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Educate Pregnant Women on Negative Effects of Tobacco Use During Pregnancy in Okaloosa County, Florida

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Social Change Portfolio

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Contents

OVERVIEW

Keywords: smoking during pregnancy, adverse effects of tobacco use on the fetus, raising awareness, help pregnant smokers quit, increase positive health outcomes.

Educate Pregnant Women on Negative Effects of Tobacco Use During Pregnancy in Okaloosa County, Florida.

Goal Statement: Increase pregnant smokers' awareness of the adverse effects of tobacco use on unborn babies and identify local resources that can be utilized to help pregnant women quit smoking and maintain a tobacco-free lifestyle.

Significant Findings: In Okaloosa County, Florida, studies have found that pregnant women who continue smoking while pregnant comprise nearly double the state average of 7.4 percent among White women (e.g. 13.1 percent), and nearly four times the 3.6 percent of Black women in Florida (McLaughlin, 2017). Given the wide range of adverse outcomes associated with tobacco use during pregnancy, the author recommends that various stakeholders and community institutions work collaboratively to devise plans, strategies, and interventions at various levels to address this problem and implement different programs (e.g., Baby & Me Tobacco Free) that aim to help pregnant smokers with their tobacco dependence and connect them with resources and treatment services that can improve health outcomes (Nyambe, Van Hal & Kampen, 2016).

Objectives/Strategies/Interventions/Next Steps

The primary goal of this Social Change Portfolio is to increase pregnant smokers' knowledge of the adverse effects of tobacco use during pregnancy and postpartum, while the main objective is to decrease the negative health outcomes associated with tobacco use during

pregnancy (i.e., decrease rates of miscarriage, premature birth, low birth weight, stillbirth, and infant mortality in Okaloosa County, Florida; Florida Department of Health, n.d; Salihu, Aliyu, Pierre-Louis & Alexander, 2003). To reach the goal and attain the objective, it is essential to assess what are the most salient risk and protective factors that contribute to the high rates of negative health outcomes in the area. In this respect, one risk factor that has been shown to contribute to higher rates of pregnant smokers in rural areas is limited educational attainment by the mother. For example, the prevalence of smoking is highest among women with a high school diploma or GED, followed by those with less than a high school diploma (Drake, Driscoll & Mathews, 2018). On the other hand, local WIC clinics represent an important community-level protective factor, as they provide pregnant smokers in rural areas with various programs, services, and resources (e.g., information, education, counseling interventions, advice, support, and smoking cessation services) aimed at curbing negative outcomes of smoking during pregnancy (Olaiya et al., 2015).

Based on these findings, the author believes that one strategy that can be used to improve health outcomes in the area involves a collaborative effort between various providers in the community (i.e, mental health providers, health care clinicians, such as primary care physicians, gynecologists, nurses, and health department personnel) to use the same approach to opening the dialogue about tobacco use during pregnancy. One such intervention is the 5As approach: ask, advise, assess, assist, and arrange, which takes only a few minutes to complete and may promote quitting among pregnant smokers, as well as improving maternal and child health outcomes in the long run (American Association for Respiratory Care, 2020; Olaiya et al., 2015). Ensuring that all providers use the same approach, as well as the same available resources in the community, would evidence to the public (i.e., pregnant smokers) not only a unified effort on

their part, but also that these clinics are working towards a common goal to benefit the entire community.

To take things a step further, the author suggests that counselors in Okaloosa County, Florida collaborate with personnel from local Women, Infants, and Children (WIC) clinics to address the issue of tobacco use during pregnancy. One way to accomplish this step would be by implementing the 5As approach at all WICs locations, beginning with, if necessary, training the personnel on how to conduct the interview, and continuing with assisting and arranging treatment for tobacco dependence services by referring and connecting pregnant smokers with the resources that can help them quit for good (e.g., counseling interventions, advice, support, support groups, and smoking cessation services (Fallin-Bennet et al., 20; Olaiya et al., 2015).

Another avenue that can be employed to enhance positive health outcomes involves working with local stakeholders to advocate for the implementation of a smoking cessation program aimed directly at helping pregnant women quit using tobacco. One such program is the BABY & ME -Tobacco Free Program (BMTF), an evidence-based cessation initiative created to help pregnant women quit smoking for good and reduce the burden of tobacco use on the pregnant and postpartum population (Baby & Me-Tobacco Free Program, 2020). In addition to helping pregnant women quit smoking for good, the program also offers those who successfully quit diaper vouches for up to twelve months, provided they test tobacco-free.

INTRODUCTION

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

Smoking during pregnancy is shown to lead to a host of negative outcomes, such as miscarriage, premature birth, low birth weight, stillbirth, birth defects (e.g., cleft lip and cleft

palate), sudden infant death syndrome (SIDS), perinatal mortality, as well as a higher risk of ear infections, respiratory problems, and asthma after birth (Florida Department of Health, n.d; Salihu, Aliyu, Pierre-Louis & Alexander, 2003). Moreover, recent studies have also validated that maternal smoking during pregnancy is associated with infant mortality (Salihu, Aliyu, Pierre-Louis & Alexander, 2003). In Okaloosa County, Florida, the data shows even more alarming trends. Women who continue to smoke after becoming pregnant comprise almost twice the state average of 7.4 percent among White women (e.g. 13.1 percent), and nearly four times the 3.6 percent of Black women in Florida (McLaughlin, 2017). Factors that impact smoking rates among pregnant women include their education level, socioeconomic status, race and ethnicity, marital status, as well as alcohol and/other substance use/misuse (Salihu, Aliyu, Pierre-Louis & Alexander, 2003). Based on such distressing findings, an appropriate measure at this stage would be to devise a prevention plan to address the smoking rates among pregnant women in the area and to educate them about the adverse outcomes of tobacco use on their unborn babies, to help them quit smoking and reduce infant mortality numbers.

PART 1: SCOPE AND CONSEQUENCES

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

It is a well-known fact that smoking can cause many adverse side effects, such as cancer, heart disease, and stroke (Centers for Disease Control and Prevention [CDC], n.d.). Despite such dire consequences, many people continue to smoke, and recent research shows alarming data about women who become pregnant and carry on with tobacco use. In Okaloosa County, Florida, the issue represents a major health concern, and data collected between 2013 and 2015 indicate

that women who continue to smoke after becoming pregnant comprise almost twice the state average of 7.4 percent among White women (e.g. 13.1 percent), and nearly four times the 3.6 percent of Black women in Florida (McLaughlin, 2017).

Such findings are disturbing, on the one hand, because smoking can be prevented, and on the other, more importantly, because smoking during pregnancy puts both the mother and the baby at risk. Negative outcomes of smoking during pregnancy include miscarriage, premature birth, low birth weight, stillbirth, birth defects (e.g., cleft palate, cleft lip, or both), damage to the baby's developing brain that can last through childhood and into teen years, sudden infant death syndrome (SIDS), perinatal mortality, as well as a higher risk of ear infections, respiratory problems and asthma after birth (CDC, n.d.; Florida Department of Health, n.d; Salihu, Aliyu, Pierre-Louis & Alexander, 2003). Additionally, research has confirmed that maternal smoking during pregnancy is associated with infant mortality (Salihu, Aliyu, Pierre-Louis & Alexander, 2003).

According to data provided by the CDC (n.d.), over 21,000 infants died in the United States in 2018, and the four leading causes of infant death at the time were birth defects, preterm birth, maternal complications, and sudden infant death syndrome (SIDS). Similarly, in Okaloosa County, elevated rates of infant mortality due to preterm birth and low birth weight are registered in the same areas associated with high numbers of pregnant smokers (Ascension Sacred Heart Health System, 2020; McLaughlin, 2017). Despite lack of evidence to suggest a correlation between the two, the Florida Department of Health has found that 42 percent of all infant deaths and 64 percent of all Black infant deaths in the Okaloosa County between 2013 and 2015 occurred in rural areas identified as the most crowded with low-income families, and poor rural

neighborhoods represent a common risk factor for smoking, as well as producing pregnant smokers (County Health Rankings, 2020; McLaughlin, 2017).

As mentioned above, smoking may cause plenty of negative outcomes, and in pregnant mothers, it can have devastating effects on the unborn baby. Moreover, smoking tobacco during pregnancy has a high price, as the cost of neonatal healthcare in Florida due to smoking while pregnant has been estimated to reach $ 336 million annually (America's Health Rankings, 2020). For example, a study published in 2002 found that maternal smoking increased the relative risk of admission to the NICU by nearly 20% and that NICU infants cost $2496 per night in the NICU and $1796 while in the regular nursery compared to only $748 for non-NICU infants (Adams et al., 2002).

In addition to the economic consequences discussed above, there are other considerations relative to the risks associated with smoking while pregnant. For example, preterm birth is shown to have grave implications for maternal mental health and infant development. In this respect, research suggests that mothers who give birth to preterm babies are at risk for maternal mental health issues, including depression and posttraumatic stress disorder (PTSD; Anderson & Cacola, 2017). Moreover, because depression and PTSD are frequently comorbid, they may impact the family dynamics and interactions, affect the quality of the relationships between family members, as well as lead to an increased number of sick days taken off work and decreased productivity while at work (Anderson & Cacola, 2017; Feitosa & Fernandes, 2020).

Given the wide ramifications of smoking during pregnancy and its disastrous consequences following birth, the author aims to devise a prevention plan that addresses the high rates of pregnant smokers in the area, intending to increase awareness of the adverse effects of

tobacco use on unborn babies and identify local resources that can be utilized to help pregnant women quit smoking and maintain a tobacco-free lifestyle.

PART 2: SOCIAL-ECOLOGICAL MODEL

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

To design an effective prevention plan that addresses tobacco use among pregnant women, it is essential to assess the risk and protective factors that impact their smoking habits (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). One model that can be utilized to assess various influences on pregnant women's tobacco use is the Social-Ecological Model (SEM) which targets diverse levels/rings of influence across multiple contexts: intrapersonal/ individual factors (e.g., developmental history, knowledge, attitudes, behavior, self-concept, and skills), interpersonal processes (or primary groups, for example, family, peer groups and relationship factors), organizational factors (e.g., Health Care Systems, Work Sites, State/Local Health Departments), community factors (e.g., Community/State/Regional Advocacy Organizations, Media, Coalitions), and public policy factors for local, state and national laws and policies (e.g., Federal Government Agencies, such as the Centers for Disease Control and Prevention [CDC], the National Institutes of Health [NIH]; Nyambe, Van Hal & Kampen, 2016).

Because a discussion involving all the levels mentioned above can make the subject of a paper in itself, the author will only present risk and protective factors for tobacco use during pregnancy that are present at the individual, family, peer group, and community/ cultural levels. As such, this section will focus on key features of risk and protective factors, to prioritize those aspects that are the most relevant to the pregnant smokers in Okaloosa County, Florida. Given

each area/region will present with individualized risk and protective factors that affect pregnant women's smoking habits, it is important to focus on reducing those risk factors and strengthening those protective factors that are most closely related to the use of tobacco among pregnant women in the Okaloosa County, Florida (SAMHSA, 2019).

Individual-level Factors

Individual-level risk factors for pregnant smokers may include a woman's genetic predisposition to addiction or exposure to tobacco prenatally (SAMHSA, 2019). Reduced ability to manage stress is another risk factor for pregnant women, as some pregnant women perceive smoking as protective of their well-being (Flemming, McCaughan, Angus & Graham, 2015). Another study found that the heaviness of smoking before becoming pregnant is one of the strongest predictors of smoking while pregnant (Homish, Eiden, Leonard & Kozlowski, 2012). Individual-level protective factors include individual characteristics, such as positive self-image, self-control, self-efficacy, or social competence (SAMHSA, 2019).

Family-level Factors

In terms of family influences, research shows that women are more likely to smoke while pregnant if their partner is a smoker, as well (Fleming et al., 2015; Homish et al., 2012). Being a single mother, having other children, being of low socioeconomic status, divorce, substance use/misuse in the family, family dysfunction and lack of family support are other risk factors that may lead to tobacco use during pregnancy (Fleming et al., 2015; Homish et al., 2012, SAMHSA, 2019). Family-level protective factors may include a supportive partner, a strong couple relationship, good family resources (both material and emotional), a warm and responsive family environment, and good family support during pregnancy and after birth (Fleming et al., 2015).

Peer/Group-level Factors

Research on Peer/Group-level risk factors for pregnant women shows mixed findings. Some studies have found that having friends who smoke negatively impacts pregnant women's smoking habits, while others suggest that there is no correlation between the two, nor is it clear if tobacco exposure in the workplace presents a risk for increased smoking in pregnant women (Homish et al., 2012). At the same time, however, having strong relationships and good social support networks are great protective factors at the peer/group level, as peer/group support and encouragement can help pregnant women mediate some of the stress associated with quitting, as well as being an outlet for pregnant women to express their feelings, frustrations, and concerns (CDC, n. d.).

Community-level Factors

According to data provided by the U.S. Census Bureau (2019), about 11.4 percent of the population from Okaloosa County, Florida live below the poverty line. Such findings are distressing, as research suggests that poor rural areas constitute community-level risk factors for pregnant smokers (McLaughlin, 2017). Moreover, poor neighborhoods are also known for increased availability of tobacco, as tobacco industries target these regions more often than urban areas (McLaughlin, 2017). Lastly, poor neighborhoods can be a risk factor for pregnant smokers because inhabitants of these areas have limited work and economic opportunities, thus limited income and resources, which in turn may cause pregnant women to experience more stress, as well as an increased prevalence of mental health concerns (e.g. depression; Flemming et al., 2015).

On the positive side, communities often provide pregnant smokers with protective factors, as well, for example, faith-based local resources (SAMHSA, 2019). Also, because of their low socioeconomic status, many pregnant women qualify for special supplemental nutrition

programs such as Women, Infants, and Children (WIC). Besides these services, WIC clinics represent important community-level protective factors, as they offer pregnant smokers valuable resources in terms of information, education, counseling interventions, advice, support, and smoking cessation services (Olaiya et al., 2015).

PART 3: THEORIES OF PREVENTION

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

Given that individuals' behaviors are influenced by many factors within the various contexts they inhabit, clinicians and mental health professionals use health behavior theories to explain and address health problems that affect different populations. Together with research, theories of prevention help practitioners investigate what factors influence the target population's behavior, interpret findings from various studies, better understand the dynamic interactions between behavior and environmental context and thus develop and tailor appropriate strategies and interventions that help improve health outcomes (National Cancer Institute, 2005). One theory that can help clinicians explain and address the health problems that arise from using tobacco during pregnancy is the Theory of Reasoned Action and Planned Behavior (TRA/PB).

Developed by Fishbein and Ajzen, the TRA/PB is based on the principle that behaviors are influenced by intentions to carry out behaviors, while intentions are a function of a person's attitudes, social and subjective norms, and perceived behavioral control (Hage & Romano, 2013; National Cancer Institute, 2005). Relative to women who continue smoking after becoming pregnant, TRA/PB can be used as a model that addresses the most salient attitudes and beliefs that motivate pregnant smokers to continue using tobacco or adapt to new and more healthy-enhancing behaviors (Hage & Romano, 2013). With this in mind, the model may be

applied during visits with various practitioners (e.g.mental health counselors, health department clinicians, primary care physicians), when pregnant women who use tobacco can be asked directly about their beliefs (attitudes) about smoking and its effects on their pregnancy, for example, “What do you think about the effects of smoking while pregnant?” “ How do you believe it can impact your baby’s overall health and development?” “Would you like to change anything about your smoking behavior?” Next, clinicians can ask their pregnant clients about how others important to them think about their smoking habits, for example, “What does your partner think about your smoking while pregnant?” “Do your friends ever comment on your smoking now that you are pregnant?“ (Hage & Romano, 2013). Lastly, clinicians can ask the pregnant smokers about how much control they believe that they have over their smoking: “What do you know about the relationship between smoking and cancer or low birth weight and premature birth?” “How much control do you believe you have over your smoking habits?” “Do you believe you can quit?” “May I share some information about the adverse effects of smoking while pregnant (e.g., health education), as well as some resources that may help you quit, for example, counseling, incentive-based programs or ways to access social support networks? (American Association for Respiratory Care, 2020).

Such questions offer clinicians a great opportunity to begin a dialogue with their pregnant clients about the adverse effects of smoking on both mother and fetus, as well as opening a new avenue for practitioners to provide their pregnant clients with education and resources that can help them reduce/quit smoking and improve health outcomes (American Association for Respiratory Care, 2020). One brief intervention for smoking cessation can include the five 5 As approach: ask, advise, assess, assist, and arrange, which takes only a few minutes to complete and may promote quitting among pregnant smokers, therefore improving maternal and child

health outcomes (American Association for Respiratory Care, 2020; Olaiya et al., 2015). Additionally, these questions may enable the clinicians to identify particular concerns for specific individuals, thus helping the practitioners to tailor and design interventions and strategies that meet the unique needs of each pregnant woman (National Cancer Institute, 2005).

In the state of Florida, in addition to the Tobacco Free Florida program that is a statewide initiative where smokers can find free tools and resources that can help them quit (e.g., 27/4 access to a trained Quit Coach, online resources, a 2-week starter kit, support groups, and social media resources; Tobacco Free Florida, 2020), there are also cessation programs aimed directly at helping pregnant smokers quit. One such program is the BABY & ME -Tobacco Free Program (BMTF), an evidence-based cessation initiative created to help pregnant women quit smoking for good and reduce the burden of tobacco use on the pregnant and postpartum population (Baby & Me-Tobacco Free Program, 2020). The BMTF program offers free counseling services, resources, and incentives (e.g., diaper vouchers) to pregnant women who smoke at the time of enrollment, or who have quit within three months of becoming pregnant (Baby & Me-Tobacco Free Program, 2020). After the birth of the baby, women may receive diaper vouchers for up to twelve months, provided they test tobacco-free.

Although the BMTF program has gained national recognition and research suggests it is effective in promoting smoking cessation in pregnant women, it is not available in all states and all counties within a state (Zhang et al., 2017). Okaloosa County, Florida, for instance, does not provide such a program. In fact, the program is available only in two locations in the state of Florida, in Lecanto and New Smyrna Beach, respectively (Baby & Me-Tobacco Free Program, 2020). At the same time, however, research findings show that the BMTF program holds significant promise at reducing the odds of having low birth weight infants, which is

encouraging, as it can lead to potentially major public health and policy ramifications (Zhang et al., 2017).

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

Prevention and health promotion are closely related (Conyne, Horne & Raczynsky, 2013). Prevention entails not only reducing risk factors but also enhancing strengths and fostering well-being, while health promotion aims to help all individuals lead happy, thriving lives (Conyne, Horne & Raczynsky, 2013). The latter is easier said than done, however, because, in reality, various social, economic, and political factors often serve to perpetuate inequity rather than offer optimal conditions for all individuals within the community. Given the various contexts that influence and interact with individual characteristics to affect behavior, "a social justice vision of prevention would seek to block those societal structures, policies and hierarchies (or "social determinants") that limit access to resources based on group or individual characteristics, such as age, race, ethnicity, social class, poverty, religion, gender, immigration status, sexual orientation, and language" (Conyne, Horne & Raczynsky, 2013, p. 29; Lund et al., 2018).

For pregnant smokers in Okaloosa County, Florida, the most salient social determinants for their mental health and well-being comprise demographic factors (e.g., age), economic factors, (e.g., their socioeconomic status), neighborhood factors (e.g., poor rural areas), and educational attainment (e.g., high school diploma or GED; Drake, Driscoll & Mathews, 2018; Lund et al., 2018; McLaughlin, 2017). Given these factors are more prevalent in poor, rural areas, many pregnant women in Okaloosa County, Florida live in cities identified as

having the highest number of poor families in the area, which puts them at increased risk for tobacco use, thus a higher incidence of low birth weight babies, premature birth and infant mortality, in addition to higher costs associated with neonatal health care (Adams et al., 2002; Florida Department of Health, n.d.; McLaughlin, 2017).

In light of such findings, a social justice orientation to prevention would require that pregnant women in Okaloosa County, Florida be included and given an active voice in the prevention process, from start to finish, which means they would participate in the design, implementation, and evaluation of programs that are developed to increase the strengths of the community, while also intervening with larger systems (e.g., local and community policies) to address various social and physical environments within the community (Institute of Medicine, 2012; Vera & Kenny, 2013). Some strategies that can be used for larger system change may include community organizing, building political coalitions, and raising awareness of particular community problems with key constituent groups and decision-makers (Vera & Kenny, 2013). Furthermore, including the target program participants in such programs would also lead to more effective and culturally relevant prevention programs (Vera & Kenny, 2013).

One mechanism to increase the cultural relevance of a prevention program for pregnant smokers in Okaloosa County, Florida is a community-based participatory action research program (CBPAR/PAR), where preventionists and community members join efforts to identify needs, assets, goals, and strategies to reach desired health outcomes (Institute of Medicine, 2012; Vera & Kenny, 2013). In other words, PAR involves the ongoing collaboration between the academic researchers, the members of the affected community, and the various stakeholders within the community (e.g., the pregnant women and their families, health department agencies, health care clinics, mental health professionals, local and community-based institutions and

organizations, public policies, etc.) in every step of the process, that is, in formulating, conducting, interpreting and disseminating the results of the research (Institute of Medicine, 2012). Additionally, PAR may lead to intersectional action, changes in social and physical features of the environment, the development of programs and policies to improve population health, as well as collective empowerment, which enables communities to better identify and solve their problems through more efficient processes of assessing their needs and advocating for policies, while also leading to people having increased control over their lives (Baum, MacDougall & Smith, 2006; Institute of Medicine, 2012).

A second mechanism to increase the cultural relevance of a prevention program for pregnant smokers in Okaloosa County, Florida is the Social Media and Public Health Education approach, which aims to change people's knowledge about health, risk factors, and determinants, in this case, seeking to educate pregnant women about the adverse effects of tobacco use during pregnancy, both for the mother and child and to increase their knowledge about the risks associated with low birth weight, premature birth and infant mortality due to smoking while pregnant (Anderson & Cacola, 2017; CDC, n.d.; Institute of Medicine, 2012). Taking into account that women who live in poor, rural areas are more likely to have limited access to educational resources, the main goal of the social media and public health education approach is to increase pregnant women's awareness, knowledge, and attitudes about tobacco use during pregnancy, risk factors and lifestyle changes that improve health outcomes (CDC, n.d.; Institute of Medicine, 2012). Additionally, social marketing strategies can also be used as a "process to influence human behavior on a larger scale, to achieve specific behavioral goals for societal benefit" (e.g., antismoking campaigns; Institute of Medicine, 2012, p. 34).

And because the term “larger scale” often involves prevention interventions that target groups of people, rather than therapeutic interventions with individuals and families only, there are a few ethical considerations that need to be addressed, if prevention efforts are to be effective. Some considerations include, but are not limited to, informed consent, confidentiality, evaluation, information dissemination among stakeholders, and relationships with clients (e.g., participants) and other professionals (American Counseling Association [APA], 2014). Also, it is important to protect and promote the autonomy of communities of participants, and prevention specialists must avoid imposing their own values on the target participants and their communities (Hage & Romano, 2013).

Although the aforementioned ethical issues may present various challenges throughout the prevention program, informed consent and confidentiality are often the most discussed topics in terms of ethical implications for prevention programming. Relative to informed consent, prevention programs are most commonly designed for groups of people or communities. Thus, because there is no clear defined client, the typical informed consent process that takes place with regular clients is hard or even impossible to follow in prevention interventions (Hage & Romano, 2013). As a result, appropriate consent will have to be obtained from all the stakeholders that partake in the prevention intervention at hand, so that the dignity and autonomy of those participating are ensured (Hage & Romano, 2013). Concerning confidentiality, given there are large groups of participants and/or communities involved in the prevention program, all parties involved need to be informed of the potential risks to confidentiality, while also taking all the necessary measures to protect participants’ confidentiality (Hage & Romano, 2013).

PART 5: ADVOCACY

Educate Pregnant Women on Negative Effects of Tobacco Smoking During Pregnancy

The latest publication of the Multicultural and Social Justice Counseling Competencies (MSJCC) recommends that in addition to self-awareness, knowledge of client worldview, and skills for establishing a strong counseling relationship, counselors also possess multicultural and social justice competencies in terms of counseling and advocacy interventions (Multicultural and Social Justice Counseling Competencies, 2015). In this respect, privileged and marginalized counselors intervene with, and on behalf of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels to increase awareness of certain health issues and bring about change to improve the affected population's health outcomes (Multicultural and Social Justice Counseling Competencies, 2015).

The first step in developing effective advocacy interventions is to identify possible barriers to addressing the target problem at the institutional, community, and public policy levels. In terms of tobacco use during pregnancy, at the institutional level, research shows that the most common barriers to addressing smoking with pregnant women are deficits in knowledge and confidence on the part of the healthcare providers, perceived lack of time, and concerns about damaging the client relationships (Naughton et al., 2018). Another barrier appears to be the lack of support for smoking cessation from health care providers, in particular for vulnerable groups, such as people of low socioeconomic status, people with mental illnesses, and people who are homeless (Fallin-Bennet, Scott, Fallin-Bennet & Ashford, 2019).

At the community level, barriers to addressing tobacco use among pregnant smokers include limited or no access to treatment, and restricted access to Medicaid coverage of treatment for tobacco dependence (Fallin-Bennet et al., 2019). Although many health care providers ask and advise clients about tobacco use (employing the 5As approach), few assess, assist or arrange

treatment for tobacco dependence services to help clients quit smoking (Fallin-Bennet et al., 2019). As for Medicaid barriers, many states limit the enrollees' access to smoking cessation treatments (e.g., individual counseling, group counseling, and seven cessation medications approved by the U.S. Food and Drug Administration [FDA]) by imposing requirements for prior authorizations and co-payments (Fallin-Bennet et al., 2019).

At the public policy level, barriers to addressing tobacco use among pregnant smokers include a lack of comprehensive smoke-free laws and limited local tobacco control policies. Fortunately, the Florida Department of Health in Okaloosa County has taken various initiatives to educate the public about the dangers of secondhand smoke and to encourage residents to join the fight against tobacco, with the ultimate goal of making Okaloosa County a healthier place to live, learn, work, and play (The Florida Department of Health in Okaloosa County, 2016). Additionally, the Florida Department of Health's Tobacco Free Florida campaign is a statewide cessation and prevention campaign that aims to protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts
(The Florida Department of Health in Okaloosa County, 2016).

Counseling and Advocacy Interventions

The fourth domain of the Multicultural and Social Justice Counseling Competencies (MSJCC) recommends various advocacy actions that counselors can take to bring about awareness relative to local health and mental health concerns and improve the quality of life of the vulnerable populations within the communities they serve. These "action" guidelines include Counseling and Advocacy Interventions that privileged and marginalized counselors can utilize to intervene with, and on behalf of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels to increase awareness of certain health

issues and bring about change to improve the affected population's health outcomes (Multicultural and Social Justice Counseling Competencies, 2015).

One action that multicultural and social justice competent counselors can take at the institutional level is to collaborate with various local social institutions (e.g., families, schools, businesses, churches, community organizations) to address issues of power, privilege, and oppression impacting privileged and marginalized clients (Multicultural and Social Justice Counseling Competencies, 2015). For example, counselors can collaborate with personnel from local Women, Infants, and Children (WIC) clinics to raise awareness about how marginalized and vulnerable clients (e.g., pregnant women from low socioeconomic backgrounds) lack access to smoking cessation treatments or fail to access such resources based on stigma and lack of accurate information (Fallin-Bennet et al., 2019). Including Women, Infants, and Children (WIC) sites as points for intervening with pregnant and postpartum women can lead to increased support for smoking cessation for pregnant women from healthcare providers, thus increased assistance and arrangements for treatment services for those with tobacco dependence (Association of State and Territorial Health Officials, 2013; Fallin-Bennet et al., 2019).

At the community level, multicultural and social justice competent counselors can take initiative to explore with privileged and marginalized clients how community norms, values, and regulations embedded in society may hinder or contribute to their growth and development (Multicultural and Social Justice Counseling Competencies, 2015). Studies on rural communities suggest that rural subgroups share certain cultural assets, norms, and values, which may emerge from their experiences within small, geographically remote social and organizational systems (Talbot et al., 2019). Also, research exploring health-enhancing resources in rural areas in the U.S. has found that people in rural communities value civic engagement, reciprocity, and mutual

aid, as well as close-knit social networks, with overlapping personal and professional relationships (Talbot et al., 2019).

Although close relationships and good social support networks represent important protective factors for pregnant smokers, they may also pose challenges because they may lead to the social and intergenerational transmission of pro-tobacco norms, as well as the normalization and social acceptance of tobacco (Talbot et al., 2019). In light of such findings, counselors can open up the dialogue with privileged and marginalized clients regarding how such social norms and attitudes may lead to increased tobacco use during pregnancy, aiming to improve the health outcomes both for the mother and the child during pregnancy and in the postpartum period.

At the public policy level, multicultural and social justice competent counselors may employ social advocacy outside of the office setting to address local, state, and federal laws and policies that hinder equitable access to employment, healthcare, and education for privileged and marginalized clients (Multicultural and Social Justice Counseling Competencies, 2015). As mentioned above, many pregnant women in low socioeconomic, rural areas quality for Medicaid services, but due to existent barriers to accessing treatments for tobacco dependence (e.g., requirements for prior authorizations and co-payments), numerous pregnant smokers cannot access such smoking cessation treatments (Fallin-Bennet et al., 2019). Given this inequity to healthcare access, counselors (in collaboration with local health care providers) may advocate for policy-level changes to remove the aforementioned barriers to Medicaid coverage of treatment for tobacco dependence, as access to these services may lead to improved health outcomes for mother and fetus, as well as decreasing the risks factors for low birth weight, premature birth, and even infant mortality (Anderson & Cacola, 2017; Fallin-Bennet et al., 2019).

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