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Social attitudes towards smoking in pregnancy in East Surrey: A qualitative study of smokers, former smokers and non-smokers

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Abstract A qualitative study was undertaken to explore social attitudes towards smoking by pregnant women, mothers of preschool children and their partners based in Merstham and Horley, East Surrey. All respondents felt that smoking in pregnancy was associated with considerable social stigma and negative social attitudes. Non-smokers were particularly negative in their views on smoking in pregnancy feeling that it was socially unacceptable. Women who smoked during pregnancy reported various negative social experiences such as receiving criticism from health professionals and community associates. They reported feeling under pressure to quit to achieve social acceptability as much as for health improvements. Some pregnant smokers denied smoking to health professionals, partners and colleagues and used private smoking places out of public view to reduce the chances of detection. Women who smoked or had a partner who smoked were more accepting of smoking in pregnancy than non-smokers and former smokers. Moreover, residents from the more socio-economically deprived area of Merstham were more tolerant of smoking in pregnancy and parenthood, compared to Horley-based respondents, regardless of their personal smoking status. They gave examples of local women they knew who had smoked in pregnancy without apparent complication. While all respondents were aware of health risks associated with smoking, smokers did not feel the risks were personally relevant to them and were exaggerated in an anti-smoking society. Health professionals need to be aware that pregnant women may not disclose smoking activity due to perceived social stigma and may require more intensive smoking cessation support services in socio-economically deprived areas.

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Introduction

Smoking in pregnancy is the single largest preventable cause of morbidity and mortality for women and their infants (Walsh, 1994) with low birth weight, premature delivery, perinatal death and respiratory diseases being particular concerns (Castles et al., 1999). It has been estimated that the economic burden to the NHS associated with smoking during pregnancy is approximately £1500 per smoker (Tappin et al., 2005). The NHS Centre for Reviews and Dissemination (1998) recommend that pregnant women be offered intensive advice and support to stop smoking based on the belief that prenatal counselling combined with written health information can improve cessation rates. However, it is estimated that a third of pregnant women smoke and only a quarter of smokers quit during pregnancy (Tappin et al., 2005). This would suggest that there are a complex set of social, psychological and medical factors associated with the decision to persist in smoking that are not addressed by traditional health promotion interventions operating in antenatal and postnatal health care settings.

Most surveys of smoking in pregnancy rely upon self-report measures that may not reflect the true prevalence of maternal smoking activity. Indeed, under-reporting of smoking amongst pregnant women is estimated to be between 7% and 15% when compared to cotinine levels from urine samples (Walsh et al., 1996). Unfortunately, biomedically validated measures of smoking maybe of limited use in research and clinical settings since it will only record recent smoking activity and many women attempt to quit and relapse at various stages of their pregnancy (Pickett et al., 2005). Increasingly, smoking is regarded by the general public as anti-social activity and this is reflected in a number of recent legislative developments such as reducing public places where smoking is permitted, requiring tobacco manufacturers to print health risk messages on their packaging and banning tobacco advertisements. However, the process of changing social attitudes is not uniform across all sections of society and affluent, educated members of society would appear to have the strongest anti-smoking attitudes (Johansson et al., 2004). Given that smoking is associated with social stigma, pregnant women may feel under particular pressure to deny smoking and saliva verified measures of smoking cessation support this view since they are more highly correlated to self-report measures in the 3 months prior to conception and in the post-partum period (Colman and Joyce, 2003).

Many studies have examined public knowledge of the risk factors associated with smoking in pregnancy and the reasons for smoking by pregnant women (for example, Haslam and Draper, 2001). However, few studies have explored social attitudes towards smoking in pregnancy and their influence on the behaviour of pregnant women. This is unfortunate since traditional smoking cessation interventions based on the biomedical model of health education have only a limited impact on the long-term cessation rates of pregnant women (Orleans et al., 2000). Indeed, 60% of pregnant quitters resume smoking within 6 months post-partum (Colman and Joyce, 2003). Smoking in pregnancy is associated with social disadvantage, high parity, low income, being a single parent, low education and teenage parenthood. It is likely that negative social attitudes towards smoking in society and increasing restrictions on the public places where smoking is permitted affect the smoking activity of pregnant women and new parents. Women may feel reluctant to admit that they are smoking during pregnancy and around their infants to health professionals due to social stigma. Unfortunately, covert smoking maybe difficult for health professionals to detect when women are not admitting that they smoke during pregnancy and important smoking-related messages may not be delivered to those patients who are most in need. Furthermore, there are likely to be individual differences in the social acceptability of smoking in pregnancy and parenthood according to socio-economic characteristics of the communities where women live and raise their families. In one study, Pickett et al. (2002) has shown that working-class communities provide more acceptance of smoking in pregnancy because they are associated with high levels of work-related stress and they foster social attitudes in which alcohol and cigarette use are normative behaviours that serve as coping mechanisms for a difficult life. Health promotion is not encouraged in such communities since the focus is on daily survival rather than possible future outcomes. In their study, women from working-class areas were nearly four times as likely to be smokers as women from middle-class areas. Women from middle-class households, but in working-class areas, were twice as likely to be smoking during pregnancy as those women living in middle-class areas. Furthermore, of 155 pregnant women admitting to smoking, the proportion of working-class residents in the local area was positively associated with the number of cigarettes smoked per day. Overall, living in a working-class area doubled the chances of smoking during pregnancy regardless of individual social class and other socio-demographic