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Ing-Marie Claesson, Eva Hultgren and Marie Blomberg



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

Ing-Marie Claesson, Eva Hultgren, Marie Blomberg.

Division of Obstetrics and Gynecology, Department of Clinical and Experimental Medicine, Faculty of Health Sciences, Linköping University, Department of Obstetrics and Gynecology in Linköping, County Council of Östergötland, Linköping, Sweden

Short title: Discussing lifestyle habits at contraceptive counselling

Keywords: Contraception, counselling, alcohol drinking, life style, tobacco, body weight.

Correspondence:
Ing-Marie Claesson
Division of Obstetrics and Gynecology
Department of Clinical and Experimental Medicine
Faculty of Health Sciences
Linköping University
SE - 581 83 Linköping, Sweden
Tel. +46101032923
Fax: +46 13 148156

**Email:** Ing-Marie.Claesson@liu.se

## 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.

Keywords: Contraception, Counselling, Alcohol drinking, Life style, Tobacco, Body weight.

## 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.

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 between, 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 $\geq$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 $\geq$5. In a Swedish study among pregnant women the cut-off point of $\geq$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 we investigated whether this opinion differed between women in the LRG and HRG, but no significant difference was found ($p=0.821$).

The study participants' experience and attitudes towards discussing alcohol and tobacco habits and the weight with the midwife are shown in Table 4. A majority of the women thought that the discussion about alcohol and tobacco habits and the weight was not intrusive or embarrassing and that it was a good thing that the midwife brought up the topic for discussion. In a sub-analysis we investigated the differences of these impressions, between the LRG and HRG. There was a significantly higher percentage of women in the HRG who thought that the discussion about alcohol habits was intrusive (10.9 %) and embarrassing (46.7 %), compared with women in the LRG (5.3 %, 6.9 % respectively) ($p=0.008$, $p<0.001$ respectively). There was also a higher percentage of women in the HRG who thought that the discussion about tobacco use (35.3 %) and weight (42.1 %) was embarrassing, compared with women in the LRG (7.9 %, 19.4 % respectively) ($p<0.001$, $p=0.011$ respectively). After adjusting these two dependent variables for socio-demographic factors there was still a

difference between the two groups concerning whether the discussion about the alcohol and tobacco habits and weight was embarrassing (alcohol; odds ratio (OR) 13.86, confidence interval (CI) 6.77-28.36, $p<0.001$, tobacco use; OR 2.86, CI 1.14-7.17, $p=0.026$, weight; OR 2.64 CI 1.27-5.48, $p=0.009$). There was no difference between the groups concerning the opinion that it was good that the midwife brought up the topic for discussion ($p=0.277$).

The women were further asked to assess which factors might influence people in general to decrease or stop drinking. A majority of the women considered that poor health (91.6 %), partner (78.1 %), friends (76.7 %) and health professionals (68.8 %) had an important influence on decision-making. Media had an unimportant influence according to 68.0 % of the study population. In the following sub analysis we found that significantly fewer women in the HRG (54.4 %) said that health professionals had an important influence on the decision to decrease or stop drinking, compared with the women in the LRG (74.4 %) ($p=0.028$).

## Discussion

In this large descriptive study a majority of the women stated that a discussion taking place during contraceptive counselling concerning alcohol habits and their weight was important. Only half of the women found a discussion about tobacco use important. A significantly higher percentage of women in the HRG thought that the discussion about their weight, alcohol and tobacco use was intrusive and embarrassing compared with women in the LRG. Most women had not discussed drinking habits during the preceding year with any health caregiver other than the midwife. The midwives in the Swedish antenatal and contraceptive units are familiar with discussing life style factors when facing pregnant women. The climate during these talks is critical for the result. The more the talk is characterized by empathy and respect for the situation of the women the more relaxed the conversation will be. The concept of motivational interviewing is useful when the aim of the talk is to make conscious of the problem and to increase the motivation for changing habits [26]. Most of the Swedish midwives are familiar with this concept and use it when they meet pregnant women. The concept might also be useful when discussing life style habits in contraceptive counselling situations. As there was a greater percentage of women in the HRG than among the women in the LRG who thought that the discussion about the weight, tobacco and alcohol habits was intrusive and embarrassing, it is challenging for the midwife to design a discussion where all women can feel comfortable and in line with the spirit of motivational interviewing, i.e. an approach characteristic of collaboration about a change, but also with respect for the women's decision not to make a change [26]. A majority of the women in the HRG stated that they were planning for childbirth in the future. Based on this fact, the midwife has an important task to provide information about the importance of abstaining from alcohol when planning for pregnancy.

The area of lifestyle habits does not always have an obvious place in the discussion with caregivers. In a study by Johansson et al. [15] the majority of the patients reported that they could not recall having received any lifestyle advice at their most recent visit at the primary care centre, whereas in the study by Ahacic et al. [17] 19–30% of the women reported that they had discussed life style habits at health care visits during the preceding year. These results differ from what general practitioners (GPs) and nurses in primary health care report [16]. The GPs stated that they frequently (more than 80 %) discussed smoking and exercise habits with their patients, whereas the nurses discussed these areas with 70-80 % of their patients. Alcohol habits were considered to a much lower degree, 50 % and 28 % of GPs and nurses respectively [16]. On the other hand, only a total of 19 % of the female participants in the study by Ahacic et al. [17] reported that they had been questioned about alcohol use and only 1 % of the women stated that they had received any advice or help, whereas 5 % of all participants in the study by Johansson et al [15] reported being given advice on the alcohol issue. In this last mentioned study there was a gender difference. Male patients received advice more than twice as often as female patients [15]. In the present study 7 % reported that they had discussed alcohol habits at visits in primary health care during the preceding year, but most of the women stated that no caregiver other than the midwife had asked questions about alcohol habits during the past year. An explanation could be that women in this sample were a quite healthy group and therefore only had visited primary care on a few occasions. Another explanation could be that it is still taboo to discuss alcohol habits among women.

A majority of the participants in this study stated the importance of discussing alcohol issues at a contraceptive counselling visit and declared that it was good that the midwife brought up the topic for discussion. The care seeker's view really differs from the care givers. Around 15-17 % of GPs and nurses reported that the reason for not addressing alcohol issue was the

potentially negative patient response [16]. In the study by Johansson et al. [15] around 35 % of the female patients expected being given advice about alcohol use but did not receive it at the visit with the GP. The patients who received advice were more satisfied with the visit than those who did not receive advice.

The HRG shows differences in comparison with the sample of women who engage in high-risk drinking in "Health on Equal Terms? - The National Survey of Public Health" (HET) study [27]. The Public Health Agency of Sweden investigates every year the health situation in the population. A sample of 20000 men and women in age 16-84 years, are asked to complete the questionnaire HET encompassing questions about living habits (e.g. alcohol and tobacco use, physical activity, eating habits, overweight and obesity). In the present study the percentage of younger women (<30 year) engaging in high risk drinking was greater than among women in the same age-class (<30 year) in HET, 85 % versus 24 %. The percentage of students (40 %) in the present study was also higher than the percentage of students in the HET (10 %). Alcohol habits among students have been studied earlier [28-31]. Dantzer et al. [28] investigated heavy drinking habits (four drinks or more on at least one occasion over the past 2 weeks) among 10000 female students aged 17-30 years in 21 developed and developing countries and found wide variations in the prevalence of drinking at this level. A total of 3 % of female students in Germany, Italy and South Africa reported heavy drinking, whereas 57 % of Irish female students reported the same. A study by Andersson et al. [29] aiming to analyse drinking habits among 1300 university students showed that more than 50 % of female students younger than 26 years old reported heavy episodic drinking, defined as four or five drinks or more at one occasion. The corresponding rate for female students in age-class 26-30 was 39 %. Among male as well as female students the proportion of risky drinkers were around 56 % [30]. Risky alcohol habits, defined as AUDIT-C $\geq$5 points have

been investigated in a sample of 300 female medical students [31]. Twenty-four per cent of these students were risky drinkers during their first study year.

A total of 103 women were tobacco users but only 86 % of them reported that they had discussed tobacco habits at the visit. It is possible that this part of the counselling which consisted of two questions only had passed faster than the parts concerning alcohol habits and weight/BMI. The woman was asked to complete the AUDIT form and that led obviously to a more extensive follow-up discussion. The circumstances might have been the same when it comes to weight. A reflection and discussion followed obviously after measuring the weight and calculating the woman's actual BMI. On the other hand, the midwife who also takes care of pregnant women is familiar with tobacco issues. It is thought possible that tobacco use during pregnancy emphasized deeper discussions than among non-pregnant patients.

This study has weaknesses as well as strengths. Unfortunately, information on the woman's actual BMI at the visit was not available which makes comparisons of attitudes towards discussing weight impossible over the BMI strata. The selected cut-off point is based on previous study result [25]. A lower cut-off level would increase the number of women belonging to the HRG and possibly the relationship between the two groups. However, this study is, to our knowledge, the first one investigating opinions about discussing life style factors in contraceptive counselling and our results indicate that a majority of the women found a discussion concerning alcohol habits and weight as important at the contraceptive counselling. Our results also indicate that fewer women in the HRG assessed that health professionals had an important influence on making a decision to decrease or stop drinking, compared with the women in the LRG. Therefore there is a challenge for midwives who face women in contraceptive counselling to develop the information in an appropriate manner.

## Declaration of Conflicting Interests

The authors declare that there is no conflict of interest

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**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

**Table 2. Lifestyle habit inventory of the study population** (n=535)

| | N | % |
|---|---|---|
| **Assessment of general health** | | |
| Excellent | 86 | 16.1 |
| Very good | 272 | 50.8 |
| Good | 148 | 27.7 |
| Fairly good | 27 | 5.0 |
| Bad | 0 | 0.0 |
| Did not reply | 2 | 0.4 |
| **Tobacco users** | | |
| No | 429 | 80.2 |
| Yes | 103 | 19.3 |
| Did not reply | 3 | 0.6 |
| **Discussed tobacco habits at the visit[a]** | | |
| No | 12 | 11.7 |
| Yes | 89 | 86.4 |
| Did not reply | 2 | 1.9 |
| **Discussed the weight/BMI[b] at the visit** | | |
| No | 72 | 13.5 |
| Yes | 456 | 85.2 |
| Did not reply | 7 | 1.3 |
| **The importance of discussing alcohol habits at a contraceptive counselling** | | |
| Very important | 209 | 39.1 |
| Quite important | 248 | 46.4 |
| Not so important | 66 | 12.3 |
| Not at all important | 6 | 1.1 |
| Did not reply | 6 | 1.1 |
| **AUDIT[c] points** | | |
| <6 points | 467 | 87.3 |
| ≥6 points | 47 | 8.8 |
| Did not reply | 21 | 3.9 |
| **Frequency of drinking over the past year** | | |
| Abstainer | 21 | 3.9 |
| Once a month or less | 165 | 30.8 |
| 2–4 times per month | 287 | 53.6 |
| 2–3 times per week | 50 | 9.3 |
| 4 times per week or more | 6 | 1.1 |
| Did not reply | 6 | 1.1 |
| **Typical quantity of drinking among users** | | |
| 1-2 standard glasses† | 237 | 44.3 |

| | | |
|---|---|---|
| 3–4 standard glasses | 199 | 37.2 |
| 5–6 standard glasses | 64 | 12.0 |
| 7-9 standard glasses | 12 | 2.2 |
| 10 or more standard glasses | 2 | 0.4 |
| Did not reply | 21 | 3.9 |
| | | |
| **Frequency of heavy episodic drinking (6 glasses or more per occasion)** | | |
| Never drink heavy episodic | 187 | 35.0 |
| Less often than once a month | 275 | 51.4 |
| Every month | 49 | 9.2 |
| Every week | 10 | 1.9 |
| Daily or almost daily | 0 | 0 |
| Did not reply | 14 | 2.6 |

[a] Among tobacco users.
[b] BMI = Body Mass Index.
[c] Alcohol Use Disorder Identification Test.
† 1 standard glass=12 g of pure alcohol.

**Table 3.** Background characteristics among women in the low- and high risk group concerning their points in the Alcohol Use Disorders Identifications Test; < or ≥ 6 points

| | **Low risk group < 6 points** | | **High risk group ≥ 6 points** | | |
|---|---|---|---|---|---|
| | **n** | **%** | **n** | **%** | ***p*[a]** |
| **Age;** year | | | | | 0.002 |
| ≤19 | 12 | 2.6 | 1 | 2.1 | |
| 20-24 | 118 | 25.3 | 24 | 51.1 | |
| 25-29 | 141 | 30.3 | 15 | 31.9 | |
| 30-34 | 56 | 12.0 | 1 | 2.1 | |
| 35-39 | 64 | 13.7 | 3 | 6.4 | |
| ≥40 | 75 | 16.1 | 3 | 6.4 | |
| **Parity** | | | | | <0.001 |
| No previous children | 276 | 59.4 | 41 | 87.2 | |
| ≥1 previous children | 189 | 40.6 | 6 | 12.8 | |
| **Planning for childbirth in the future**[b] | | | | | 0.022 |
| Yes | 277 | 71.6 | 37 | 88.1 | |
| No | 110 | 28.4 | 5 | 11.9 | |
| **Marital status** | | | | | <0.001 |
| Married/cohabiting | 305 | 65.6 | 16 | 34.0 | |
| Other family situation | 160 | 34.4 | 31 | 66.0 | |
| **Tobacco users** | | | | | <0.001 |
| No | 392 | 83.7 | 24 | 51.1 | |
| Yes | 76 | 16.3 | 23 | 48.9 | |
| **Education level**; year | | | | | 0.059 |
| ≤9 | 11 | 2.4 | 4 | 8.5 | |
| 10-12 | 169 | 36.6 | 17 | 36.2 | |
| ≥13 | 282 | 61.0 | 26 | 55.3 | |
| **Occupation status** | | | | | 0.036 |
| Gainfully employed | 327 | 70.2 | 25 | 53.2 | |
| Unemployed | 21 | 4.5 | 3 | 6.4 | |
| Student | 101 | 21.7 | 19 | 40.4 | |
| Leave of absence | 12 | 2.6 | 0 | 0.0 | |
| Sick-leave | 5 | 1.1 | 0 | 0.0 | |
| **Assessment of the general health** | | | | | <0.001 |
| Excellent | 78 | 16.7 | 3 | 6.4 | |
| Very good | 244 | 52.4 | 20 | 42.6 | |
| Good | 128 | 27.5 | 16 | 34.0 | |
| Fairly good | 16 | 3.4 | 8 | 17.0 | |
| Bad | 0 | 0.0 | 0 | 0.0 | |

[a] Comparison between LRG (<6 p) and HRG (≥6 p) was made using chi square test

[b] Among women <40 years

**Table 4**. The study participators' impression of the discussion with the midwife concerning alcohol and tobacco habits and the weight.

| | **Agree completely or partially** | | **Disagree** | | **No opinions** | | **Did not reply** | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| "The discussion about the **alcohol habits** was intrusive" | 30 | 5.6 | 462 | 86.4 | 21 | 3.9 | 22 | 4.1 |
| "The discussion about the **tobacco habits** was intrusive" | 12 | 2.3 | 326 | 60.9 | 8 | 1.5 | 189 | 35.3 |
| "The discussion about **my weight** was intrusive" | 33 | 6.1 | 405 | 75.7 | 11 | 2.1 | 86 | 16.1 |
| "The discussion about the **alcohol habits** was embarrassing" | 53 | 9.9 | 437 | 81.7 | 23 | 4.3 | 22 | 4.1 |
| "The discussion about the **tobacco habits** was embarrassing" | 38 | 7.1 | 291 | 54.4 | 17 | 3.2 | 189 | 35.3 |
| "The discussion about **my weight** was embarrassing" | 98 | 18.4 | 346 | 64.7 | 6 | 1.1 | 85 | 15.9 |
| "It was a good thing that the midwife brought up the **alcohol habits** for discussion" | 445 | 83.1 | 12 | 2.2 | 62 | 11.6 | 16 | 3.0 |
| "It was a good thing that the midwife brought up the **tobacco habits** for discussion" | 287 | 53.6 | 8 | 1.5 | 49 | 9.2 | 191 | 35.7 |
| "It was a good thing that the midwife brought up **my weight** for discussion" | 441 | 82.5 | 11 | 2.1 | 45 | 8.4 | 85 | 15.9 |