Midwives` Experiences and Attitudes to a Smoking Cessation Programme for Pregnant Women: A Phenomenographic Study

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Abstract

Background: Women who smoke whilst pregnant are increasing globally. Midwives are seen as frontline professionals for providing smoking cessation interventions to pregnant women. Yet, there is a dearth of studies on attitudes of these professionals to smoking cessation work in pregnancy. Aim: This paper reports on a study that explored midwives` experiences and attitudes toward a smoking cessation programme of a midwifery service in England. Method: This study utilised a phenomenographic methodology. A criterion purposive sampling approach was used, and 17 participants were recruited to take part in the study. Semi-structured interviews were undertaken for data collection, and a thematic analysis was used, based on Sjöström and Dahlgren`s approach. Results: Four superordinate themes emerged from the data analysis: reasons for smoking; attitudes toward smoking in pregnancy; attitudes toward the smoking cessation programme, and barriers to smoking cessation. Conclusion: Smoking cessation should not be considered in isolation from the lives of pregnant women. Midwives need ongoing training and support to enhance their skills, knowledge and confidence in smoking cessation work.

Keywords: *Attitudes, Midwives, Phenographic methodology, Pregnancy, Smoking cessation*

1. Introduction

Smoking is noted in the United Kingdom (UK) and many other parts of the world as a public health concern, an assertion attributable to its negative health consequences (World Health Organisation, WHO, 2002; Salihu & Wilson, 2007). Health problems, such as lung cancers and cardiovascular diseases, considered as some of the leading causes of mortality in the universe, are in the main attributed to smoking in many countries, including the UK (WHO, 2002). Taking this into account, the UK Government developed a comprehensive strategy to reduce smoking detailed in the 1998 White Paper entitled *Smoking Kills* (Bryce, Butler & Gnich, 2009). Although the strategy was developed for the entire UK population, it focused on individuals most at risk of smoking, such as young people and adults of socially and economically disadvantaged communities, and pregnant women (McGowan, Hamilton, Barnett, Nsofor, Proudfoot & Tappin, 2010). A range of approaches are included in the strategy, and example of these include guidelines for brief interventions, bans on smoking at work, public places and tobacco advertising (Allwright, Paul, Greiner, Mullall, Pursell & Kelly, 2005).

The overall effect of these approaches is a reported decrease in incidence and prevalence of smoking (McNeill, Raw & Whybrow, 2005). Even though this is the case, an apparent growth in smoking rate is noted among females. This is a function of an increase in smoking initiation among young girls (Blenkinsop, Boreham & McManus, 2003). Acknowledging this, Delpisheh, Kelly, Rizwan, Attia, Drammond & Brabin (2007) projected that the number of women smoking worldwide will triple with time. Such a claim is worrying and it is even more of a concern if the population of women who smoke include those who are pregnant. Apparently, this is the case as some women smoke while pregnancy and even continue to do so after childbirth (Lumley, Chamberlain, Dowswell, Oliver, Oakley & Watson, 2009). This is a concern for midwives, particularly those who work closely with pregnant women and their partners as part of antenatal and postnatal health care provision. These important roles, including regular and direct patient contact place these professionals in a better position to promote smoking cessation in pregnancy and even parenthood. Yet, there are very little studies on midwives` views of smoking cessation work with pregnant women in the UK. Hence, this study seeks to explore the experiences and attitudes of midwives working in a maternity service in England toward a smoking cessation programme.

2. Background

Maternal smoking during pregnancy is an established risk factor to the general wellbeing of mothers and their babies (Bull 2007). Its prevalence has been noted to vary from state to state (Price, Jordan & Drake, 2006). In Scotland, for example, 23% of pregnant women were reported in 2006 to smoke whilst pregnant (Information and Statistic Division, 2006). In the same year, 17% of women in England and Wales admitted to smoking during pregnancy (Information and Statistic Division, 2006). Taking the UK as a whole, 30% of women were reported in 2006 to smoke during pregnancy (Delpisheh et al. 2007). This UK rate of maternal smoking during pregnancy is higher than the rest of Europe, Canada and the United States of America (Bull, 2007).

In addition to regional differences, the prevalence of women smoking whilst pregnant also varies by socioeconomic status. In working-class communities of lower socioeconomic status, smoking in pregnancy is a normative and acceptable behaviour (Bull, Burke, Walsh & Whitehead, 2007). The outcome of the 2004 Family and Children Survey revealed that more than half of mothers in the lowest socioeconomic group in the UK had smoked during their last pregnancy (Department of Work and Pensions, 2006). The highest rates were noted among women in households where neither the pregnant women nor her partner were in employment (Department of Work and Pensions, 2006). These rates indicate that the lower the socioeconomic status the higher the likelihood of prenatal smoking.

Maternal smoking also differs by age and ethnicity. In relation to the former, pregnancy-related smoking is persistently reported in the literature to decrease with maternal age (Bull et al. 2007). Adolescents, for example, are more likely to smoke during pregnancy than women 20 years and older (Salihu & Wilson, 2007). In relation to ethnicity, white women are more likely to smoke during pregnancy than their black and Asian counterparts (Mathews, 2001). Irrespective of the differences in rates highlighted, maternal smoking during pregnancy harms women and unborn babies.

Maternal smoking whilst pregnant increases the risk of mothers developing lung and cervical cancers, which account for one in three middle-aged deaths of women in the UK (Mulder, Robles de Medina, Huizink &Van den Bergh, 2002; WHO, 2008). Added to this, smoking during pregnancy is associated with serious health problems such as miscarriage, preterm birth and stillbirth that in turn may result in increased perinatal morbidity (Hammoud, Bujold, Sorokin, Schild, Krapp & Baumann, 2005; McGowan et al. 2010). Babies of mothers who smoke whilst they are pregnant are more likely to have respiratory problems, lung cancer, lower birth weights, slower growths and higher chances of cot death (Di Franza, Aligne & Weitzmn, 2004). In addition to this, incidents of diabetes mellitus, obesity, attention deficit

disorder and other learning difficulties have been noted in adulthood among individuals exposed to maternal smoking in utero (Montgomery & Ekbam, 2002; Langley, Rice & Van de Bree, 2005). Despite this wealth of evidence that smoking can damage the health of unborn babies, siblings and mothers, its incidence among pregnant women is still high in the UK (Lumley et al. 2009).

Approximately, one in every three pregnant women in the UK smoke during pregnancy (Pound, Coleman & Adams, 2005). Acknowledging this rate and the health implications of smoking, the UK Government set up strategies to reduce smoking during pregnancy. An example of these strategies includes forming a free NHS Pregnancy Smoking Helpline that involves midwives as active health promoters. Such involvement of midwives is a function of the view that pregnancy is perceived as an opportune time for smoking cessation work with women (McGowan et al. 2010). This is because about 70% of women in the UK have at least one baby (Information and Statistic Division, 2004). The use of the Pregnancy Smoking Helpline strategy, couple with the application of motivational interviewing and provision of cessation advice by midwives and other healthcare workers, such as health visitors have resulted in an overall decline in the prevalence of smoking in pregnancy (Lumley et al. 2009). However, this decline has not been consistent across all communities, as higher rates are still noted among pregnant women from lower socioeconomic backgrounds (Bull et al. 2007). This is because of the physical and psychological addiction to cigarettes, irritability associated with cessation, acceptance of smoking as normative behaviours that may serve as coping approaches for life difficulties, and midwives` attitudes toward smoking in pregnancy (Bull & Whitehead, 2006).

Attitude relates to enduring positive or negative feelings about a person, object or issue (Petty & Cacioppo, 1996). Attitudes also include people's perceptions and overt behaviour toward an object or stimulus, which in this case relates to a smoking cessation programme and maternal smoking during pregnancy. In other words, attitudes provide people with ready reactions to and interpretation of events (Gross, 2010). This study considers how midwives feel about, think about and behave in response to smoking cessation work in pregnancy. Successes of cessation work with women can be influenced by midwives` attitudes toward maternal smoking. In other words, attitudes are powerful attributes that can influence the working relationships between pregnant women and midwives, and the latter`s commitment in enabling the former to quit smoking. However, little is known about midwives attitudes toward smoking cessation with pregnant women.

3. Method

3.1 Aim

This paper reports on a study that explored midwives` experiences and attitudes toward a smoking cessation programme of a midwifery service in England.

3.2 Design

This study utilises a phenomenographic methodology to describe midwives` attitudes and experiences of smoking cessation work with pregnant women. Given that attitudes are fluid and people may not experience phenomena in the same way, phenomenographers usually set out to identify the multiple experiences, attitudes and understandings of a particular phenomenon (Marton, 1981). They also seek to describe the underlying relationships between people`s experiences, attitudes and understandings of phenomena. The experiences, understanding and attitudes are together referred to as conceptions in phenomenographic methodology. They are the outcomes of interactions between people with their external worlds, which in this case relates to the phenomena under exploration. Although these conceptions can be accessed in different ways, conversation using an open or semi-structured interview format is considered a potent means of doing so (Svensson, 1997). This indicates that experiences, attitudes and understandings (conceptions) of a phenomenon are jointly constituted or developed by researchers and participants.

3.3 Sampling and participants

The study was carried out in one maternity service of a Healthcare Trust in England.

This maternity service had 20 midwives involved in facilitating the smoking cessation programme for pregnant women. A letter was sent to all the midwives inviting them to a meeting to discuss the study. The midwives were informed at the meeting about the aim of the study, its significance and eligibility criteria. An information leaflet that contained the study`s aim and eligibility criteria was also given to each midwife. Towards the end of the meeting, midwives were

reminded to read the information leaflet given to them and to contact the researcher if they meet the eligibility criteria. All the midwives made contact with the researcher and expressed their willingness to participate. Sampling was criteria purposive and 17 of the 20 midwives met the inclusion criteria for participation, and were therefore eligible to be interviewed. A follow-up letter was then sent to each of the 17 midwives eligible for participation confirming date, time and venue of interviews.

3.3.1 Inclusion criteria of the study

1. Registered midwives with two or more years of experience of working with pregnant women who smoke.
2. Registered midwives with two or more years of experience of smoking cessation work with pregnant women.
3. Registered midwives who speak English fluently.

3.3.2 Exclusion criteria of the study

1. Registered midwives with less than two years of experience of working with pregnant women who smoke.
2. Registered midwives with less than two years of experience of smoking cessation work with pregnant women.
3. Registered midwives with difficulty communicating in English.

3.4 Data collection and analysis

Ethical approval was gained from the National Research Ethics Services and Research site Ethics Committee. Informed consent was sought and obtained from each midwife before data collection. Data were collected using a semi-structured interview guide in a designated room in the midwifery service. Each interview lasted for about 45 minutes and was audio taped.

All interviews were transcribed verbatim and transcripts were analysed manually using Sjöström and Dahlgren (2002) seven steps approach to analysis outlined in figure 1 below. The analysis was carried out in parallel with the interviews, and was conducted iteratively throughout the interview period until category saturation was achieved.

Step 1: Familiarisation: Read transcripts several times to increase familiarity of material.

Step 2: Compilation: Search transcripts for statements that correspond to the aim of the study.

Step 3: Comparison: Analyse identified statements for similarities and differences. Group statements with similar content together.

Step 4: Grouping: Examine identified statements for conceptions. Group statements with similar conceptions together (formation of conceptions).

Step 5: Articulation: Re-examine or repeat analysis of conceptions to enhance meaning. This stage informs the formation or identification of descriptive categories.

Step 6: Labelling: Labels the descriptive categories of conceptions to reflect their meanings.

Step 7: Contrasting: Compare descriptive categories for similarities and differences to ensure that each has a unique character.

Fig. 1 Sjöström & Dahlgren (2002) Seven Step Approach to Analysis

4. Findings

Six main thematic categories emerged from the interviews' data. They were (1) reasons for smoking, (2) attitudes toward smoking in pregnancy, (3) attitudes toward the smoking cessation programme, and (4) barriers to smoking cessation. These themes were further divided into subthemes indicated in bold italics. Extracts from participants' narratives are used to support discussions presented.

4.1 Reasons for smoking

This theme focuses on midwives` attempts to explain the reasons why women smoke whilst pregnant using their smoking cessation work experiences. Coping with life pressures in socioeconomically disadvantaged communities was the most cited reason for smoking during pregnancy.

Most of the women who use our service are from crowded estates with limited resources. They are single,

unemployed and dependent on the state for survival. They smoke to cope with life difficulties.

Smoking during pregnancy was considered by some participants as a normative behaviour and a habit or addiction for women living in communities that are socially and economically disadvantaged. Added to this, most participants frequently talked about tension release as a rationale for women smoking during pregnancy. In essence, tension release relates to expression of feelings of anger and frustration (Sandy, 2013). According to participants, women repeatedly reported during smoking cessation work feelings of anger and frustration. Participants communicated a shared opinion about these emotions. They claimed that women`s feelings of anger and frustration were mostly evoked by unwanted pregnancies, conflicts with others and financial difficulties. The majority of participants reiterated on a number of occasions that expression of anger by women is in the main socially unacceptable. However, failure to express emotions of this nature could result in the development of mental health problems. It was therefore not surprising to note during interview for some participants to report feelings of hopelessness, helplessness and anxieties expressed by some of the women in the smoking cessation group. For these participants, women smoke during pregnancy to alleviate these mental health problems.

Some pregnant women smoke to manage their mental health issues. They also smoke to manage their anger.

For most part, participants also associated mental health problems experienced by some of the women in their smoking cessation group with feelings of abandonment and rejection. They reported how feeling abandoned and rejected can lead to commencement of smoking.

Some of the women face constant abuse. They have not tasted true love...have not really felt accepted by their partners and others. Smoking is their way of looking for acceptance and love.

For some women, smoking is a quest for acceptance and love. Few participants associated this assertion to weight-related anxieties expressed by some of the pregnant women in the smoking cessation group. They reported that these women were frequently preoccupied with their weight; they claimed that they were overweight. These women, participants asserted, use cigarette smoking as an approach to enable them to lose weight, an outcome consistent with findings of prior studies (Foster & Hirst, 2014).

Nicotine supresses appetite. It can affect people`s eating habit, which in turn can lead to weight loss.

4.2 Attitudes toward smoking in pregnancy

Participants reported two sets of attitudes; positive and negative toward smoking in pregnancy. In relation to positive attitudes, there was a near consensus among participants that giving up smoking during pregnancy was very important because of the medical risks associated with the behaviour.

Smoking is not good for the mothers. It can lead them to develop respiratory problems. It can also cause foetal death and intra-uterine growth retardation.

The need for pregnant women to quit smoking was further emphasised by most participants because of social reasons. Examples of these include the cost of cigarettes and the limited number of public places where smoking is permitted. For some participants, these approaches may not lead to a reduction in smoking rates among pregnant. What is therefore needed, participants stressed, is an adoption of a non-judgemental approach when working with these women. They claimed that such an approach would enable midwives to listen to women, understand the issues leading to their smoking behaviour and implement tailor-made cessation interventions.

It is imperative not to be judgemental. Being a good listener is essential for understanding the reasons for smoking.

A number of participants expressed readiness and willingness to support women to quit smoking. According to participants, readiness relates to having the right and adequate skills and knowledge for effective smoking cessation work. In addition to this, the majority of participants claimed that women who smoke in pregnancy need midwives` commitment to offer cessation help and an optimistic view that such help will result in at least quit attempts. Being optimistic or hopeful will enable midwives to spend more time with women as well as enhances the latter`s motivation for change. Although controversial, few participants confidently stated that some women should be encouraged to smoke in pregnancy. They believed that such a stance is appropriate for women with mental health difficulties and / or stressful family problems, like divorce, who may find smoking as an effective coping strategy.

Women with mental health problems need to smoke to manage and cope with their difficulties. We should encourage them to do so.

Participants also expressed negative views about smoking in pregnancy. The majority were in favour of the blanket approach to discourage women from smoking in pregnancy. Such an approach, perceived as negative by some participants, does not only ignore the individual needs of women, but it may also perpetuate the need for smoking. Two participants persistently expressed condescending attributes toward smoking and women who smoke in pregnancy. They

described the behaviour as disgusting and women as irresponsible.

Smoking in pregnancy puts the health of the unborn at risk. It is also a health risk for the mothers. It is certainly an irresponsible and disgusting act.

These descriptors are indications of stigmatisation and labelling. Some participants reported that women who smoke in pregnancy often feel stigmatised because of the labels ascribed on them by healthcare workers and people around them.

One of the women we work with said that they are sometimes, if not always, described as self-fish and uncaring and lacking in priorities.

Claims were made by most participants that these labels indicate disrespect. So, pregnant women may find them humiliating. Such experiences, participants stressed, may lead to more smoking behaviour.

4.3 Attitudes toward the smoking cessation programme.

Positive and negative attitudes toward the smoking cessation programme were noted in participants` narratives. Stating with the former, there was agreement among most participants that the smoking cessation programme was effective. This assertion was based on the view that it enabled some women to quit smoking. As a result of this, participants stressed that involvement in cessation work with pregnant women should be a critical aspect of the professional responsibility of all midwives.

As midwives, we should encourage women not to smoke in pregnancy. This should be one of our core roles and responsibilities. We should be advising these women against smoking.

The provision of advice, which mainly focused on health risks, was considered one of the effective approaches used during cessation work. However, participants asserted that its effectiveness was in the main a function of the multidisciplinary and consistent stance adopted.

Every healthcare worker, including health visitors and doctors were involved in the smoking cessation programme. Our consistent and team approach enhanced the effectives of the programme.

In addition to the adoption of a multidisciplinary and consistent approach, the majority of participants were of the opinion that people are more likely to quit smoking if they are empowered in cessation work. Empowerment in this case relates to the provision of advice and information, participants reported.

We provided advice and information to women in different formats. We discussed with women and provided leaflets, and these made them to make informed decisions to quit smoking.

Most participants claimed that some women quitted smoking because of the manner they were spoken to. Participants attributed this to the view that people`s behaviours are generally influenced by their interactions and context in which they find themselves. Put in another way, behaviour change can be achieved when people are engaged in a meaningful manner. Thus, motivational interviewing strategies, such as reflective listening, paraphrasing, open questions and reflections were employed during cessation work to encourage women to discuss about smoking and their readiness to change. Some participants claimed these strategies created a safe space for women to talk about their anxieties and difficulties relating to quitting smoking.

In addition to these positive views, participants also reported a range of negative attitudes toward cessation work in pregnancy. Some claimed that enabling approaches, such as motivational interviewing, were generally ineffective in leading women to quit smoking. These participants stressed that using aggressive styles in communicating health risks are more likely to result in positive outcomes; women quitting smoking.

The women needed to be embarrassed, told off and scared. Using these styles would make them to stop smoking.

Apart from these aggressive approaches, instances of apathy or lack of interest in smoking cessation work were observed in participants` narratives.

It is certainly a waste of time and energy to talk to the women to stop smoking. Irrespective of our effort, they will continue to smoke. This is more so if you are gentle with them.

These negative attitudes were perceived by some participants as barriers to smoking cessation work with some of the pregnant women.

4.4 Barriers to smoking cessation

Whilst midwives were perceived as the most appropriate healthcare professionals to offer smoking cessation advice, it is noted that some members of this professional group lack the enthusiasm or motivation to do so. Lack of motivation to work with pregnant women was deemed by some participants to deter smoking quit attempts.

Some of us lacked the motivation to spend time with women. This had a negative effect on the provision of general health promotion and cessation advice. This made women to continue to smoke.

Lack of confidence in smoking cessation work was another barrier talked about during interviews. Few participants reported that they lacked confidence in their ability to provide smoking cessation advice to pregnant women. These participants added that enabling women to stop smoking is not their area of expertise. Lack of time to provide smoking cessation support and limited staffing levels were the most frequently reported barriers to help pregnant women quit smoking.

The maternity service is really under-staffed. So, our focus is on the physical needs of the women and babies. Apart from this, some us are not confident and skilled to help women to quit smoking.

The need for training in approaches to prevent smoking in pregnancy was emphasised at interviews. Whilst some participants felt that they need to be trained in specific areas such a nicotine replacement therapies (NRTs) and motivational interviewing, some felt they needed further training to enhance their confidence in smoking cessation work.

We need to be trained to improve our confidence and effectiveness in cessation work. We need more guidance on the National Institute of Health and Clinical Excellence (NICE) guidelines on the use of NRTs for pregnant women

In addition to fear of using NRTs, some participants were concerned that engaging in discussions relating to smoking cessation may prevent women from attending their appointments.

5. Discussion

This studied explored midwives attitudes and experiences of a smoking cessation programme. All the pregnant women who participated in this programme were from working-class families of socioeconomically disadvantaged communities in the East of London. Participants of this study provided a range of reasons why women smoke in pregnancy. One of the most cited reasons was coping with life pressures in working-class communities, a view also reiterate by Bull et al (2007) in their study of social attitudes toward smoking in pregnancy. Tension release was another reason that was frequently talked about by some participants. They reported that the women of the smoking cessation programme usually bottle-up angry emotions. These emotions were by and large generated by a mixture of problems, like financial difficulties and unwanted pregnancies. Delays in managing these emotions may lead to experiences of anger, frustration and anxiety. Such a cocktail of emotions could lead to the development of mental health problems or psychological tension that requires a safety valve for safe expression (Sandy, 2013). Smoking in pregnancy, a private and controllable behaviour, is perceived by women as an effective means for restoring emotional calmness, an opinion also reflected in this inquiry (Bull 2007). This assertion is a function of the view that women are generally uncomfortable to externalise their anger against others for fear of repercussions. Added to this, expression of these emotions by women is also socially unacceptable.

Achievement of emotional calmness or reduction in psychological tension through smoking can negatively reinforce smoking behaviour. This means that pregnant women who maintained a calm emotional state by smoking may continue to do so whenever they encounter psychological tension. For these women, smoking is a learned behaviour. Given that the experiences of psychological tension are common occurrences in disadvantaged communities (Department Work and Pensions, 2006), women in these environments are therefore more likely to frequently smoke in pregnancy to alleviate the same. It is therefore not surprising for some participants of this study to describe smoking in pregnancy in these communities as a habitual and normative behaviour that serves as a coping strategy for stressful experiences.

Another explanation for smoking in pregnancy was centred on the search for love. Some participants reported that some of the women in their smoking cessation group frequently complained of feelings of abandonment and rejection as they were constantly exposed to threats of separation from their partners. According to participants, these threats were mainly a function of the women being overweight. Thus, these women commenced smoking and continued to do so for weight control purposes. Taking into account the multitude of reasons provided, smoking in pregnancy is certainly a complex behaviour that should not be considered in isolation from the lives of pregnant women. An ecological perspective is therefore needed for understanding the reasons why women smoke while pregnant. This perspective suggests that the behaviour of smoking is a product of an interaction of both individual and environmental determinants, such as attitudes of healthcare professionals.

Previous studies reported mixed attitudes of healthcare professionals, including midwives toward smoking in pregnancy, but mainly negative ones (Bull, 2007; Bull et al. 2007; Bryce et al 2009). Even though the findings of this study in part support earlier findings in the context of mixed attitudes, positive attitudes were the most mentioned and discussed themes. The discussions on attitudes were mainly associated with health risks associated with women smoking whilst pregnant. Given that maternal smoking can negatively affect the health of women, siblings and unborn

babies (WHO, 2008; Lumley et al. 2009), there was a shared opinion amongst most participants that it should be discouraged and stopped during pregnancy. Implementation of such a blanket approach, particularly to women who live in environments where smoking is an acceptable behaviour and dependent on it to cope with stresses of life, is a challenging task to achieve. Added to this, such an approach, which in essence indicates disregard for the individual needs of women, may also lead to an increase in smoking behaviour.

Descriptors, such as an irresponsible and disgusting act were noted in the narratives of two participants to describe smoking in pregnancy. Similar descriptors were reported by other researchers, such as Bull et al (2007) in their report of a study on social attitudes toward smoking in pregnancy. The use of these labels in the present study indicates a misinterpretation of the motives underpinning women`s smoking behaviour; which in essence relates to coping with life pressures and alleviation of psychological tension (Bull & Whitehead, 2006; Bryce et al. 2009). The use of labels also denotes a communication of frustration that was compounded by lack of effective ways of encouraging women to stop smoking in pregnancy. It was therefore not surprising that participants requested specific training in this area, an outcome also reported in a range of prior research studies (Bull 2007; McGowan et al. 2010). It is critical for training to address the underlying psycho-socioeconomic issues motivating women to smoke in pregnancy and to use empowering approaches, such as motivational interviewing, instead of aggressive styles in communicating health risks. Participants were of the opinion that training can enhance their knowledge, skills and confidence in smoking cessation work.

Whilst participants accepted that they had a professional responsibility to be involved in smoking cessation work with pregnant women, they also felt that the smoking cessation programme was effective because it adopted a multidisciplinary and consistent approach. What also helped to enhance the effectiveness of the smoking cessation programme were midwives commitment and willingness to offer cessation advice. However, some barriers to smoking cessation work were reported by some participants. Examples of these include lack of time and limited staffing levels.

6. Limitations

This study has demonstrated that individual interviews are effective methods for researching attitudes towards smoking cessation programmes. Despite this, there are some limitations to the study. The study was carried out on one smoking cessation programme facilitated by midwives of a single midwifery service. The findings are based on retrospective accounts of midwives' attitudes and experiences of the smoking cessation programme. Such accounts are subject to memory bias. However, these accounts provided valuable insights and a context for understanding experiences and attitudes to smoking cessation in pregnancy.

7. Conclusions

This study has shown that midwives have mixed attitudes toward smoking in pregnancy, but mainly positive ones. The study has also demonstrated that midwives have good understanding of why women smoke in pregnancy. It also indicated that midwives are knowledgeable of the health risk of smoking for mothers, unborn child and siblings. Participants stipulated that involvement in cessation work with pregnant women should be a critical aspect of midwives` professional responsibility. It was therefore not surprising for them to express willingness to enable women to stop smoking in pregnancy. Even though this was the case, few participants stressed that some women, such as those with mental health difficulties, should be encouraged to smoke in pregnancy. They claimed that women with these problems find smoking as an effective approach to cope with their difficulties.

Participants reported that the smoking cessation programme was effective, but stressed that it effectiveness was enhanced mainly by the multidisciplinary and consistent approach adopted. Despite this, some barriers to smoking cessation work were reported by participants. Examples of these include lack of time, limited confidence and staffing levels. The need for specific training to provide comprehensive smoking cessation service to women in disadvantaged communities was identified in this study. Support group for women in this community should be developed to compliment midwives` smoking cessation programmes. Further research using a mixed method approach is needed to better understand midwives` attitudes towards smoking.

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