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**Talking about smoking cessation with post-natal women: Exploring midwives'  
experiences**

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RUNNING HEAD: SMOKING CESSATION WITH POST-NATAL WOMEN

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### **Abstract**

This study explored midwives' experiences of talking to post-natal women about smoking cessation. Face-to-face semi structured interviews were held with seven midwives based in the UK. Thematic analysis identified themes which provided understanding as to factors determining discussion of smoking cessation. Six themes were identified which were Post-natal Women Factors, Midwife Factors, Providing Information, Involving Others, Priorities, and Whole Family Approach. Implications for midwives working with post-natal women are discussed, including the need to increase the involvement of other healthcare professionals in supporting post-natal women to stop smoking.

*Keywords:* Women, post-natal, smoking cessation, midwives, interviews

## **Talking about smoking cessation with post-natal women: Exploring midwives' experiences**

Maintenance of smoking cessation after pregnancy remains a challenge, with many women who quit during pregnancy relapsing by six months (Logan et al. 2017). Factors relating to relapse post-natally are numerous, including not coping well with the stress of a new baby, having a partner or friends and family who smoke, post-natal depression, being from a lower socioeconomic background, and being worried about weight gain (National Centre for Smoking Cessation and Training (NCSCT) 2019a).

In the UK, guidelines recommend that smoking is addressed post-natally as well as ante-natally (National Institute for Health and Care Excellence (NICE) 2010). Support may be required shortly after delivery, for example nicotine replacement therapy to reduce withdrawal discomfort (NCSCT) 2019b). However, support in the post-natal period appears to play a less important role for health professionals than in the ante-natal period (Flemming et al. 2015).

The current study used interviews to explore some of the issues involved in providing smoking cessation advice in the post-natal period, and reasons why midwives do or do not raise the subject of smoking cessation with post-natal women. Further, the study also sought to understand some of the reasons post-natal women were, or were not, referred for stop smoking support.

## **Methods**

### **Participants**

Seven UK-based midwives from one health service were recruited for the study. Sample size was determined following guidelines from Smith (2008). Data saturation was reached after the seventh interview with no new themes emerging. Participants ranged in age from 39 to 57 years and had worked as midwives between seven and 34 years. All participants were female

as the profession in the UK is still predominantly female, with 106 male and nearly 37,000 female midwives (NMC 2019). Pseudonyms are provided in the Findings and Discussion section below, but other personal information is not provided to protect the identity of participants.

### **The Interviewer**

The Interviewer (first author) is female and employed as a lead stop smoking nurse specialist in the Stop Smoking Service. At the time of data collection, she was also a trainee health psychologist, and this research was carried out as part of her doctorate training. She had little contact with participants prior to conducting the study and had met two of the midwives through the course of her work, in meetings that were smoking cessation related.

### **Materials**

A semi-structured interview schedule was formulated using concepts from the Theory of Planned Behaviour (Ajzen 1991) and was guided by suggestions for question format by Francis et al (2004). The questions also included aspects from conducting brief interventions with smokers. The 25 questions included questions on attitudes ('What do you believe are the advantages in asking post-natal women about smoking status?'), subjective norms ('Are there any individuals or groups who would approve of you advising post-natal women to stop smoking?') and perceived behavioural control (What factors enable you to refer women for stop smoking support?). The interview schedule was piloted with two midwives who both found questions easily understood.

### **Procedure**

Ethical consent was obtained from the UK health service where the midwives and the researcher were employed, and the Ethics Committee of Staffordshire University. Participants were recruited by approaching the head of Midwifery, explaining the purpose of the research and asking for permission to request participation from midwives. An information sheet

outlining the purpose of the research was supplied and emailed to staff. When potential participants contacted the first author, a date and time to conduct the interviews was arranged.

In the interview session, participants read the information sheet and indicated written informed consent. Once happy to commence, the audio-recorder was switched on. The interview schedule provided a guide for conducting interviews and participants were encouraged to talk freely. Additional questions were asked where appropriate, to enable new areas raised by participants to be explored in more depth. At the end of the interview, participants were debriefed about the purpose of the study and were given the opportunity to ask any further questions.

Interviews varied from 20 minutes to 45 minutes. Interviews were transcribed verbatim prior to being analysed.

### **Data Analysis**

The audio-taped interviews were transcribed and then analysed using thematic analysis (Braun and Clark 2006), allowing us to identify patterns emerging from within data. Data were analysed initially by the first author who identified key shared themes across interviews, and then discussed these with the second author who validated the themes through reading the original transcripts and ensuring that saturation had been reached. The final themes, associated quotes, and theme headings were agreed by both authors through a series of face to face and e-mail discussions.

### **Findings and Discussion**

Six themes emerged from the analysis which were common across all interviews; selected quotes are used for illustration below. To maintain anonymity, pseudonyms are used to identify participants below. All quotations are reported verbatim.

#### **Post-natal Women Factors**

Midwives believed post-natal women might feel they were being judged if they admitted to smoking and may find it difficult to disclose this to the midwife, particularly if they had stopped during pregnancy:

DAWN: I think because they've had the information ante-natally, they know that smoking's not good for them, they might feel a bit defensive.

Pregnant and post-natal women may find it difficult to admit to smoking and therefore communication should be sensitive and client-centred (NICE 2010). In the post-natal period, women can experience a range of emotions and can be vulnerable to mental health concerns (Care Quality Commission, 2018). It was perceived that at a time of adapting to motherhood there may be too many other things for a new mother to deal with, and that referral for smoking cessation support might be more appropriate at a later stage:

ANNABEL: I don't think there's any disadvantages in actually referring her, but I think like I said before, there might just be too many demands on her time and energy in the immediate post-natal period, I think possible it's maybe in the later post-natal period, maybe on discharge from, to the Health Visitor, or maybe at the six week post-natal check.

An alternative view was that some women may be grateful about being asked if they were smoking as midwives believed they may feel more motivated to stop smoking after the birth of the baby.

BERYL: I think if the woman is, if you're pushing on an open door and she wants to give up smoking and she's in that right place at the time. The women will feel grateful and probably quite relieved that they're actually going to get some help.

Many women want to remain smoke-free, but contrary to midwives' beliefs, motivation to quit is lowest in the first three months post-birth (Cooper et al. 2017). Concerns about weight gain or depression may influence their motivation to remain abstinent (Levine et al. 2010). However

an intervention that addressed mood, stress and weight concerns directly was not found to be more effective than an intervention that did not (Levine 2016).

### **Midwife Factors**

Midwives believed strongly that giving advice and information about smoking cessation and other health information was a large part of their role, supporting other studies examining midwives' perceptions of smoking cessation (Röske et al. 2009; McLellan et al. 2019):

ANNABEL: We have a responsibility to address baby safety issues and to talk about sudden infant death syndrome [pause] and about how ill-advised it is to have people smoking.

Midwife smoking status was raised by Beryl who thought midwives who smoke might find it difficult to raise the topic of smoking cessation saying "I think midwives who smoke might struggle with it". Midwives were not asked about their own smoking status, but Gillian disclosed that she was a smoker. Whilst her own smoking made her question how advice about smoking cessation would be perceived, she accepted this was part of her role and would still address the issue:

GILLIAN: It's not something that I would I bring up, but I don't have a problem saying to people that I do if they've asked. Ehmm, but then I suppose it's like the pot calling the kettle black isn't it. At the end of the day I don't really find it's a problem. If anything, I suppose I can understand more, ehmm the difficulties through trying to stop myself in the past.

The health behaviours engaged in by health professionals themselves, for instance smoking, may influence whether they discuss smoking or offer support (Pipe et al. 2009; McLellan et al. 2019), although Gillian reports that this did not influence her decision to discuss smoking cessation.

### **Provision of Information**



Providing information about smoking was viewed as an important part of being a midwife. However, there was also a perception that midwives might be seen as “nagging” women if they asked about smoking status. If, however, stop smoking information was given as part of another message which was relevant to post-natal women, participants believed this was more readily accepted by women and also their families:

ELIZABETH : If you talk about sudden infant death they will be more honest with you than if you just suddenly come out and said “do you smoke” They see it as part of helping baby, so they’re more likely to answer me honestly.

Messages which are developed with the aim of reaching a specific population are defined as targeted communication (Noar et al. 2007). Using a targeted message about SIDS enabled midwives to raise the topic of smoking as part of this message without singling out the woman’s smoking behaviour in isolation.

Some messages were tailored specifically for individual women. For instance, Annabel spoke about how she might need to adapt information depending on the social circumstances of women:

ANNABEL: If we tell them right you really must now eat 5 fruit and veg a day, breastfeed your baby, stop smoking, lose weight, walk, you know and become this wonderful super-mum we’re not going to achieve any of it. You have to pick out for each individual family, the messages you think you can get across.

Providing health information adapted for the needs of the individual has been demonstrated to be more effective than providing generic information (Kreuter et al. 1999). Midwives were keen to support women to stop smoking but were also realistic what might be achievable for the individual, taking her personal circumstances into consideration.

### **Involving Others in Providing Support**

Participants strongly identified talking about smoking cessation as part of their role, but also acknowledged the importance of involving other professionals in helping women stop smoking. Midwives acknowledged the expertise of the Stop Smoking Service, suggesting a good awareness of the effectiveness of stop smoking support.

ELIZABETH: Because the stop smoking support are professionals and they know how to deal with the women, ehmm in the long term.... to hopefully keep them off the smoking.

In addition to the Stop Smoking Service, midwives believed that promoting smoking cessation was not just a midwife role and that other healthcare professionals could also be involved. Beryl refers to the skills nursery nurses have in addressing the issue of second-hand smoke.

BERYL; Our nursery nurses do that they're really good about talking about second hand smoke, you haven't got to be frightened of saying, if you smoke and your baby goes to bed with you, it's a much higher risk of cot death, and this is really really serious.

NICE (2018) suggests that brief advice to stop smoking should be given to all smokers and that all healthcare professionals should refer smokers to a Stop Smoking Service for support. It appears that nursery nurses do address smoking, but there could be more emphasis on referring individuals for stop smoking support.

### **Priorities**

Talking about smoking cessation was one of multiple messages midwives had to deliver to new mothers. Many of the messages related to caring for the baby meaning there was less emphasis on maternal smoking. The information discussed such as infant safety and wellbeing are core topics in guidelines for post-natal care (NICE 2006). Having to cover these issues is likely to be time consuming, leaving less time to discuss smoking cessation:

ANNABEL: There's a lot to get across emm you know there's all the stuff around infant feeding which is very important. There's the other stuff around sudden infant death syndrome. You're talking to them about food, you're talking to them about ehmm the role of the health visitor and developmental stuff and drinking and breast feeding and then we go to smoking as well. It's an awful lot of information coming their way in the early post-natal period.

Smoking relapse during the postpartum period is also associated with a lower likelihood of breastfeeding (Disantis et al. 2010). Thus, supporting post-natal women who quit during pregnancy to stay quit and encouraging those who are still smoking to consider quitting may also enhance breastfeeding rates.

All seven midwives believed it was important to discuss smoking particularly in relation to SIDS, but less priority was placed on offering a referral for stop smoking support. Gillian reflected on how she had never thought of referring women, even though she always discussed smoking with post-natal women she saw. The reason she gave for this was the greater emphasis placed on smoking cessation in pregnant women:

GILLIAN: I'd always kind of thought of the focus being more in the ante-natal period. Yes, advising women post-natally, but it's never really been something that I've focused strongly on.

Guidelines for smoking cessation are aimed predominantly at pregnant rather than post-natal women (NICE, 2010). The NHS "saving babies lives" care bundle and The Royal College of Midwives (RCM) state that midwives should discuss smoking with pregnant women, but do not mention the post-natal period (NHS England 2019; RCM 2019). This may have an influence on whether referral for stop smoking support is offered during the post-natal period. More recently guidance from the NCSCT discuss the post-natal period in more detail than earlier guidance (NCSCT 2019b).

### **Whole Family Approach**

Talking about smoking in the post-natal period was frequently done in the woman's house and this offered an opportunity to promote smoking cessation with family members and friends. Women who quit during pregnancy, but who have partners who smoke are four times more likely to return to smoking after the birth (Mullen 2004) and therefore discussions around smoking should also include partners who smoke. The family could provide a source of support: either encouraging the woman to quit or, if they smoked, by also quitting smoking. Beryl acknowledged that family support could be useful, but care was needed to ensure the support was not perceived as bullying:

BERYL: In the home you've got that wider audience [pause] it could go two ways, they could either carry on encouraging her or it could turn into a bit of bullying, so you have to be careful of that. But also they might say well actually you know, if you give up I will as well. So they might have a better support mechanism.

Social support provided by an intimate partner is suggested to be the best source of support (Schwarzer et al 2004). Midwives believed if the post-natal woman wasn't a smoker, but her partner was, she was always pleased when the midwife suggested the partner should quit:

FIONA: You often see, if the dad smokes in the house and you're asking about smoking and passive smoking. You often see the mum thinking "yeah go on ask him" and go for it, and they really appreciate that you're bringing it up, because it causes them a lot of arguments sometimes and stress.

For women who smoke, social support from a partner may help a woman's motivation to stop smoking and can help the woman's self confidence that she can quit (Pollak et al. 2006).

It is important therefore, that midwives include partners as well as other family members in post-natal discussion about smoking.

### **Conclusion**

This analysis suggests midwives are committed to supporting smoking cessation, though do not appear to be making full use of the opportunity to promote smoking cessation by offering referral to Stop Smoking Services. NCSCT (2019b) suggests protocols should consider smoking cessation support for women in the post-natal period. The post-natal period offers an opportunity to address smoking cessation and may stimulate quit attempts by new parents (Winickoff et al. 2010). According to accounts presented here, smoking cessation was often given lower priority than other areas, yet very brief advice (VBA) used to talk about smoking can take as little as 30 seconds (NICE 2019). Stop Smoking Services could address this by providing training for midwives to support them to do this effectively. NCSCT provide simple brief guidance how to deliver VBA including measuring carbon monoxide exposure (NCSCT 2019b). Whilst aimed at pregnant women, VBA could also be conducted with post-natal women.

The use of semi-structured interview schedules was an effective method of exploring midwives' experiences of discussing smoking cessation with post-natal women as it provided flexibility to follow up new areas that arose during the discussion (Smith et al. 2010). The first author is a Coordinator of a Stop Smoking Service and this may have influenced the way in which the transcripts were analysed. The second author does not work in smoking cessation but has conducted research on smoking and this may have influenced her interpretation of transcripts. However, the second analysis was conducted blind and similar themes were identified by both authors, lending some credibility to the analysis. Future directions for research could involve exploring the experiences of nursery nurses and health visitors who are involved with post-natal women.

Recommendations for midwives would be to:

- Attend stop smoking brief intervention training to provide them with awareness of what Stop Smoking Services offer and the skills to enhance their interactions with post-natal women;
- Undertake the online VBA training offered by the NCSCCT which includes the use of video demonstrations. Currently the organisation encourages staff to undertake generic VBA by advertising this on the organisation's Intranet and by providing feedback on numbers accessing training. This could also be done for the VBA pregnancy online module;
- Offer smoking cessation support to all post-natal women and their partners;
- Advise women what kind of support they will receive from Stop Smoking Services;
- Make use of a Making Every Contact Count (NHS, 2019) approach within midwifery practice to ensure a joined-up approach when advising on health behaviours such as smoking cessation;
- Ensure other health professionals are aware of whether the woman has taken up a stop smoking referral or not, for example health visitors.

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**Key Points**

1. This was a qualitative study investigating some of the issues faced by midwives when talking about smoking cessation with post-natal women.
2. Seven UK midwives took part in face-to-face semi-structured interviews where they discussed reasons why they did, or did not, discuss smoking cessation with post-natal women.
3. Analysis revealed that midwives were committed to supporting smoking cessation, though smoking cessation was often given lower priority than other areas.
4. Midwives recognised the importance of involving partners as well as other family members in post-natal discussions about smoking.
5. Midwives also recognised the need to increase the involvement of other healthcare professionals in supporting post-natal women to stop smoking.
6. Results demonstrate the importance of providing smoking cessation training for midwives to support women in the post-natal period.

**CPD Reflective Questions**

1. What personal and/or professional factors affect whether you do or do not raise the issue of smoking with post-natal women
2. Why do you think smoking cessation may have lower priority than other areas in the post-natal period? What do you think might raise smoking cessation as a priority?
3. In your role as a midwife what could you do to encourage other healthcare professionals to be more involved in talking to post-natal women about smoking cessation?