar approach can be replicated *within* smoking cessation services to give women the chance to discuss what they feel and need.

Recommendations

1. It was powerful to listen to women's views and experiences, and we learned a lot from them. We hope that all service providers and front line staff read this report, and use it to shape the support provided, including the conversations they have with individual women.

2. Those providing smoking cessation support should have an understanding of the potential cultural differences in attitudes and smoking behaviour among the different groups of people, and should shape interventions around these. This includes, for example, recognition that some Eastern European women may be more accepting towards smoking in general.

3. The majority of the women we spoke to were from low income backgrounds and living in areas of multiple deprivation. It is imperative that any smoking cessation services for pregnant women take into account the wider determinants of health, and the additional barriers to quitting that these create.

4. Make sure that pregnant women who smoke have access to support to manage their anxiety and stress. This could include yoga, Cognitive Behaviour Therapy, and mindfulness sessions. Health professionals delivering cessation support should have an awareness of the role of stress in women smoking, and be able to refer women to appropriate help.

5. The role of family is key to helping women stop smoking. Smoking cessation support should:
    a. Look at how family and friends can be encouraged to support women to quit
    b. Be offered to family members when a woman becomes pregnant

    Care will need to be taken to make sure that the needs of women who experience domestic violence, or whose families are unaware of their smoking, are sensitively met. We encourage more engagement with women and their families about what they want support to look like.

6. Support venues should be child-friendly, with books and toys available.

7. Information should be accessible. For some of the Slovakian women, images rather than words on flyers were more appropriate as they could read neither English nor Slovakian. Leaflets should be easy to read. We found that having an interpreter present was an essential factor in being able to have direct discussions and recommend that, where possible, interpreters are present at group sessions.

8. There should always be follow-ups and reminders for appointments. Women said that calls, texts, and WhatsApp messages were more effective than a letter.

9. There should be no assumptions about who smokes and who does not, with every GP and midwife asking the question of every pregnant woman.

10. Given the often covert nature of South Asian women's smoking, and that we spoke to this group in the smallest numbers, we believe it would be useful to carry out further engagement with South Asian women to gain a better understanding of their smoking during pregnancy.

11. Women in all groups mentioned people they knew who had stopped smoking with the use of e-cigarettes. We recommend clear communication of health messages around e-cigarettes/vaping and discussion of e-cigarette use with women.

12. Cessation support services should make links with key organisations that have built up relationships with these groups. This could be the key to starting discussions and ensuring the main stop smoking messages filter back into the community.

Appendices

Appendix 1 – Demographic data

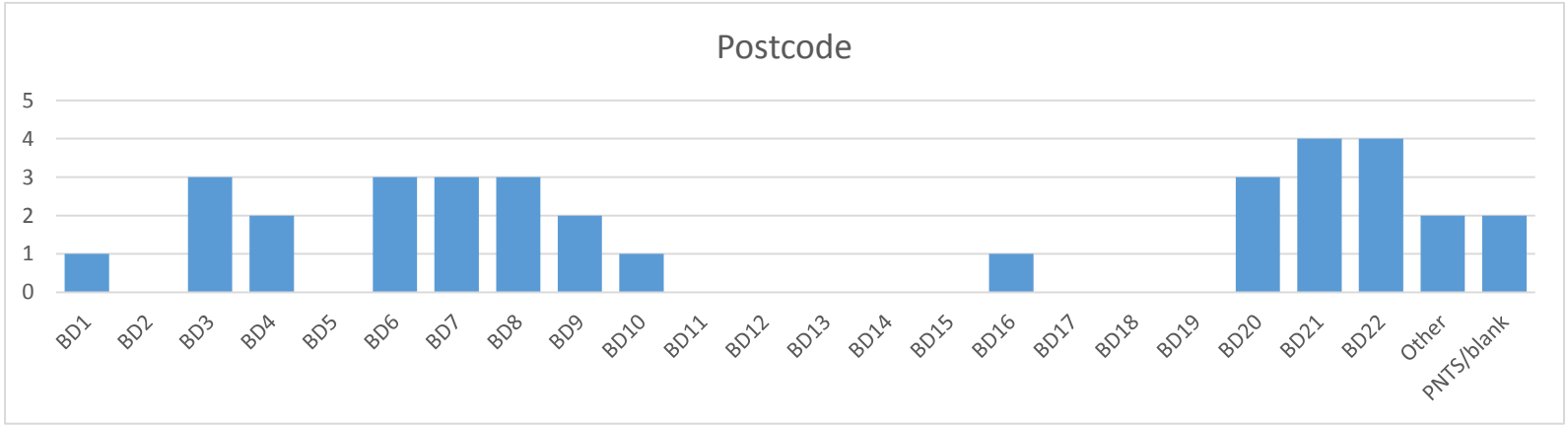
Appendix 2- Questionnaire and Focus Group

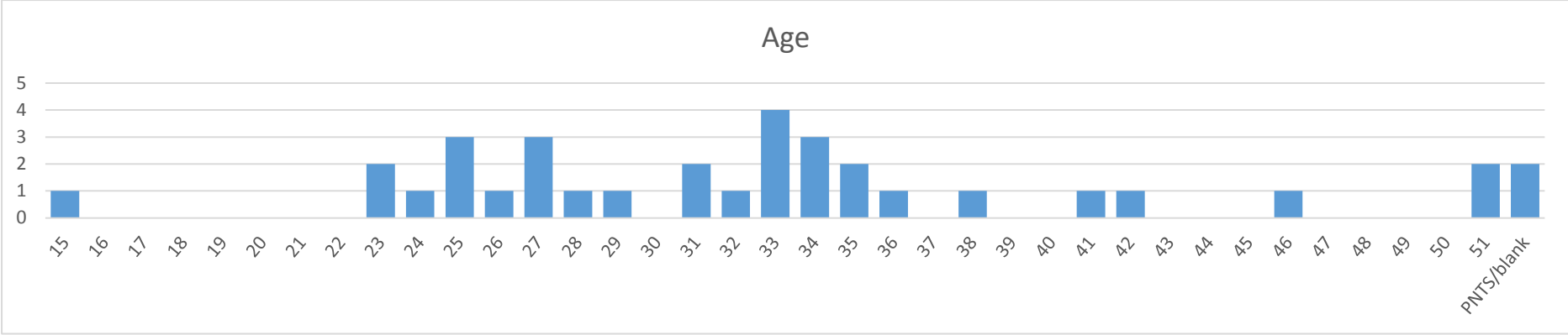
Focus group 1: 4 Pakistani women

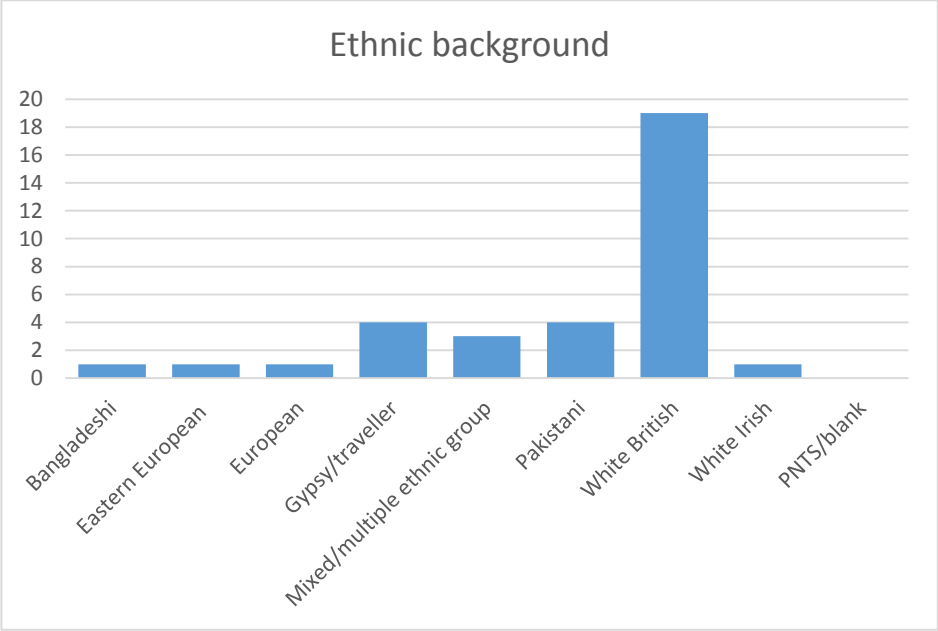
Focus group 2: 14 women, 13 identifying as Slovakian and 1 Czech

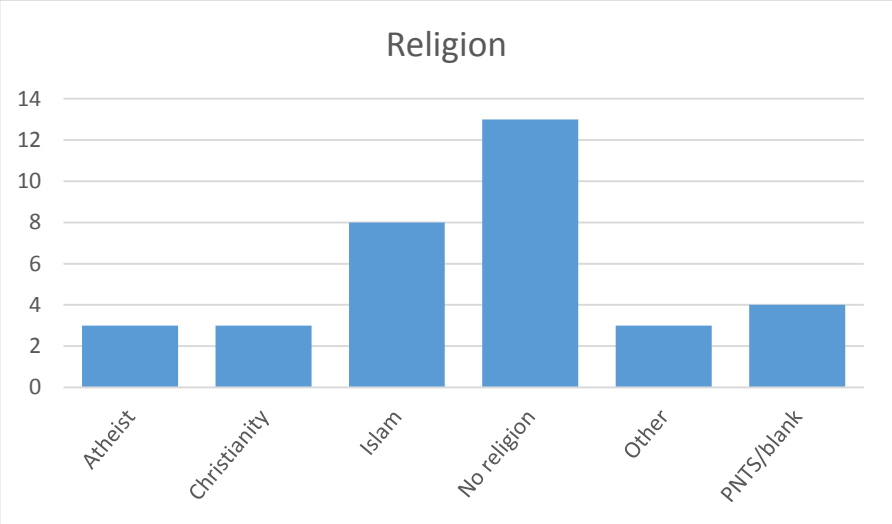
Focus group 3: 17 women with a variety of ethnic backgrounds

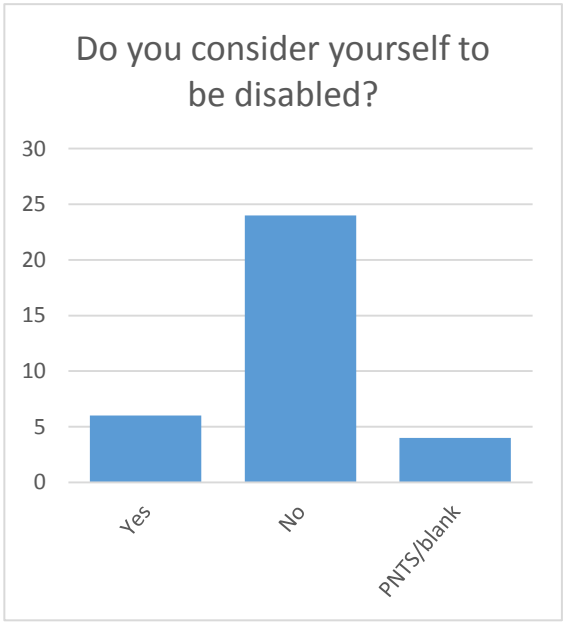
Below is the demographic data for the 34 women who completed questionnaires.

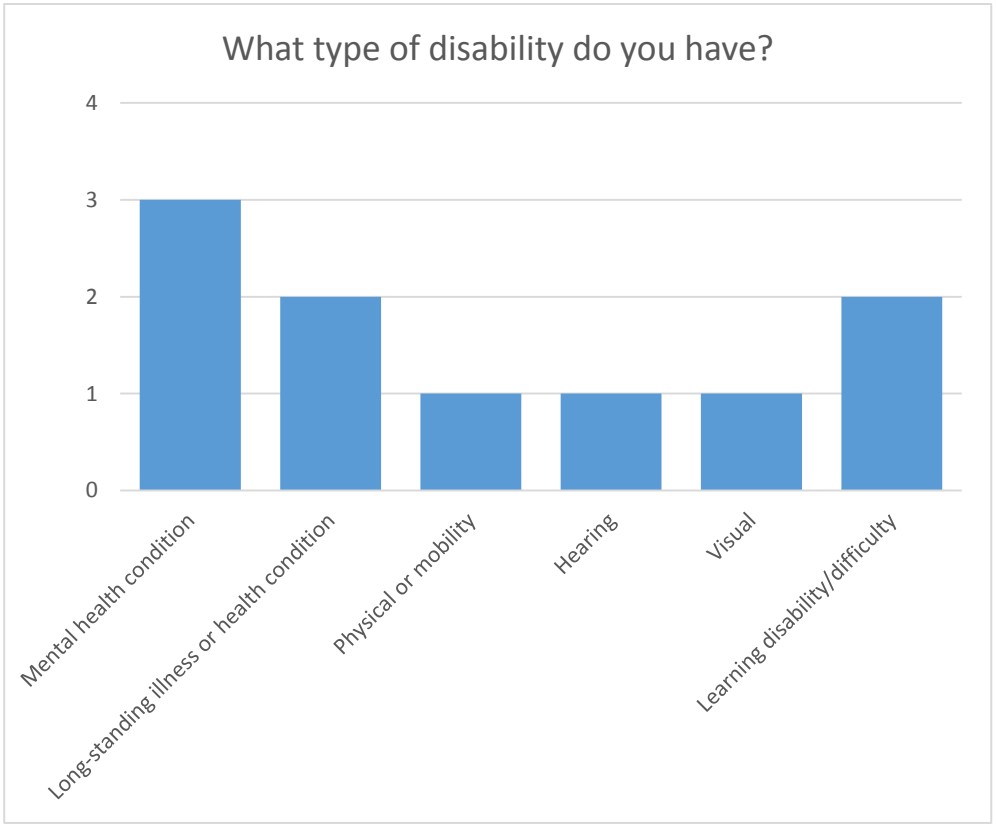


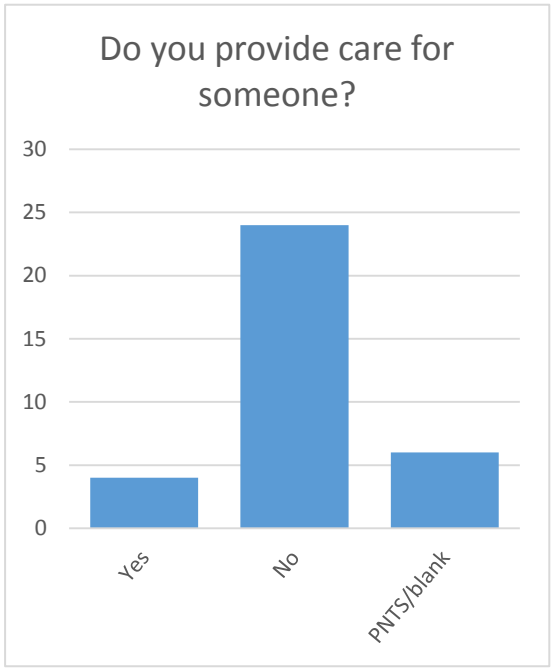

Age
5
4
3
2
1
0
15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 PNTS/blank

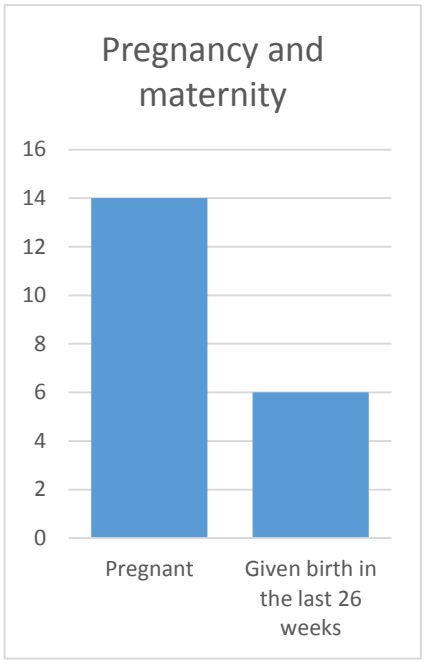

Ethnic background
20
18
16
14
12
10
8
6
4
2
0
Bangladeshi
Eastern European
European
Gypsy/traveller
Mixed/multiple ethnic group
Pakistani
White British
White Irish
PNTS/blank

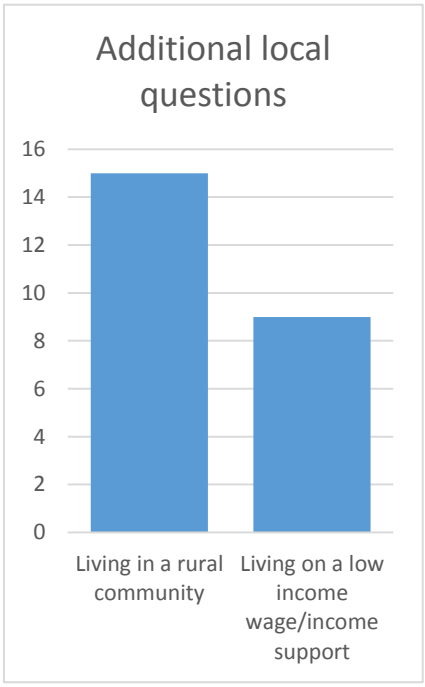

Religion
14
12
10
8
6
4
2
0
Atheist
Christianity
Islam
No religion
Other
PNTS/blank


Do you consider yourself to be disabled?
30
25
20
15
10
5
0
Yes
No
PNTS/blank


What type of disability do you have?
4
3
2
1
0
Mental health condition
Long-standing illness or health condition
Physical or mobility
Hearing
Visual
Learning disability/difficulty


Do you provide care for someone?
30
25
20
15
10
5
0
Yes
No
PNTS/blank


Pregnancy and maternity
16
14
12
10
8
6
4
2
0
Pregnant
Given birth in the last 26 weeks


Additional local questions
16
14
12
10
8
6
4
2
0
Living in a rural community
Living on a low income wage/income support