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The design of a smokefree home leaflet and home pack: a Guernsey case study

Vidya Amey

Guernsey Adolescent Smokefree Project (GASP), Guernsey, Channel Islands

514

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Abstract

Purpose – This paper aims to explore the beliefs and attitudes of young mothers in relation to smokefree homes and passive smoke in Guernsey, and to encourage them to contribute to the designing of a smokefree home leaflet and pack aimed at young mothers.

Design/methodology/approach – Semi-structured interviews were conducted with 11 participants (aged 17-23 years).

Findings – Most participants were smokers, however, they all knew what passive smoke was and asserted that their homes were smokefree. Even if they were unable to list specific impacts of second hand smoke on children, they all agreed that children should be protected. A few of them described the difficulties in telling people not to smoke around their children in other people's homes and in cars. Moreover, some young mothers said that they found it hard to persuade their partners not to smoke around the children.

Originality/value – This paper presents the respondents ideas for promoting and supporting smokefree homes for young mothers and informing a smokefree home leaflet and home pack: providing information about passive smoking during parenting sessions, preferably after the baby has been born; giving parents a pack with giveaways linked to smokefree homes; encouraging parents to be assertive to friends and family who try to smoke around children; and getting both partners involved.

Keywords Passive smoking, Smoking, Mothers, Parents, Children

Paper type Research paper

Introduction and background

There is an evolving body of literature that explores the relationship between childhood second hand smoke exposure and the development of various diseases in babies and children (Holliday *et al.*, 2009; Cheraghi and Salvi, 2009; Lovasi *et al.*, 2010). It has now been well established that parental smoking at home commonly exposes children to second hand smoke (SHS) (Jarvis *et al.*, 2000; Ferrence and Ashley, 2000; Sims *et al.*, 2010; Priest *et al.*, 2008); maternal smoking having a greater impact than paternal smoking in terms of children's SHS exposure (Royal College of Physicians, 2005; Jarvis *et al.*, 1985). As underlined by Bloch *et al.* (2010), there is little guidance on how to limit the exposure to SHS at home even if it has now been well established that "there is no safe level of exposure to second hand smoke" (WHO, 2008).

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Research has shown the link between smoking and socially disadvantaged people (Goddard and Green, 2005; Graham, 2003). Smoking remains one of the biggest causes of the growing inequality in health between higher and lower income groups (Richardson, 2001; Wanless, 2004; Robinson and Kirkcaldy, 2007a; Robinson and Kirkcaldy, 2007b; Akhtar *et al.*, 2010; National Institute for Health and Clinical Excellence, NICE, 2010). A number of qualitative research studies have provided insights into the reasons why disadvantaged parents find it hard to have a smokefree home (Hill *et al.*, 2003; Robinson and Kirkcaldy, 2007b; Robinson and Kirkcaldy, 2009). Some of the barriers mentioned have included the absence of outside space for smoking, the restricted power of parents to impose a smokefree home because of shared accommodation or their inability to smoke outside as it would involve leaving the baby or child, and parents' beliefs that older babies could tolerate smoke or remove themselves from a smoky environment.

We still do not know which kind of interventions work with low-income groups (Boyce *et al.*, 2008; Priest *et al.*, 2008), but according to Priest *et al.* (2008) the only effective intervention in the reduction of SHS exposure at home would appear to be intensive counselling.

Guernsey has a small population of 62,000 people (States of Guernsey, n.d.) and until now, no qualitative or quantitative research linked to young mothers and passive smoke has yet been carried out. Annually, there is an average of 34 mothers under the age of 20 years old (Guernsey maternity Stork system 2005-2009). The Guernsey Adolescent Smokefree Project (GASP), which is a small smoking prevention charity, believed that to be able to trigger any kind of health behaviour change, there was a need to understand and learn more about the attitude and thoughts of the target group (Boyce *et al.*, 2008).

In 2006, Guernsey introduced smokefree legislations. To track the changes in attitudes and health behaviour of young people, a "young people's" survey is carried out every three years. The last survey done in 2007 showed that 94 per cent of children (aged 10-11 years, $n = 575$) had never smoked; but only 60 per cent of them had a smokefree home. In 2009, an optional survey was repeated and this time, the children ($n = 377$) having smokefree homes had increased by 4 per cent.

Following the results from the latest survey, GASP decided to put into place various projects concerned with smokefree homes (Amey, 2010). These projects targeted the most vulnerable portions of the population of Guernsey to help them make their homes smokefree, primarily to protect babies and children from SHS. One new initiative was to focus on a vulnerable group of young mothers who attended the Swissville Family Centre run by the Guernsey's Health and Social Services Department (Directorate of Children and Young Peoples' Services). They had relational, legal, social, as well as financial problems. The team at the Centre consisted of a health visitor, a student social worker, two support workers and a team manager who took referrals from professionals such as midwives, school nurses, doctors and social workers. The Young Mothers' Group Meeting was held from 11.00-13.00 hours on a weekly basis where young mothers were taught various skills aimed to help them improve their family life and parenting.

The aim of this case study is to explore and understand the behaviour and beliefs of young mothers below the age of 23 years, towards passive smoking and to get their input in designing a smokefree home leaflet that would be distributed to all young

mothers of the island. We also wanted to obtain their ideas about what to include in the smokefree home pack that would also be delivered to the young mothers in the future.

Study expectations

GASP speculated that the young mothers at Swissville would be mostly smokers and smoked around their children at home and in cars. We expected that the mothers would not consider quitting. We believed that this specific group is oblivious of the impacts of passive smoke on babies and children. We also speculated that the mothers would defend smokers' rights and would find various justifications to explain their smoking habits around their children. We also expected the mothers to be unwilling to take ownership of the leaflet.

Methodology

The case study was set in The Theory of Reasoned Action (TRA) framework which is based on the premise that people are rational beings who use and process information that are available to them. Their behaviours are shaped by intention (motivation) and by what they believe society expects them to do (Ajzen and Fishbein, 1980). We share Fishbein and Middlestadt's (1987) belief that a change in behaviour entails a change in beliefs. To trigger a change in behaviour, we thus needed to identify and understand the initial behaviour of the young mothers in relation to passive smoking. To have a benchmark, we looked into the four elements that Fishbein and Middlestadt (1987) identified as key areas that were to be taken into consideration when studying behaviour, that is:

- (1) action (how many cigarettes the mothers smoked and whether they stopped at some point during their pregnancy);
- (2) target (the beliefs of the mothers on passive smoking and its impacts on children);
- (3) context (in what situation they tend to smoke more); and
- (4) time (when they tend to be tempted to smoke next to their children).

We acknowledge that the TRA has some limitations which include for example the "linearity of the theory components", as noted by Kippax and Crawford (1993), who point out that in some situations, such as for the use of seatbelts, people got used to the new behaviour before changing their negative attitudes or beliefs whereas the model suggests that the a change of belief comes first. In that present study, we believe that, because it is hard to legislate against smoking in homes, the behaviour will have to be triggered by a change in beliefs and it is very unlikely that the change in behaviour will happen as a result of legislation.

The aims of the study were to explore and understand the behaviour and beliefs of young mothers towards passive smoking and to then devise appropriate educational interventions. Participants were recruited from the existing group of young mothers attending Swissville. The average attendance of young women each week was 14. To ensure that they would participate in the project, we used the following recruitment strategies:

- (1) The staff workers at Swissville had a preliminary talk with the young mothers who were present to encourage them to come to participate in the project 2.

- (2) The mothers who were absent when the preliminary talk was carried out were contacted by phone and the aims of the project were explained to them.
- (3) Lunch was offered at the same time, from 11.00 - 13.00 hours, so as not to disturb their routines.
- (4) They were told that there would be two interviews that would be carried out by a dedicated social worker whom the young mothers had already met at Swissville in the presence of the project director.
- (5) They were reassured that we were not going to try to convince them to stop smoking, but that we needed their help for the smokefree home project.

By empowering the mothers and saying that we needed their help we hoped to make them feel more comfortable and to have an easier access to their views and beliefs about SHS through the use of focus groups (Greenbaum, 2000). We wanted to privilege the thoughts, behaviour and experience of the young mothers. Hence, we remained relatively open and non-directional while participating fully in both sessions. The interviews were done by two people, the social worker (LS), and the project co-ordinator, at all times in order to decrease bias. We also used questionnaires to obtain feedback from the participants.

The first interview was conducted at Swissville to define the profile of the group, to check and analyse their smoking status and the reasons behind that status and lastly and finally, to explore their attitudes opinions on smokefree home. Confidentiality was stressed throughout our intervention.

In the second interview, the participants contributed to the contents of the leaflet and the contents of smokefree home packs that would be handed out to all young mothers. We also used that session to dispel some of the myths they had about SHS and to provide them with information. An evaluation sheet was given at the end of the second session to get feedback on the project and a carbon monoxide test was proposed.

In the results section, extracts from the discussions and questionnaires from both sessions are used to illustrate key themes around second hand smoke.

Results

Characteristics of the study participants

A total of 11 women, aged from 17 to 23 years old, were identified and all agreed to participate in two meetings. One of them was currently pregnant with her second child. The majority of them described themselves as full time mothers with only one working part-time. In total, nine of them were smokers and also lived with a partner, another adult, or parents who smoked.

Smoking habits of the participants

All the young mothers but one all said that they tried to quit when they were pregnant. Of the participants, five managed to cut down, but only three of the 11 had stopped smoking altogether. The reasons given by those three participants were to protect the baby, with one also mentioning morning sickness. More than half acknowledged that they had been advised mostly by midwives to stop smoking when they were pregnant. Out of those three participants, only one remained a non-smoker after giving birth. The other two, as well as the five other smokers who had cut down on the number of

cigarettes they had been smoking during pregnancy, resumed their pre-pregnancy smoking habits.

One participant said that she resumed her initial smoking habit because “when the baby’s been ratty all day, it’s just a chill out thing” and three participants agreed that stress was a major factor. Of the participants, four mentioned temptation because other people smoked around them, and one mentioned boredom.

Young mothers’ beliefs and attitude towards SHS

All the participants knew what passive smoke was and all of them believed that babies and young children should be protected from cigarette smoke.

They knew some of the impacts of passive smoke on children but remained very vague using words like “affects children’s development”, “affects their lungs and their health”, or “illnesses”. Only one participant mentioned asthma.

The mothers had developed their own concept of smoking and SHS. One of them believed that children were addicted to the smoke and that was why they cried when parents smoked away from them. Two other participants believed that SHS is worse than smoking because the filter in the cigarette was filtering the chemicals.

The mothers asserted that they did not smoke in their homes or in their cars (The majority of them admitted that they did not travel in cars very often). However, as they started to relax, one participant admitted that she smoked in the bathroom, two participants agreed that they would sometimes “hang out of their windows” to smoke and another participant said that if she could not go outside, she would “light up under the cooker extractor so that the smoke doesn’t go into the room.” While probing, we also found that the participants found it relatively easy to ask their friends not to smoke around their children; however they found it harder with members of their family or their partners. Also, more than half of the participants said their children were exposed to SHS in other people’s home, and sometimes in other people’s cars, and agreed with one participant who said “It’s not really ok but I can’t say much it’s not my car.”

We asked them what they thought about other parents who smoked around their children and all of them reacted quite vehemently against those parents believing that “they should be fined”, “they are stupid”, “that’s not right” or even “if their kids get ill it’s their fault it will teach them a lesson”. However, some of them also added “I can’t judge other people” otherwise they would feel guilty and said it would be hypocritical as they themselves were smokers.

Ideas on how to encourage young mothers to have a smokefree home

The leaflet. We consulted all the leaflets on smoking and pregnant women as well as on passive smoke that were already available on the island, condensed the information, simplified the words and changed the tone to adapt it to our target audience. The content of the leaflet followed the three pieces of advice from “Using Information to Promote Healthy behaviours” (Robertson, 2008). First, the message had to be clear and simple as research suggested that people found it easier to remember simple messages. Second, the message had to be put forward using a “gain frame” which the leaflet reflected through the sections entitled “Benefits of Smoke-Free Homes and Cars”. Third, the reader had to be emotionally engaged which was achieved though the focus on the health of the children and babies of the participants. The new leaflet entitled

“Smokefree Homes for your Family” was initially printed on a doubled-sided A4 sheet of paper, folded into three parts

A few pictures were used to illustrate the headings which were: definition of passive smoke, effects of passive smoke on babies and young children, benefits of smokefree homes and cars, true or false, and how you would make your home and car smokefree. The section entitled “true or false” was initially a compilation of various beliefs expressed by young people during the project co-ordinator’s smoking prevention sessions in school settings. However, we also left enough space to quote any distorted beliefs we might come across while doing the project with the young mothers.

The final structure and content of the smokefree home leaflet was elaborated with the young mothers. They suggested:

- the use of pictures of young mothers and their children instead of using pictures of more mature women;
- the use of questions instead of statements for the subtitles for example, “effects of passive smoking on babies and young children” was changed into “what effects can passive smoking have on babies and young children?”;
- a simplified definition of SHS without the use of words such as “mainstream smoke” and “sidestream smoke”;
- a more elaborated explanation of how the 85 per cent of smoke from a cigarette permeates all material such as clothes, carpet, hair;
- the section on smokefree cars should be smaller as most of them did not have a car;
- using quotations from mothers to dispel myths; and
- using bright, attractive colours for background colours such as blue, pink and yellow.

Contrary to our expectations, the mothers took ownership of the leaflet and were proud of the final product but they still thought that the leaflet alone would not be enough. They agreed that at least one session on the impacts of passive smoke on children’s health should be part of parent craft sessions and not part of a formal medical consultation. They specified that the session should best take place after the birth of the baby.

The smokefree home session. In the one hour smokefree home session, the focus was on some of the major chemicals found in cigarettes and in second hand smoke. An activity was carried out to help the mothers guess the various diseases linked to SHS and the session ended with advice on how to make their home smokefree. Finally, we handed out a smokefree home pack with giveaways and asked for their feedback on the contents. We provided them with brief information about smoking cessation services and proposed a carbon monoxide test at the end of the session. Only three participants said they would use the carbon monoxide monitor which highlighted once more that we made the right decision to ensure that in this project the focus was not on smoking cessation but on the prevention of passive smoke around children.

This session was mostly focused on giving out information and the mothers were very receptive to it. The women did not contest the information provided about the impacts of smoking and SHS as opposed to the research participants in the study done by Robinson and Kirkcaldy (2007a). They actually seemed to be unaware of many

issues linked to smoking and SHS and when they learnt about the various impacts on the health of children, they did not try to redistribute the blame contrary to our expectations. The mothers thought that “learning about the specific impacts of passive smoke on children” was the most useful part of the project.

The pack. Initially, the proposed pack contained the following items:

- a mouse mat with advice on how to make your home smokefree;
- a car air freshner;
- one smokefree home sticker;
- one smokefree car sticker; and
- an orange tangle toy with Quitline number and the leaflet.

The mothers suggested we replace some of the smokefree items, especially those linked to cars by more stickers for smokefree home, a smokefree bib and a smokefree magnet. They thought that the smokefree signs could help them express their view of wanting their home to be smokefree in a less confrontational way.

Further suggestions. The mothers felt it was difficult to make a home smokefree if there were no garden. They mostly believe that it was easier to convert a room into a smoking room or to smoke near the window. They also suggested that if people really wanted a smokefree home the best way to achieve this was to be assertive with other people, mostly partners and family members and get them to smoke outside.

Discussion

The aims of this study were to explore the beliefs, attitude and behaviour of young mothers in relation to smokefree homes and SHS in Guernsey and to develop a leaflet and a home pack aimed at that specific target group.

The findings of the case study confirm that most young mothers were smokers and even if some of them stopped smoking while they were pregnant, the majority of them commonly and quickly picked up the habit again after the delivery of the baby (Robinson and Kirkcaldy, 2009; NICE, 2010; Oncken *et al.*, 2010). As already pointed out by McDermott *et al.* (2006) the cause of the relapse was commonly justified by the stress linked to motherhood. This trend reinforced the importance of providing information about smokefree homes, because even if it were not as effective as smoking cessation, it was one step in the right direction to protect children and for parents to consider quitting (Escoffery *et al.*, 2009).

The participants genuinely seemed to have a lack of knowledge on the issue and this could be clearly seen through their beliefs that children could become addicted to smoking by breathing in second hand smoke or that SHS was worse than smoking. Beliefs about passive smoke have an impact on the intentions and behaviours of the mothers according to the TRA (Ajzen and Fishbein, 1980). The quality of knowledge about passive smoke can have a significant impact on people’s behaviour about SHS (Blackburn *et al.*, 2003; Gilpin *et al.*, 1999) and this is why the educational part of the study- the smokefree home session – is an important part of the process of change in behaviour towards having a smokefree home.

The phenomenon of participants initially say that they had a smokefree home and then admitting to smoking in some areas in the house, were also given by the participants in Robinson and Kirkcaldy (2007b) research.

Their strong condemnation of mothers who smoked around their children and babies was quite surprising, as we were expecting them to be more on the defensive. This disapproval of passive smoke was stronger than their disapproval of smoking while being pregnant. This attitude was also present in the participants of the study carried out by McDermott *et al.* (2006, p. 435) where one of the mothers asserted that passive smoking is “just disgusting, completely irresponsible”.

The interactions with the young mothers revealed that many of them felt powerless when other people smoked in their respective homes and cars. They also felt powerlessness in front of the smoking behaviour of their respective partners. Similar behaviours and feelings were evoked by women, as reported by Nichter *et al.* (2010). Altering their partners’ behaviour seemed to be a daunting task. The women thought they did not have the right to say anything because they themselves were smokers.

“Volition control” (Fishbein and Middlestadt, 1987) was thus raised to explain to the mothers that even if some of them were addicted to smoking and could not stop smoking, they could still protect their children from passive smoke. The mothers were reminded that they had the power to change their behaviours. It has also been suggested that techniques on how to ask people not to smoke around their children without getting into a conflict situation should be taught (Gehrman and Hovell, 2003; Thomson *et al.*, 2005).

As far as the design of the leaflet was concerned, the mothers were very proud of the final product as their views and ideas had been taken on board. They were also very pleased with the pictures of their own children and themselves. Despite that feeling of pride, they all acknowledged that the leaflet alone would not be useful in changing behaviours. Carre *et al.* (2008) referred to the distribution of leaflets on chronic obstructive pulmonary disease (COPD) to point out those leaflets in that piece of research had not impacted on the participants’ behaviour even if they had a better understanding of COPD. Indeed, research shows that material such as leaflets and pamphlets work best when used in conjunction with face-to-face advice (Bauman, 1997). It was interesting to get such feedback from the target group who contributed to the leaflet. Also, according to Carre *et al.* (2008), the messages in leaflets could be reinforced by health care professionals, through verbal communication, and part of a medical consultation. Our target group in this case study however thought that such sessions on smokefree homes should not be part of a formal medical consultation. The staff at Swissville had already pointed out that this group of socially stigmatised people avoided contact with formal institutions. It was therefore not surprising that the mothers suggested that the smokefree homes sessions should be included in any existing interventions, whether it be at their own homes or at Swissville or during parent craft sessions.

This case study showed that a small, socially stigmatised and isolated group could be targeted for smokefree home interventions.

Limitations of the research

There are several limitations of this study. First, because Guernsey has a small population of around 60,000 people, the sample size is also small, hence we acknowledge that the results may not be transferable to other countries. However, generalisation is not the ultimate goal of this case study. Indeed, “an appropriate size for a qualitative study is one that adequately answers the research question” (Marshall,

1996). Through the case study we ensure that we keep track of our goals and the procedures can undoubtedly be transferable to smaller communities even if the study itself cannot be applied to a whole population. Stigmatised segments of many countries tend to be very specific groups, which are not necessarily big. Crouch and McKenzie (2006) also promote the use of very small samples which are preferably smaller than 20 because they “facilitate the researcher’s close association with the respondents, and enhance the validity of fine-grained, in-depth inquiry in naturalistic settings”.

One further potential source of bias could be that most of the participants are already under a lot of stress for various reasons. The feeling of being judged by society might have led them to give answers that they thought were socially acceptable. However, this social pressure and the ongoing process of denormalisation of smoking here in Guernsey, or what Ajen and Fishbein (1980) refer to as “subjective norm” will hopefully have an impact on the participants intention to change their behaviours towards passive smoke.

Conclusions

All the young mothers, despite the fact that they were mostly smokers, were happy to have taken part in the project. They asserted that they did not smoke near their children and strongly believed that children should be protected from SHS. However, they acknowledged that they did not know a lot about the impact passive smoke could have on children. They also evoked some of the situations that made it difficult for them to prevent other people to smoke around their children. They all actively contributed to the designing of the smokefree home leaflet and of the smokefree home pack. With small groups such as the Young Mums Group at Swissville, there is an opportunity to focus on the group and give them the support they need to make their home smokefree.

Recommendations

GASP proposed the following recommendations for Guernsey:

- (1) Deliver at least one session on smokefree homes and passive smoke to young mothers as part of parent craft session. Integrate those sessions in existing frameworks whenever possible (Oncken *et al.*, 2010).
- (2) Train health visitors who are already working closely with the target group to deliver the session because they have nurtured a relationship with the young mothers.
- (3) Create and distribute:
 - leaflets on the impacts of SHS aimed at young parents; and
 - smokefree home packs with giveaways (such as smokefree home stickers, fridge magnet, bib).
- (4) Modify the leaflet to target other mothers as well.
- (5) Empower young mothers to make them feel confident to say no to smoking near their children
- (6) Organise a partner/husband group so that they can get the same support young mothers are getting; there was an urgent need to raise awareness among fathers (Mahfoud *et al.*, 2010).
- (7) Assess the impact of the leaflet, home pack and session on SHS in a later survey.

Proposed recommendations for the rest of the world:

- Similar awareness raising projects could be carried out in other small island state where people have a lot of support from health visitors. Small groups, such as the one we had been working with, offered the opportunity to collect specific information from individuals to then use this information to design the most effective message or intervention (Stretcher and Velicer, 2003). The leaflets and packs could be adapted or altered according to the profile and culture of target group as tailoring of effective messages involved understanding their socioeconomic background, their values and beliefs and their cultures (Baezconde-Garbanati and Garbanati, 2000).

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About the author

Vidya Amey is the Project Manager for Guernsey Adolescent Smokefree Project (GASP: www.gasp.org.gg). She has a Master's in English and a Master's in Education and her special interest is in working the tobacco control field. Currently, she focuses on how the different initiatives linked to tobacco prevention education have had an impact on the young people of Guernsey. Vidya Amey can be contacted at: vsurrun@hotmail.com

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