



Smoking during pregnancy: The attitudes, practices and experiences of midwives

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Methods

- 24 in-depth, individual interviews
- semi-structured
- 16 clinics, urban centres, 4 provinces
- Gauteng, Eastern Cape, Northern Cape, Western Cape

Current Practices

- Smoking status assessed at first booking
- Documented on clinic card
- Follow up inconsistent, problem orientated approach
- Advised to quit or cut down (5 a day)
- Growth retardation, LBW and reduced lung function
- Limited knowledge of risks and unable to give practical advice
- No educational resources

Current Practices

- “It is mostly during the first booking that we ask about smoking. You don’t ask the question all the time, unless you get the smell of smoke. Int 8.
- When I problem comes up, I give advice. If it doesn’t, I won’t give advice or check to see if they have cut down or stopped.” Int 4.
- To educate, to educate, to keep on emphasising. More than that I don’t know.” Int 20.

Midwives' beliefs

- Smoking an important issue in antenatal care
- Coloured women high risk group
- Convinced of harm - calcification of placenta, LBW, own experiences
- Emotional response
- "I tell women that it is very, very wrong to smoke during pregnancy." Int 15.

Perceived role

- Health education the responsibility of midwives
- Duty to inform women of the risks
- Conceded not doing enough
- Competing priorities : HIV, alcohol and drugs

Perceived role

- “It is not our responsibility to stop women smoking, We must tell them about the dangers, but it is ultimately their decision. It is their life and their baby.”
- “I told her that she must not feel bad. It is our fault as health educators. Maybe we could have gone into it in greater depth and really explained to you. Maybe if you had known, you would not have done this.” Int 14.

Knowledge and beliefs of pregnant women

- Vague understanding
- Concept of risk difficult to understand
- Denial of personal risk and severity of harm
- Fatalistic, low self efficacy, personal control

Knowledge and beliefs of pregnant women

- “They think however it is going to turn out, it will turn out anyway. They see ‘Smoking Kills’ on the packs, but they don’t believe it.” Int 11.
- “The general response is that it is too difficult to give up. Even those with a history of miscarriage will tell you its too difficult to give up.” Int 20.

Knowledge and beliefs of pregnant women

- “If nothing happened in their previous pregnancies and I tell them they should stop smoking, they look at me as if I really do not know what I am talking about.” Int 20.

MWs attitudes to pregnant women who smoke

- Judgemental and disapproving
- No understanding of behavioural change theory
- Sympathetic to circumstances of disadvantaged women
- Smoking a bad habit rather than an addiction

MWs attitudes to pregnant women who smoke

- “I get very irritated when they don’t take responsibility for their own health and their baby’s.” Int 8.
- “They can smoke as much as they like, but not when they are pregnant.” Int 3.
- “I said to one lady, ‘I wish I could phone the police because you are abusing your child.’” In17.
- “These women should buy food instead of cigarettes.” Int 23.

Adherence expectation

- Low compliance with advice
- PW resistant to changing behaviour
- PW unconcerned
- Women with planned pregnancies responded more positively
- MWs demoralised, but persist out of sense of duty

Adherence expectation

- “Generally, women who smoke will carry on. What we say does not matter.”
- “ We try, but mothers have a will of their own.”
- “Some manage to stop with lots of encouragement and praise, but it is very few.”
- If it is a wanted pregnancy, they will try and do what is right and take your advice more readily. But if it isn't, they have this don't care attitude.”

Communication with PW

- Authoritarian approach: paternalistic, domineering, expectations of compliance
- “They tell me that I scold them. But I say whatever I want. I am not scared of anyone who comes here.” Int 7.
- “It is her baby, so it is for her to listen and do something about it.” Int 6.
- “ If the baby is growth retarded, I give them an incredible lecture.” int 4.

Communication with PW

- Confrontational approach: threatening, guilt
- “When I smell smoke, I fight with the patient. I say, ‘Didn’t I explain to you? Why don’t you listen? Is your baby not important to you?..” Int 13.
- “The reason I go so hard on her is because I want her to understand that it is wrong. I know the consequences. It is because we care. I cannot just leave a person doing something wrong.” Int 14.

Communication with PW

- A mutual approach: Friendly, approachable, equal, affirming, empathetic, less frustrated
- “I am here to help. I want the patients to feel comfortable talking to me and not be afraid. If they see you as an authority figure, they won't approach you for help.” Int 18.
- “I try to make friends with them, talk and make jokes.” Int 19.

Communication with PW

- “When I talk to them I sit amongst them, then they relax. If you stand in front of them, then it is like you are the boss and you are going to tell them what to do.”
- “We used to have a problem here where people felt that the nurses were treating them like children. They didn’t even explain things, they just said, ‘you better stop smoking’. Really, that only makes them resist. I feel it is important for people to feel their dignity.” int 10.

Counselling skills

- “ I have no problems with counselling. I have a lot of experience. It is the women who don't like it. They don't respond as they should.” Int 7.
- “ I would like to know how to approach women who smoke. It is not easy to say the right thing. You know they need more help, but you don't know what help to give. So, I think it would be good to get training in counselling. ” Int 10.

Pregnant women's responses

- Passive, uninterested, resentful
- Conceal or understate their consumption
- Keen to limit consultation time
- More active participation desired by mws

- "Some women do listen, but with others it is like talking to a wall." Int 14.
- "They laugh sheepishly and say they will cut down." Int 20.

Pregnant womens' responses

- "Some of them are receptive and others are very defensive. They just tune out when you are talking. You can see that they are not interested." Int 8.
- "They look at you like you don't know what it is like to be in their situation, like it is easy for you to talk, you don't even smoke and you don't relate to my problems. " Int 13.

How midwives feel

- Disheartened, demotivated, sense of failure, helpless in face of social problems
- “It seems like I can’t do anything. Sometimes I feel I am wasting my time. I feel discouraged.”
- “I feel like I have failed as a midwife when a patient takes that attitude.”
- I am angry inside, but I can’t show that to the patient because it will only make things worse.”

How midwives feel

- “I feel bad because I really do want to help them stop smoking. I wish there was something I could do to motivate them to stop this harmful practice.” Int 16.
- “I am so busy that I can’t assist or get emotionally involved with someone who does not want to stop smoking. I just give her advice and then move on to the next one.” Int 4.

Perceived barriers

- Shortage of staff
- Long waiting times
- Lack of continuity of care
- Feel ill equipped, this affects their confidence
- “ There is a very, very serious shortage of staff. There is so little quality time for the patient and really no time for education.” Int 13. (60:3)

Perceived barriers

- “The problem is you can’t build trust because they may see me today, but someone else the next time. So, it is difficult to follow up on our questions about smoking” Int 10.
- “When they respond, you know they need more help, but we don’t know what kind of help to give them. We have no videos or pamphlets.”

Suggestions for intervention

- Willing to become involved
- Concerned to try and improve situation
- More medical knowledge and training in counselling skills
- Intervention to alleviate long waiting times
- Reinforcement of mws' advice
- Real life case studies
- Peer educators
- Support groups

Summary

- Smoking cessation a midwife's responsibility
- Convinced of harm
- Self efficacy is quite low
- Low expectations of success
- Negative attitude of pw affects their motivation
- PW underestimate and deny personal risk
- Approach adopted by mws provokes resistance, defensiveness

Summary

- Mws expressed dissatisfaction with communication with pw
- Blamed pw, did not critically reflect on their own approach
- Mws need understanding of behavioural change and training in patient-centred approaches
- Alleviate feelings of failure, anger, frustration
- Intervention to ease pressures on mws