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AN EXPLORATION OF MIDWIVES' ATTITUDES TOWARDS GIVING WEIGHT-RELATED ADVICE TO OBESE PREGNANT WOMEN WITH A BODY MASS INDEX (BMI) OF 30kg/m<sup>2</sup> OR MORE

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# An Exploration of Midwives' Attitudes Towards Giving Weight-Related Advice to Obese Pregnant Women with a Body Mass Index (BMI) of 30Kg/m<sup>2</sup> or More.

## Key Phrases

- 1) In the UK midwives are responsible for offering health-related advice to obese pregnant women and women who have recently had a baby, and they have many opportunities to do so.
- 2) Effective interventions to enable pregnant women to manage weight-related behaviours are in development.
- 3) Implementation of interventions is dependent on midwives attitudes and willingness towards providing appropriate information.
- 4) Midwives introspection, for example responses to women's cues and concerns around risking relationships with women hindered advice giving.
- 5) By addressing personal issues around body image midwives would be better placed to develop effective communication techniques and offer obese, pregnant women appropriate weight-related advice.

## Abstract

Maternal obesity is recognised as a challenge for contemporary and prospective maternity services and it is estimated that 1 in 5 pregnant women are obese posing significant risk to maternal, fetal and newborn mortality and morbidity. As key practitioners in maternity care midwives are currently seen as frontline professionals delivering weight related advice to obese pregnant women.

Objective: to explore midwives' attitudes towards offering obese pregnant women weight-related advice during pregnancy and the puerperium.

Design: a qualitative descriptive approach. Nine midwives were interviewed using an in-depth interview schedule. Data were analysed using Colaizzi's (1978) seven-stage thematic approach.

Findings: midwives' knowledge of risk associated with maternal obesity was good; advice giving was mainly confined to community practice; the amount and consistency of advice was determined by: women's responses, women's apparent motivation to change and midwives' self-perception as a role model. Four key themes emerged: challenges for practice; perceived proficiency; advice giving skills and midwives' perceived relationship with a woman.

Implications and Conclusion: midwives need to address personal issues around body image, as they appear to hinder advice giving, before they can develop effective communication techniques to be able to offer obese pregnant women weight-related advice. The recommendation is to investigate ways in which issues of body image influence midwives ability to offer weight-related advice.

## **Introduction**

Maternal obesity is recognised as a challenge for contemporary and prospective maternity services as it is estimated that in 2007 24% of women in the UK aged 16 years or more posing significant risk to maternal, fetal and newborn mortality and morbidity were obese (ONS, 2008). Furthermore 1 in 5 pregnant women have been classed as obese (Soltani, 2009; Richens, 2008a). In the United Kingdom (UK) midwives are the lead professional for providing antenatal care and are responsible for offering obese pregnant women advice, e.g. managing weight and making healthy choices around diet and exercise during pregnancy and the puerperium (Shribman and Billingham, 2009; DH, 2011). Women with a raised BMI i.e.  $\geq 30\text{Kg/m}^2$  at the first 'booking' assessment are identified as obese and subsequently categorised at a higher risk than their non-obese or overweight counterparts (BMI 25.0-29.9Kg/m<sup>2</sup>) and by virtue of this risk access maternity care pathways and care from other healthcare professionals such as obstetricians and dietitians. During pregnancy, obesity poses significant health risks for women, the developing fetus and the developing child, including; increase risk of pre-eclampsia, gestational diabetes, stillbirth, intrauterine growth restriction as well as an increased failure rate of vaginal birth after caesarian section of 25%; (Ramsey et al, 2006; Perez-Pastor et al, 2009; CMACE, 2010 & 2011; DH, 2011, Tennant et al, 2011). Midwives have a number of ideal opportunities to offer guidance and support which is timely as many women feel motivated towards making healthy lifestyle choices during pregnancy (Jackson et al, 2011). However, effective information giving techniques in this context are unclear as are effective support strategies and interventions that improve maternal and neonatal outcomes in the long term (Poston, 2012; Powell and Hughes, 2012; Thangaratinam et al, 2012; Fuber et al 2013). Overall, the promotion of healthy eating

during pregnancy and advice to refrain from dieting dominate advice giving as does the long term goal to enable women to continue to make healthy lifestyle choices postnatally (CMACE/RCOG, 2010; NICE, 2006 & 2010; DH, 2011; Poston, 2012).

Observations in and reflections on clinical practice coupled with emerging literature have identified different attitudes of midwives towards obese pregnant women as has the time, place and nature of advice. For example, midwives have expressed concern about upsetting women whilst pregnant i.e. being the one who spoils the pregnancy and risking the chance to develop a bond and trusting relationship with women. Other midwives have been observed to assess obese women's knowledge of personal risk during pregnancy and, subsequently, place full responsibility upon women to take action or make women feel humiliated or stigmatised about their size (Fuber et al, 2011; Schmied et al, 2011; Smith et al, 2012). Consequently, some midwives absolve themselves from the responsibility of addressing issues around obesity. Such observations have been reported for sometime as Pervin (2003) noted that when women were already aware of the associated risks of obesity during their pregnancy midwives made no impact on their behaviour. This was consistent whether the midwives' advice was positive, e.g. giving regular advice and checking progress about healthy eating during pregnancy; neutral, e.g. acceptance that women will decide without any proactive involvement from the midwife; or ambivalent, e.g. if women were interested in weight-related advice then that was acceptable and midwives would respond; if not, that was equally acceptable and no action was required.

Further challenges for midwives have been noted in particular subconscious biases influencing personal attitudes and beliefs which may well alter the way in which

midwives provide advice (Hollins-Martin and Bull, 2008; Irwin, 2010). Indeed, Knight and Wyatt (2010) highlighted that midwives' attitudes were a potential barrier to the recruitment of obese pregnant women in their study on dietary interventions which impacted on both recruitment to their study and random allocation.

Maternal obesity has been highlighted as a high risk condition as it increases financial costs to maternity services by virtue of specialist equipment and increased time for consultation and antenatal assessments due to difficulty in fetal monitoring for example. A potential litigious situation could arise where a sub-optimal outcome could occur as a consequence of obesity and where there was no evidence of weight-related advice or appropriate management of an obese pregnant woman particularly if the woman isn't sufficiently obese to warrant a specialist care pathway (Symon, 2006; Griffith, 2008; NHSLA 2012). The NHS Litigation Authority's analysis of maternity claims (2000-2010) found 0.1% of births were subsequently part of a claim to the value of £3.1 billion during this period (NHSIA, 2013). Improvements in fetal monitoring and ensuring staff have time to deliver services appropriately were particularly identified as key actions to mitigate against risks (NHSIA, 2012 & 2013); managing and caring for obese pregnant women form part of this ambition.

The literature clearly evidences maternal obesity as an increasing challenge for maternity services from a range of perspectives: e.g. clinical outcomes; women's experiences; the education of midwives; resource intensiveness; practical challenges and unknown effectiveness of interventions to enable women in the long term (Heslehurst et al, 2007; Bainbridge, 2008a; Keller et al, 2008; Heslehurst et al 2013). However, interventions can only be effective when implemented as they were intended. This relies on midwives being equipped with appropriate knowledge, skills and motivation. All of these elements

are influenced by attitudes towards the health issue in question. Currently there is a surge in investigations of midwives' and or healthcare professionals' attitudes towards giving health related advice to obese pregnant women and plausible interventions possibly because of a paradox between wanting to care and not knowing how within this context (Nunes 2009; Herring et al 2010; Schmied 2011; Smith et al 2012; Heslehurst et al 2013).

This paper presents findings from a qualitative study exploring midwives' attitudes towards giving weight-related advice to obese pregnant women with a Body Mass Index (BMI) of 30Kg/m<sup>2</sup> or more and adds to the current literature as each study reveals new complexities.

## **Method**

A social constructivist world view was adopted for this study (Neuman, 1991; Cresswell, 2009) which enabled an investigation into complex interplay between respondent's personal perspectives on their clinical practice. The extent to which the first author (researcher) assessed the real situation i.e. the credibility of the study, was judged by the co-author who judge the researcher's interaction, behavior, influence and shape on data collection (questioning) and the endorsement of two transcriptions from original audio-recording of data as suggested by Oppenheim (1992) and Gomm et al (2008).

Dependability was assured by using an interview guide and co-author endorsement of the analytical journey by independently coding and comparing two different transcripts.

Reflexivity also enabled the researcher to reflect on and account for the influence of her presence when collecting, analysing and interpreting data. These processes are helped to address potential bias so that the value and aim of the study was maintained (Bowling, 2002; Green and Thorogood, 2004). The most significant potential bias was the possible

conflict of interests between the researcher's clinical roles whilst undertaking the role as researcher. Assurance offered at the local research ethics committee and lengthy discussions with the co-author helped to balance the first author's positioning as a 'researcher'. It has been suggested (Green and Thorogood, 2004) that credibility and dependability would be increased by returning data to participants so that they could recognize themselves within it. But Bailey (1997) cautions against this; noting that participants may not view or analyse data in the same way, possibly leading to discrepancies of opinion. Thus, member checking did not take place and stage 7 of Colaizzi's (1978) analytical framework was not utilised (Table 2).

### Participants

A non-probability, purposeful sampling approach was used to recruit a target of 10 participants who could best inform the research question (Neuman, 1991). Participants' information sheets (PIS) were posted to 110 midwives within an NHS Trust in England with a covering letter inviting potential participants to contact the researcher. There were no exclusions as all midwives were in roles where they could deliver weight-related advice to obese pregnant or postnatal women, and could provide a rich description of their thoughts and attitude (Neuman, 1991). Seventeen midwives responded (16%), 10 were purposively selected from community and hospital settings and across age groups to ensure variation in the sample and offered an interview. The remaining 7 midwives were thanked for their interest, by letter, once the sample was agreed.

### Data Collection

One-to-one in-depth interviews were undertaken using a topic guide with open ended questions; prompts and probes were used as a means to orientate participants thoughts



and draw responses as suggested by Oppenheim (1992) (Table 1). All participants chose the hospital premises to be interviewed and agreed to it being audio-recorded.

### Data Analysis

A thematic analysis using Colaizzi's (1978) seven-stage approach was used (Table 2) which ensured a thorough data analysis through a comparative process of participants' accounts. This included coding and classification of data into themes representing the phenomenon i.e. midwives' attitudes to giving weight-related advice to obese pregnant women. To strengthen the credibility of the analysis, themes were generated directly from data; all emerging themes given equal importance.

### Ethical Consideration

To meet NHS standards, ethical approval was sought and secured by Local Research Ethics Committee (National Research Ethics Service; NRES) and NHS Research and Development Governance to secure access to NHS staff.

### Findings

Of the 10 midwives invited to interview 9 actually took place; five hospital midwives and 4 community midwives; 1 interview could not be arranged within the period of data collection. The age of participants ranged from 29-52; years in clinical practice ranged from 4-23years. Potential selection bias was apparent as midwives who volunteered were similar in their ability to engage with the interview process and provide candid, open responses; therefore, by default, different to those midwives who didn't volunteer to take part. Four participants had less than one year's clinical experience and whilst the

sampling criteria did not include a range of BMI amongst participants, this appeared to occur surreptitiously as noted by respondents' comments.

Four thematic clusters emerged from the data; text in italics refers to participants' descriptions and the wider literature drawn upon to support or refute emerging themes to assure believability (Bowling, 2002). Examples of participant's narrative are presented to ground analytical summaries in the data (Green and Thorogood, 2004). Responses were coded e.g. I2 relates to interview two; quotations from all respondents are included. Key themes are drawn into the discussion

### **Thematic Cluster 1: Challenges for Practice.**

This cluster related to challenges universally expressed by participants about the clinical environment. It includes reference to midwives feeling pressured with managing their time; the availability of bariatric equipment to undertake clinical assessments and concerns when clinical procedures were more complex and findings uncertain because maternal obesity hindered practice.

*“You can't hear the fetal heart sometimes...for very big women you can't do a vaginal examination, it (obesity) makes it more difficult” I5*

*“It can take longer to find the fetal heart so a 5 minute job can take a lot longer and when you've got a list of jobs in you're head still that need doing...” I9*

Feeling pressured in terms of managing time emerged amongst both community and hospital locations although some participants did candidly acknowledge that even if they

were given more time they would not necessarily use it to give weight-related advice. This was explained, in part, due to prioritising women's other needs above obesity and partly because it was a less enjoyable aspect of participants' practice. Such practical challenges have been recognized by others too. For example, Heslehurst et al (2007), Richens (2008a) and Cullum (2009) have reported similar findings especially in relation to negative attitudes towards additional financial cost associated with special equipment e.g. large blood pressure cuffs and additional scans to confirm fetal size and presentation when abdominal examination is too difficult to be accurate and remained uncertain.

### **Thematic Cluster 2: Perceived Proficiency**

This cluster of themes was concerned with midwives perceptions of personal competence in giving weight-related advice; including their knowledge about the risks associated with maternal obesity and weight-related terminology.

*“The advice I give, I feel, is safe. I think it's relevant but I think it's lacking because I don't have the knowledge” I1*

*“I don't use the word obese, I think it's insulting” I3*

Participants seemed unsure of the meaning of terminology. For example, reference was made to “the very, very, very, *obese lady*...” which equates to the term super-morbidly obese in professional context. Others used softer expressions: *Little Miss Skinny...Miss Average....Miss Extra Large*” I1

Endearing labels seemed more concerned with sanitising weight-related terminology so women were not offended and participants not left feeling uncomfortable or risk alienating women and spoiling their relationship. There is a consensus about the value of a good relationships with women but midwives must recognise their own limitations e.g. recognise inappropriate terminology, and move forward with giving accurate advice to enable, empower and educate women (Richens, 2008a; Pearson, 2009; West, 2010). The terminology midwives use to depict overweight and obese women and feelings towards terminology need further exploration to enable us to understand why it is used. In addition, the most acceptable terminology preferred by women isn't clear although terms such as 'weight', 'excessive weight' and BMI have been shown to be desirable in other contexts (Wadden and Didie 2003).

Most participants' knowledge about the risks of maternal obesity was good, which others have found too (Nunes, 2009), which helps to allay concerns that midwives' lack of awareness may marginalise the importance of offering advice (Griffith, 2008; Cullum, 2009); indeed in this study other factors seem to be influencing participants' behaviour.

### **Thematic Cluster 3: Advice Giving**

This cluster of themes relates to participants' comments on factors that enabled, impeded or disabled them in giving weight-related advice. We found that community midwives were used to broaching the subject of weight routinely as part of the booking appointment and accommodated it with varying degrees of equanimity.

*"At the first contact with them you are sort of doing a booking with them...and then you talk about obesity"*19

*“Pregnancy probably isn’t the time to start to tackle weight issues, for that pregnancy, it’s a bit late” I2*

Conversely, midwives in hospital environments seldom, or never, gave advice, explaining that they considered it to be inappropriate due to the shortness of the woman’s hospital stay which precluded building a relationship. It was the nature of the relationship with women which participants’ believed to be crucial to be able to offer weight-related advice. The nature of relationship was unclear though; perhaps participants meant that if they became too close to women it becomes too uncomfortable to offer this type of advice; or the opposite: we don’t know. Richens (2008a) and West (2010) do not support midwives’ hesitation in offering weight-related advice; they urge midwives to manage personal perspectives and concerns about damaging relationships with women (assuming they are formed or an essential criteria in the first place); thus, hesitation must be overcome. However, meeting obese pregnant women has been described as a ‘conversation stopper’ not only because of lack of training on how to manage the context but because suitable wording is difficult to find in a time-limited environment i.e. short antenatal interactions (Smith et al 2012). So whilst reports call for more women accessing weight related advice from midwives (Russell et al 2010) and more time to do so; evidenced based interventions to skill midwives are not currently available.

Participants talked about the varied nature of maternal responses to weight-related discussions, some women putting up barriers, some being receptive and midwives concerns about getting it wrong:

*“I think if you do it wrong you are up against a brick wall because once you’ve got that woman in a position where she thinks you are being judgmental and not giving advice for the right reason...”* I8

Maternal responses enabled or disabled participants’ willingness to give weight-related advice and subsequent support. Women appeared to hold power over the direction of communication and information giving. The latter needs to be overcome as persistence in giving appropriate advice over a period of time, involving women setting their own goals and care management, is reported to increase women’s motivation to change (Claesson et al, 2006; NICE, 2007). Participants talked about their assumptions around maternal motivation towards changing behaviours which seemed to both enable discussion and act as a barrier:

*“I think she knew, and if she knew and couldn’t do anything about it then telling her the risks of it (obesity) were not going to be helpful in any way”* I3

Other authors (Bainbridge, 2008a and b; Cullum, 2009;) have reported similar encounters whereby midwives have been aware that obese pregnant women have known about risks the pregnancy and yet were either unable or disinclined to engage with weight-related advice and guidance. This type of disengagement by midwives was not explored in this study or reported by others sufficiently to help us understand why.

Some participants mentioned society’s attitude towards obesity as both a barrier and lever to enable opportunities for advice giving; such attitudes traversed between acceptance of obese pregnant women and depictions of prejudiced.

*“I think we are judgmental... I think we are a fattist society”* I8

“We are more accepting of society being more overweight” I9

Participants did not explicitly say what effect these attitudes had on their advice giving but the context in which it was mentioned suggested that overweight participants felt marginalised with lower self esteem, making the broaching of weight-related advice more problematic.

Some participant’s felt that obesity is being normalised through its increasing commonality in society and they felt that this may make obese pregnant women less motivated to change behaviors and they may not grasp the associated risks. However, there is no evidence to support participant’s perspectives concerning society’s attitude towards obesity and the influence this may have regarding the reception of public health information on obesity. The media is constantly criticised for promoting unhealthy behaviors through advertising and endorsing fast-foods and fizzy-drinks; conversely, the media was viewed by participants positively for raising awareness of increasing obesity in society. Given the media attention, participants thought women should be aware of the risks of obesity and take responsibility and access help.

“...because of things like the media and fast- *foods*...*fast-* foods can be cheaper than doing home made meals at home, even though there are lots of cookery programmes on television that show *you can cook a well balanced meal in 20minutes*”I5

Bainbridge (2008b) draws attention to how the media asserts pressure on women to maintain a svelte figure whilst pregnant; Cullum (2009) refers to celebrity mothers who return to their pre-pregnancy weight quickly and how this may adversely influence

women postnatally. Both pressures may motivate women towards healthy eating and exercise behaviors but may create anxieties and have the opposite effect; neither address issues for obese women who will need long term plans to reach and sustain a healthy body weight.

Participants made reference to smoking cessation and domestic violence. Some participants commented that delivering weight-related advice was no more easy or difficult than offering advice in these contexts; for others it was more difficult:

*“I think that delivering that advice is no more challenging than asking about domestic violence” I4*

*“I think it’s a very emotive subject and I would be happier saying to someone who smokes “you shouldn’t be smoking because” ...”I8*

There is little support for practitioners who find it easier to address issues of smoking cessation or domestic violence rather than maternal obesity (Buck and Collins, 2007; Ebert et al, 2009; Randall, 2009). Indeed, when midwives avoid addressing these other behavioral issues the same justifications have been given i.e. it’s not my role; it’s not the right time or the right place; as well as enduring assumptions and concerns about upsetting women. Richens (2008b) shares her concerns about such prevarication and calls for midwives to reflect and amend their practice.

#### **Thematic Cluster 4: Midwives’ Relationship with Women.**

The cluster relates to how the majority of participants’ personal attitudes towards body weight-related to their professional attitude towards offering weight-related advice and relationships with women. Only one participant didn’t refer to her own body habitus; she gave the impression of being a confident and reflective practitioner who, by virtue of not



mentioning her own BMI or weight history, gave the impression that it was irrelevant in her professional practice.

*“I think it’s the health professionals that have got the hang up about it, not the women”*

I4

All the other participants regardless, of their BMI, talked about the positive or negative affect it had on their interaction with women when giving weight-related advice.

*“I’m quite pleased I’m a bit bigger because two years ago when I was giving this advice I was quite tiny”* I9

When midwives don’t address obesity because of their own personal ‘hang-ups’ regarding body weight, women may perceive it to be unimportant. As a result, women may not feel empowered to make healthy choices nor benefit from comprehensive advice giving (Buck and Collins, 2007; Richens, 2008b; Seddon, 2008; Herring et al, 2010; West, 2010). We found diversity between participants’ responses regarding how comfortable they felt addressing weight-related advice with obese women; some felt that whilst it wasn’t their favorite aspect practice, they managed it. However, for others their comfort level was inhibited by their introspection of how credible they perceived themselves as role models.

*“But if you look at me it’s the pot calling the kettle black isn’t it”* I1

*“One colleague says “look here I am a fat girl giving you this leaflet” but do they take you seriously?”* I9

*“I’ve had people say “well you wouldn’t know” because, I think because, I don’t have any issues with my weight”* I3

It was apparent that participant's level of comfort in offering weight-related advice influenced the advice they gave. Given that about 58% of the female adult population in England are overweight or obese (NSC Information Centre 2012 and 2013) it is likely that midwives will reflect the population profile and may well need help to address personal and professional competence. Other authors have reported health care professionals reluctance to give weight-related advice, due to both personal and professional reasons or not knowing what to say in relation to terminology or appropriate motivational narrative (Herring et al 2010; Knight and Wyatt 2010; Brown et al 2007; Brown et al 2013). Personal attitudes towards obesity preclude midwives giving appropriate advice, either because they are assuming that obese women will not be receptive or that they believe they, personally, present as poor role model and are about to humiliate themselves. Either scenario deprives obese woman from making an informed decision (Pearson 2006). Practitioner's discomfort around raising the issue of maternal obesity and the impact of self-perception as a role model needs addressing to minimise detrimental effects in terms of not managing weight and increasing risks for both the woman and newborn (Nunes, 2009; Sneddon, 2009; DH, 2010; Irwin, 2010; Knight and Wyatt, 2010).

## **Discussion**

This study has confirmed other authors who have reported midwives struggling to provide advice to obese pregnant women due to multiple forces, such as: competing demands and needs of women; time-limited interactions; uncertainty around the 'right' terminology; risking upsetting women and a lack of evidence guiding effective interventions (Russell et al 2011; Fuber et al. 2011; Heslehurst, 2011; Schmied et al. 2011;

Smith et al. 2012; Brown et al 2013; Fuber et al. 2013;Heslehurst, 2013). Other authors have also promoted the educational needs of midwives as the Holy Grail to address shortfalls in service delivery and that midwives introspection, i.e. responses to women's cues and concerns around risking relationships with women, hinder advice giving.

This study also showed that obese pregnant women appeared to have a powerful effect, consciously or unconsciously on midwives willingness to offer weight-related advice. Positive maternal attitudes encouraged and enabled midwives: conversely negative responses and lack of maternal motivation inhibited midwives willingness to advise appropriately. The power differential between women and midwives in this context seems at odds: possibly reversed resulting in a status quo perhaps in term of women modifying their health related behaviour (Foucault 1992). Women want advice (Russell et al 2010) and midwives want positive outcomes for women and offer a trustworthy and supportive service. We hypothesise that a barrier towards initiating or giving comprehensive advice and support was created by midwives who found it difficult to resolve and sideline personal perceptions of their own BMI and weight issues irrespective of what they were. It is likely that midwives need support to address personal issues to be able to responding to further education and deliver effective interventions effectively. Whether this means being comfortable with their personal body image and / or presenting themselves as role models based on other personal characteristics is beyond the scope of this study.

#### Limitations of the study.

The data collected resulted from nine interviews of differing duration which elicited varied amounts of narrative; some respondents were effusive others economical with

words. The duration of interview was limited by a participant's ability to draw on or the amount of practice experience of obese maternities. A further limitation was that the study formed part of an educational experience where reflexivity, as a skill, was still developing, as were skills in complex thematic data analysis and the presentation of findings. On reflection, the data may have benefited from a more sensitive type of analysis to explore deeper inter-relationships within the participants' narrative.

### Conclusion

This study aimed to explore midwives attitudes towards offering obese pregnant women weight related advice during pregnancy and the puerperium. Overall midwives commented upon giving weight related advice during pregnancy. There was a general agreement about factors which appear to influence midwives willingness and skill in providing weight related advice to obese pregnant women with a BMI of  $30\text{kg/m}^2$  or more. This study drew particular attention towards midwives doubt of their own credibility to offer advice based on their perception of their own body image and role modelling. This latter point appears to have been overlooked by other authors as the quest for further education coupled with effective interventions are the focus of attention; A first step may be to enable midwives to offer weight-related advice to obese pregnant women as part of a coordinated public health approach. In order for this to happen, midwives need to address their personal attitudes towards personal body image, relationships with women, advice giving, knowledge base and the practical challenges; and need help to do so. Further work is required to evaluate the effect and impact of midwives attitudes on the amount and efficacy of weight-related advice given to obese pregnant women.

### Recommendations for practice

Midwives need to address personal issues around body image to be better placed to develop effective communication techniques and offer obese, pregnant women appropriate advice.

Further work is required to evaluate the effect and impact of midwives attitudes on the amount and efficacy of advice given to obese pregnant women.

The appropriateness of terminology midwives use when communicating with overweight and obese women and feelings towards terminology needs further exploration.

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**Table 1**

**Topic:** Midwives' attitudes to giving weight-related advice to obese pregnant women.

**Keywords:** that could be interchanged within the interview questions and probes/prompt to refine the interview: Midwives, Attitudes, Beliefs, Feelings, Overweight, Obese, Healthy Living, Advice, Guidance, Support.

**Interview Questions:**

1. What are your feelings towards giving weight-related advice to obese pregnant women that you come across within your practice?
2. What do you feel about giving weight-related advice to pregnant women who are overweight?
3. What are your thoughts on giving weight-related advice to obese pregnant women?

**Prompts/Probes to maintain Interview Focus:**

1. Tell me more about your feelings on giving overweight pregnant women advice on their lifestyle.....
2. You said..... Tell me a bit more about that....
3. You said..... Expand on that if you can....
4. How do you feel about that?

**Table 2**

Stage 1:

Acquiring a sense of each transcript by reading the participant's narrative and or listen to the audio tape.

Stage 2:

Extracting significant statements or phrases by reading and re-reading the transcripts.

Stage 3:

Formulate meanings. The researcher attempts to formulate more general meanings or re-statements. Researcher must acknowledge any preconceived bias to ensure the meanings are from the participants.

Stage 4:

Organise formulated meanings into clusters of themes. These themes will aid description of participants' attitudes and beliefs.

Stage 5:

Exhaustively describing the investigated phenomenon. Incorporate the emergent themes. Theme clusters and formulated meanings to combine all the elements of the participants' experience and beliefs in a description of the phenomenon.

Stage 6:

Describe the fundamental structure of the phenomenon. Reduce the exhaustive description to an essential structure.

Stage 7:

Returning to the participants. Participants recognise themselves within the description and this helps validate the data analysis.

COLAIZZI, 1978