Action on Smoking and Health response to the Women's Health Strategy

This consultation response is on behalf of Action on Smoking and Health (ASH).

ASH is a public health charity set up by the Royal College of Physicians in 1971 to advocate for evidence-based policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK.

ASH has no links with the tobacco industry or its affiliates, and we welcome the opportunity to respond to this consultation.

Ensuring the health and care system understands and is responsive to women's health and care needs across the life course.

1. Smoking is the primary cause of preventable illness and premature death in England, accounting for approximately 74,600 deaths a year, including 28,900 women.[1] An estimated 12% of deaths among women are attributable to smoking.[1] About half of all life-long smokers will die prematurely, losing on average about 10 years of life.[2]

2. The current smoking rate for adult women in England is 12.1%.[3] Within this there are major inequalities, with rates of smoking among white women (aged 18-34) in routine and manual occupations over double that of women on average (26.7% compared to 12%).[4]

3. Pregnancy is a key opportunity to intervene with women who smoke to help them quit, with around a fifth of women who smoked during early pregnancy going on to quit by delivery in 2019/20 (12.8% at booking compared to 10.4% at delivery).[5] [6]

4. When a woman smokes during pregnancy, or when she is exposed to secondhand smoke, oxygen to the baby is restricted making the baby's heart beat faster and exposing the baby to harmful toxins. As a result, smoking or exposure to secondhand smoke during pregnancy is responsible for an increased rate of stillbirth, miscarriage, and birth defects.[7] [8] This exacerbates existing health inequalities as women from more deprived backgrounds are more likely to smoke during pregnancy and to be exposed to secondhand smoke during pregnancy. Smoking during pregnancy also increases the risk of children developing several respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes.[9]

5. The Government has set an ambition to reduce rates of smoking in pregnancy to 6% by 2022.[10] As of 2019/20, 10.4% of women were smoking at the time of delivery, equating to an estimated 60,000 babies born to pregnant smokers in England each year.[11]
6. Smoking also damages a mother's health and is associated with maternal risks in pregnancy, such as placental abruption, premature rupture of the amniotic membrane, incompetent cervix, preeclampsia, and pregnancy-induced hypertension. [8] [12]

7. An audit conducted by Barnsley Hospital NHS Foundation Trust found that women who smoked during pregnancy were more likely than non-smokers to need extra antenatal appointments, outpatient appointments, overnight admissions, ultrasound scans and longer length of stay postnatally. Women who smoked were also more likely to have significant obstetric history (particularly relating to miscarriages) than non-smokers.[13]
8. Smoking is a known risk factor for venous thromboembolism (VTE) during pregnancy and up to six weeks following pregnancy.[14] VTE is a leading cause of deaths in the UK.[15] Failure to diagnose a case of VTE may result in a patient not receiving the correct treatment and potentially developing post-thrombotic syndrome or a fatal post embolism as a result.[15]
9. As in the general population, smoking rates among pregnant women increase with indicators of disadvantage. Women from disadvantaged backgrounds are more likely to smoke before pregnancy; less likely to quit during pregnancy and, among those who quit, more likely to relapse after childbirth.[16] Rates of smoking in pregnancy in the most deprived areas of England are more than five times those in the least deprived areas.[17]
10. Women who smoke during pregnancy tend to be younger and less educated; more likely to be single and work in routine and manual occupations.[18] [19] In 2018/19, 30% of women aged under-20 were current smokers at their booking appointment compared to just 6% of women over 40.[20] High rates of smoking among women from younger, more disadvantaged backgrounds correspond with significantly higher infant mortality rates than in the general population.[21]
11. However, evidence suggests that nearly half of women who quit smoking during pregnancy relapse post-partum. Therefore, it is vital that women and their partners have access to stop smoking support before, during, and after pregnancy to help them stay smokefree.[22]

What can be done?

12. Evidence shows that stopping smoking early in pregnancy can almost entirely prevent adverse effects[23] but cessation in all stages, even in late pregnancy, benefits maternal and foetal health.[24] Reducing smoking in pregnancy and exposure to secondhand smoke is essential for supporting healthy early development among children.
13. Just over half of all women who quit smoking during pregnancy continue to stay smokefree postpartum,[22] significantly reducing their chances of developing a smoking-related disease. Reducing smoking and exposure to secondhand smoke among pregnant women and mothers would play a significant role in improving population health and tackling health inequalities.
14. NICE guideline PH26[25] and the Saving Babies Lives' Care Bundle v2[26] recommend that all women are CO (carbon monoxide) tested at antenatal appointments and offered opt-out referral to stop smoking support. To facilitate this, it is recommended that all relevant maternity staff should receive training on the use of the CO monitor and having a brief and meaningful conversation with women about smoking.
15. However, implementation is variable across the country and there is a clear need for more work to monitor and review the implementation of stop smoking support for pregnant women.[27] Evidence shows that there are major gaps in the postgraduate and

undergraduate training of maternity professionals which reduces their ability to appropriately implement NICE guidance on smoking in pregnancy.[28]

16. To address this variation, the Women's Health Strategy should include recommend that NHS England review maternity services' implementation of NICE Guidance PH26 and PH48 to assess barriers to comprehensive implementation and ensure all women are receiving the best care throughout their pregnancy. This should include specific reference to the provision of training on smoking cessation for maternity other health professionals working with pregnant women.

Maximising women's health in the workplace

17. Supporting women to quit smoking is critical to maximising women's health in the workplace. As well as being the leading cause of preventable mortality, smoking is the leading cause of preventable disease and disability in England and is responsible for over 489,000 hospital admissions a year.[29] People who smoke also need social care around 10 years earlier than non-smokers, with over one and a half million people in England (1,647,500) requiring social care support because of smoking.[30]

18. Smoking also has a significant negative impact on individual earnings and employment prospects, with long-term smokers being 7.5% less likely to be employed than non-smokers and smokers earning, on average, 6.8% less than non-smokers.[31]

19. Available evidence reveals that women who smoke have more irregular or painful periods, go through menopause at a younger age, and have worse symptoms.[32] [33] Smoking and secondhand smoke exposure also damages female fertility,[34] put women at increased risk of developing heart attacks, strokes, lung cancer, cardiovascular disease, cervical cancer, chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema.[24] [35] These are likely to significantly impact workplace productivity and earnings, with the burdens disproportionately concentrated in the most disadvantaged communities.

20. Quit success rates are on average three times as high for smokers using Stop Smoking Services than quitting unaided,[36] and tobacco dependence treatment including counselling and pharmacotherapy is highly cost-effective, as it increases quality adjusted life years (QALYs) and saves costs.[37] It is estimated that for every £1 invested in Stop Smoking Services, £2.37 will be saved on treating smoking-related diseases and reduced productivity.[38] Pro-active contacting of smokers with support to quit on an opt-out basis increases quit rates more than fourfold and should become standard.

21. The Women's Health Strategy should recommend that all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.[39] Alongside this, NHS England should review implementation of NICE guideline PH48 to ensure that NHS estates are smokefree and all patients, staff, and visitors are offered stop smoking support.[40] This will help to encourage quitting behaviour and patients, staff, and visitors from secondhand smoke. This will be particularly beneficial for women, who make up 77% of the NHS workforce.[41]

Ensuring research, evidence and data support improvements in women's health

22. Improving the quality of evidence and data on smoking is central to supporting improvements in women's health. There is particularly important for population groups with above-average rates of smoking. NICE guidelines on smoking cessation emphasise the need for vulnerable groups, including LGBT smokers and pregnant women who smoke, to be targeted and prioritised in smoking cessation initiatives and services.[42]

23. Smoking prevalence is higher among lesbians, gays, bisexuals, and transgender (LGBT) people than among other communities. In 2018, 22.2% of people who describe themselves as lesbian or gays smoked, compared to 15.5% among heterosexual people.[43] However, there is limited research and a lack of comprehensive data into why some LGBT groups have higher smoking rates.

24. Improving the quality of evidence and data on smoking among LGBT groups would support the development of more effective stop smoking interventions for this population. This would play an important role in supporting improved health among LGBT women.

25. Smoking prevalence is also likely to be disproportionately high among migrant communities from countries which typically have high rates of smoking, such as those in Eastern Europe.[44] For example, Poland and Romania have smoking rates of 25.3% and 23.5% respectively.[45] There is a clear need to improve the collection of data on smoking among high-smoking-prevalence migrant communities to ensure they are being effectively engaged by current stop smoking interventions.

26. A joint report from ASH and the Smoking in Pregnancy Challenge Group found significant room for improvement with regards to how data is collected and utilised to facilitate the delivery of stop smoking support where it is most needed during pregnancy.[13]The Women's Health Strategy should consider how NHS maternity services can improve the collection of data on women's smoking status throughout pregnancy.

Understanding and responding to the impacts of COVID-19 on women's health

27. The COVID-19 pandemic has significantly disrupted the provision of maternity care and stop smoking support, both for pregnant women and adults in general, with CO monitoring and face-to-face stop smoking support paused between March and November 2020. Longstanding staffing shortages in midwifery and health visiting services have been exacerbated due to staff being redeployed to deal with COVID-19 or being forced to self-isolate, with over three-quarters of midwives saying that current staffing levels are unsafe.[46] [47] The impact of these challenges on quit rates among pregnant women and new mums is unclear, however some maternity services have reported having difficulties engaging parents in conversations about quitting smoking.

28. There is some evidence that households with children saw an increase in exposure to secondhand smoke. Data from the YouGov Covid Tracker analysed by ASH found that 9% of non-smokers in a home with a child under-18 said they were more exposed to secondhand smoke during the first lockdown. Among smokers with a child under-18 in the home, 10% reported smoking more inside.[48]

29. The COVID-19 pandemic forced local authorities and maternity services to reconfigure their stop smoking support at an unprecedented speed. They adapted quickly and

many found that smokers welcomed remote methods of engagement such as telephone consultations.

30. There is a clear need to evaluate the remote support offered by stop smoking services and maternity services during the pandemic to identify whether this support is effective for women who smoke.

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