

# The response of pw to advice

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- ( PW resistant to quitting
- ( Anecdotal accounts contradict advice
- ( Passive in interaction

“There are a lot of women who are hardened smokers. When you start talking to them they sigh as though everyone has already spoken to them and they are fed up. They become evasive because they have no answer. They know they are doing something wrong. “ Int 12.

# Doctors' attitudes to proposed smoking cessation intervention

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- ( Positive in principle
- ( Accepted doctors could play an important role
- ( Mws should take primary responsibility

“I do think we can play a role because patients look up to doctors and trust their advice. It would be important for doctors to confirm and reinforce what the mws are saying.” Int 2.

# Doctors' attitudes to proposed smoking cessation intervention

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( Guidelines and training would be helpful

“We actually don't know what is the correct way to discuss smoking cessation with patients. If we had more knowledge of the correct strategies, we could give better advice to women. If we could have training for doctors and nurses which would suggest how to approach the problem and explain that it should not be a confrontational type of method, I am sure it will be of huge benefit.” Int3.

# Doctors' attitudes to proposed smoking cessation intervention

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“What we need is a tool, an intervention that we can believe will make a difference. At the moment, I feel there is nothing I can use except personal lecturing or encouragement and one gets the feeling of futility about the whole thing.” Int7.

# Doctors' attitudes to proposed smoking cessation intervention

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“Everything we try to do to prevent things like HIV or smoking in terms of education is farcical because in the end, it is people's circumstances which determine their behaviour. People are prepared to take risks when there is nothing much else in their lives. When you can imagine a future worth living for, then those risks become unacceptable and you are prepared to change your behaviour.” Int 6.

# Feasibility of intervention

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- ( Pessimistic that intervention could be implemented using usual care providers
- ( Public health service in crisis
- ( Budget cuts, staff shortages, increased patient loads
- ( Working conditions extremely demanding
- ( Nursing shortage a “state of emergency.”
- ( Exodus of experienced staff; fewer graduates; falling standards of training in midwifery

# Feasibility of intervention

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( Doctors feeling frustrated, angry, despondent

“At the moment, government seems too short sighted to act. People at the top don't appreciate the crisis on the ground or they simply don't care.” Int 9.

“If we were really a country that was in a huge financial crisis it might be understandable. But I don't think SA is at that stage, so it is unjustifiable to allow our services to deteriorate like this. It demoralises everybody because you are actually practising sub-standard medical care.” Int 14.

# Midwives' involvement

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- ( Doctors expressed concern for mws
- ( Mws not receptive to introduction of new programme

“The mws are having a terrible time. There is not enough staff, there is too much work and with HIV, there is more complex work. So, I think involving the mws in your project would be very difficult.” Int5.

# Feasibility of intervention

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( Too little time or capacity to provide health education

“When doctors and nurses are in stress survival mode, they are not going to have to time or inclination to sit down and spend time talking to patients. The situation is really affecting the quality of care we can give to patients.” Int 8.

“An inevitable consequence of the situation is that you become desensitised to the patient as a human being. I am doubtful your intervention could work in the current situation.” Int 6.

# Intervention

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- ( Intervention would need to ease pressure felt by staff
- ( Bring in additional staff; be independently administered and funded
- ( Doctors and nurses in a supportive role
- ( Educational resources directly to pw
- ( Alleviate the tedium of waiting for consultation

# Summary

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- ( Doctors not taking full advantage of opportunity pregnancy affords for smoking cessation
- ( Often a problem orientated approach, not identified as a priority
- ( Doctors not using most effective methods: do not assess readiness to quit, discuss strategies for quitting, ensure follow up, offer self help materials
- ( Pessimistic about influencing smoking behaviour

# Summary

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- ( Sympathy for barriers faced by disadvantaged pw entrenches this attitude
- ( Similar attitudes to midwives
- ( Disinclination to counsel pw about smoking related to: medical orientation and training; lack of confidence in skills, poor knowledge of proven efficacy of interventions;lack of guidelines and appropriate resources.
- ( Most significant barrier: crisis in health services inimical to health education activities

# Recommendations

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- ( Convince doctors of effectiveness of smoking cessation interventions
- ( Smoking cessation during pregnancy a standard of good practice, provide guidelines
- ( Need opportunities to improve communication skills and understand processes of behavioural change
- ( Provision of self help materials to be offered in context of brief, structured advice by prenatal care provider

# PW endorsement of doctor's role

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- ( In survey of pw: doctors most trusted source of information about smoking cessation
- ( 94 % of pw reported that they would like to participate in a programme if it were delivered as part of antenatal care

# Health administrators

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- ( Acknowledgment of smoking during pregnancy as important and relevant
- ( High rates of smoking and alcohol consumption among coloured pw
- ( High rates of LBW identified as priority concern, important health indicator, high cost to health service. Obstetric haemorrhage ranks 4th most common cause of maternal mortality
- ( Welcomed project, fits in with national strategy on tobacco, RCT to evaluate intervention, evidence based guidelines

# Health Administrators

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- ( Expenditure increasing 10 -12% , increased access
- ( WCape share of national health budget declining since 94. Greater equity to other provinces.

“Western Cape has been through a difficult period of downsizing and has lost over 9000 staff since 1994. This has undoubtedly put a huge strain on individuals, but nevertheless the WCape remains better staffed and better funded than virtually every other provincial service. It is still rendering good services to a lot of people. But this is not to deny that there are real shortages in certain areas.”

# Health administrators

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- ( Provincial policy: divert funds to primary care
- ( Lack of national norms for staffing is problematic, difficult to evaluate staff shortages objectively.
- ( Recognition of nurse shortages: Brain drain a global phenomenon; lack of mentorship; decreased number of graduates, HIV deaths
- ( Restructuring causing uncertainty and disruption
- ( Conditions need to improve for nurses (remuneration, career paths, training standards)
- ( Negative attitudes of nurses, counselling skills a critical need

# Health administrators

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- ( Nurses designated health education function
- ( Cautioned against a top down approach for intervention
- ( Sensitive to mws difficulties, peer educators (MTCT programme a successful model)
- ( Intervention cannot lengthen consultation time