Sexual & Reproductive Healthcare 6 (2015) 114–118

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Lifestyle habits and women's attitudes towards discussing them at a visit for contraceptive advice

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ARTICLE INFO

Article history:
Received 27 February 2014
Revised 6 August 2014
Accepted 15 August 2014

Keywords:
Contraception
Counselling
Alcohol drinking
Life style
Tobacco
Body weight

ABSTRACT

Objective: The aims of this study was to use visits for contraceptive counselling as opportunities for examining women's actual life style habits with the main focus being placed on alcohol consumption but also to evaluate the women's opinions about discussing their alcohol and tobacco habits and their weight status.

Methods: A total of 535/802 (67%) women completed a study-specific anonymous questionnaire after a contraceptive counselling visit with a midwife.

Results: A majority of the women thought that a discussion concerning alcohol habits at a contraceptive counselling session was important (85.5%) and not intrusive (86.4%) neither embarrassing (81.7%). Women with high-risk drinking habits were younger, more often tobacco users and more often planning for childbirth in the future, compared with women who did not display high-risk drinking behaviour. A significantly higher percentage of women who practiced high-risk drinking thought that a discussion of alcohol was intrusive (10.9%) and embarrassing (46.7%), compared with women not practicing high-risk alcohol consumption. Most women (72.9%) stated that no other caregiver during the preceding year except the midwife had discussed drinking habits with them. The weight was a good thing that the midwife brought up for discussion according to 82.5% of the women but the discussions about weight was more often found embarrassing (18.4%) than the discussion about alcohol habits.

Conclusion: Women who came for contraceptive counselling found the discussion concerning alcohol habits important, not intrusive or embarrassing and a good thing to be brought up by the midwife.

Introduction

Most women who come for contraceptive counselling are of childbearing age and are, in general, quite healthy with few other health care contacts. However, a recent national survey (2013) concerning lifestyle factors found that 6% of Swedish women aged 16–29 were obese, with body mass index (BMI) ≥ 30; comparable figures for women aged 30–44 were 11% [1]. Another part of the survey reported that 24% of women aged 16–29 displayed a high-risk use of alcohol whereas only 9% of women aged 30–44 displayed this practice [2]. Hazardous drinking was defined as a consumption of more than nine standard glasses (12 g pure alcohol) per week or binge drinking more than three standard drinks on a single occasion [3]. Yet another section of the survey reported that 12% of a younger cohort were daily smokers in comparison with the older group of women where 7% were daily smokers [4]. An unhealthy life style poses a high risk for complications later in life [5–8]. The adverse outcomes of obesity, alcohol and tobacco consumption before and during pregnancy are well established [9–14].

There are a few Swedish studies that have investigated the extent to which patients in primary care have been questioned and have received advice about their health behaviours [15–17]. Studies reported varying degree of discussions around lifestyle habits. If lifestyle habits were discussed, the alcohol issue was touched to a lesser extent than issues concerning exercise, diet and tobacco.

Several studies have had the goal of investigating alcohol habits, consumption before and during pregnancy and perceptions of antenatal advice among women of childbearing age [18–21], whereas among women in fertile age in contraceptive counselling, there are few studies, if any, which have investigated alcohol habits and opinions about discussing life style factors at these visits. It appears to us that staff at the contraceptive counselling units might have an excellent opportunity to discuss life style aspects and to inform women about the importance of general alcohol abstinence when planning pregnancy. We do not yet have any knowledge about how the women relate to such information if provided during counselling.

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http://dx.doi.org/10.1016/j.srhc.2014.08.002
1877-5756/

The primary aim of this study was to examine women's actual life style habits with the main focus being placed on alcohol consumption. The secondary aim was to evaluate women's opinions about being engaged in discussions about their alcohol and tobacco habits as well as their weight status, discussions that might take place when they are receiving contraceptive counselling.

Methods

Contraceptive counselling in Sweden is free of charge. Physicians as well as midwives can provide this counselling, but commonly midwives are the counsellors. During a visit at a family planning clinic the midwife will provide contraceptive counselling, ask questions about medical history, measure blood pressure, weight, and height (the latter for defining the woman's BMI). The midwife may even ask the woman about her life style habits, for example her use of tobacco and alcohol. The midwife gives positive and negative feedback to the woman and will pay attention to the good as well as harmful parts of what she is told. She also offers the woman the chance to discuss these behaviours. If needed, the midwife carries out a gynaecological examination. A visit for contraceptive counselling is 30 minutes. The midwife is licensed to prescribe all available hormonal contraceptive methods. Swedish women taking oral hormonal contraceptives as well as those who have a patch or vaginal ring are recommended to visit a family planning clinic every second to third year for medical check-up.

Swedish-speaking women (n = 802) who visited a midwife in a family planning clinic in Linköping during a 6-month period in 2010 were asked to complete a study-specific anonymous questionnaire after their visit. The questionnaire comprised of 18 questions covering socio-demographic factors, assessment of the women's general health status and alcohol habits. Further, the women were asked to estimate the importance of discussing alcohol habits at a contraceptive counselling. The study participants were also asked on the impression of the discussion with the midwife concerning alcohol and tobacco habits and the weight, whether the discussion was intrusive, embarrassing or a good thing. They were also asked if any other medical health care giver other than a midwife had asked them about their alcohol habits during the preceding year. Finally, they were asked to give their opinion about important factors in general that might decrease people's consumption of alcohol. The completed form was dropped by the women themselves in a box at the reception of the clinic. A total of 535 women (67%) answered the questionnaire.

Concerning the women's alcohol habits the Alcohol Use Disorders Identifications Test – Consumption (AUDIT-C) questionnaire was used [22]. The questions concern frequency of drinking, typical quantity of alcohol consumed and frequency of binge drinking (i.e., consuming a larger quantity at one occasion) during the preceding year. Each of the questions has a set of five responses to choose from, and each response has a score ranging from 0 to 4 points to yield a summary score ranging from 0 to 12. The threshold for alcohol misuse has been discussed. Bush et al. [22] and Bradley et al. [23] suggest in their studies including a population of US women ≥3 as a cut-off point, whereas a study by Rumpf et al. [24] in a North European population recommend a cut-off point of ≥5. In a Swedish study among pregnant women the cut-off point of ≥6 was used for expanded information and advice [25]. In this study the same cut-off level is used. The AUDIT form was filled in by the women during the visit. No extra time was added to the normal given time for contraceptive counselling.

In a sub-analysis we evaluated data depending on the AUDIT points. Women who got less than 6 AUDIT-points constituted a low risk group (LRG) and women who got 6 or more AUDIT-C points constituted a high risk group (HRG).

The study was conducted following the ethical principles of the Helsinki Declaration.

Statistics

All analyses were performed using the IBM SPSS programme, version 19.0 (IBM Corp., Armonk, NY, USA). Statistical significance was defined as (two-sided) $p \leq 0.05$. Data are reported as numbers and percentages. Group differences were estimated by using the Chi-square test on categorical variables. Furthermore, to make a more comprehensive assessment of group differences between the LRG and HRG, binary logistic regressions were performed with the participators' experience and attitudes towards discussing alcohol and tobacco habits and weight as dependent variables. These two variables were dichotomized into *agree* (containing three positive answering alternatives) and *disagree*. The grouping variables have been adjusted for age, parity, marital status, tobacco use, education level, assessment of general health and group.

Results

Background characteristics and lifestyle habits among the women (n = 535) who participated in the study are displayed in Tables 1 and 2. We also investigated the background characteristics in the LRG and HRG (Table 3).

A majority of the women (72.9%) stated that no caregiver other than the midwife had discussed drinking habits with them during the preceding year, whereas 7.1% said that they had talked about this at a visit in primary care. Fewer than 4% of the women had discussed this habit at the adolescent-, student- and/or occupational health service. Most of the women (85.5%) also stated that a discussion concerning alcohol habits is important at a contraceptive counselling session (Table 2). In a sub-analysis

Table 1
Background characteristics of the study population (n = 535).

	N	%
Age; years		
<19	13	2.4
20–24	146	27.3
25–29	163	30.5
30–34	61	11.4
35–39	69	12.9
>40	81	15.1
Did not reply	2	0.4
Parity		
No previous children	327	61.1
≥1 previous children	205	38.3
Did not reply	3	0.6
Planning for childbirth in the future[a]		
Yes	327	72.3
No	119	26.3
Did not reply	6	1.3
Marital status		
Married/cohabiting	336	62.8
Other family situation	196	36.7
Did not reply	3	0.6
Education level; year		
≤9	16	3.0
10–12	193	36.1
≥13	320	59.8
Did not reply	6	1.1
Occupation status		
Gainfully employed	362	67.7
Unemployed	25	4.7
Student	124	23.2
Leave of absence	15	2.8
Sick-leave	7	1.3
Did not reply	2	0.4

[a] Among women <40 years.