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Midwives' experiences of referring obese women to either a community or home-based antenatal weight management service: Implications for service providers and midwifery practice

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ABSTRACT

Objective: a variety of services to support women to undertake weight management behaviours during pregnancy have recently been implemented as a means to reduce the risks to mother and infant. In the UK, midwives lead the care of the majority of pregnant women and are seen as the ideal source of referral into antenatal services. However, midwives have reported concerns regarding raising the topic of weight with obese women and negative referral experiences have been cited as a reason not to engage with a service. This study explored midwives' experiences of referring women to one of two antenatal weight management services.
Design: qualitative, cross-sectional interview and focus group study, with data analysed thematically.
Setting: midwifery teams in the West Midlands, England.
Participants: midwives responsible for referring to either a home-based, one to one service (N=12), or a community-based, group service (N=11).
Findings: four themes emerged from the data. Participants generally had a positive *View of the service*, but their *Information needs* were not fully met, as they wanted more detail about the service and feedback regarding the women they had referred. *Approaches to referral* differed, with some participants referring all women who met the eligibility criteria, and some offering women a choice to be referred or not. Occasionally the topic was not raised at all when a negative reception was anticipated. *Reasons for poor uptake* of the services included pragmatic barriers, and their perception of women's lack of interest in weight management.
Key conclusions: midwives' differing views on choice and gaining agreement to refer means referral practices vary, which could increase the risk that obese women have inequitable access to weight management services. However, midwives' confidence in the services on offer may be increased with more detailed information about the service and feedback on referrals, which would additionally act as prompts to refer.
Implications for practice: weight management services need to improve communication with their referral agents and try to overcome practical and psychosocial barriers to uptake. It would be beneficial to develop a shared understanding of the concept of 'informed choice' specifically regarding referral to health promotion services among midwives. Training which demonstrates effective methods of sensitively introducing a weight management service to obese women may increase midwives' confidence to consistently include this in their practice. These measures may improve women's engagement with services which have the potential to reduce the risks associated with maternal obesity.

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Introduction

There are significant risks to mother and infant associated with maternal obesity (Abenhaim et al., 2006; Marchi et al., 2015) and excess gestational weight gain (Cedergren, 2006). There is also an established link between maternal body mass index (BMI) and risk of childhood obesity (Pirkola et al., 2010). Gaining excess weight during pregnancy is associated with post-natal weight retention (Rooney and Schauberger, 2002; Siega-Riz et al., 2004), making this a major risk factor for long term obesity. In addition, the costs of caring for obese women during pregnancy and childbirth are significantly higher than for healthy weight women (Morgan et al., 2014). As a result, public health guidance in the UK advocates promoting healthy lifestyle behaviour change during pregnancy, and the commissioning of specialised weight management services (WMS) to support those most at risk (National Institute of Health and Care Excellence: NICE; 2010). However, uptake of such services is often poor (Knight and Wyatt, 2010) and multiple barriers to attending these services have been identified (Davis et al., 2012; Atkinson et al., 2013; Olander and Atkinson, 2013).

As the primary caregivers for the majority of pregnant women in the UK, midwives are ideally placed to identify women who may benefit from WMS. Women want weight-related information (Olander et al., 2011) including information on weight management services from their midwife (Patel et al., 2013). However, midwives report lacking confidence to raise the issue of weight management with women (Macleod et al., 2013). Midwives may also perceive management of gestational weight gain as low priority and have concerns about the psychological impact of focusing on weight gain during pregnancy (Willcox et al., 2012). Additionally, the referral experience is likely to be influential in the woman's decision whether to engage with WMS (Atkinson et al., 2013). As such it is important to explore midwives' views of WMS and their role as referral agents for such services.

The present study aimed to explore midwives' experiences of referring obese women to two distinct WMS. Details of the design and delivery of the two services are shown in Table 1, and related service evaluation articles have been published elsewhere (Atkinson et al., 2013, 2016). By comparing the experiences of midwives referring to two WMS that differed in format, delivery method, duration and location, the study aimed to identify whether barriers to referral and uptake were universal or related to the specific service on offer.

Table 1
Description of weight management services.

	Home-based service	Community-based service
Format	One to one	Group (up to 8 per group)
Setting	Woman's home	Community Venue (e.g. sports centre, community hall)
Frequency & Duration	From early pregnancy to 24 months post-partum – approximately 12 visits, five in pregnancy	Weekly meetings of two hours for six weeks anytime during pregnancy
Delivery agents	Non-clinical, specially trained, Healthy Weight Advisors	Dietician, Public Health Nutritionists and Physical Activity Specialists
Content	Largely based on Social Cognitive Theory, behaviour change techniques included; goal-setting, self-monitoring, weight monitoring, action planning (implementation intentions). Tailored advice on healthy eating, physical activity, infant feeding/ weaning and active play, plus signposting to other services.	Non-theory based, sessions comprised advice on healthy eating and physical activity, plus a gentle exercise session (e.g. low impact aerobics, gym work and aqua-aerobics). Latterly weight monitoring was added to the service. Signposting to other services, including post-partum physical activity and infant feeding.

Methods

Design

A cross-sectional design was employed using semi-structured interviews and focus groups. Ethical approval was granted by the lead author's institution's Research Ethics Committee and, where required, local Research Governance approval was granted by the hospital trusts where participants were employed.

Participants

Participants were recruited from midwifery teams across the Midlands area of England where either a home-based, one to one weight management service (n=12) or a community-based group weight management service (n=11) was available to overweight and obese women. All participants were community midwives, except two from the home-based service who worked in specialist hospital clinics attended by women with a raised BMI. All participants were female. Demographic information was not collected from focus group participants (n=5) for reasons of confidentiality and time constraints. The remaining 17 participants that were interviewed were aged between 34 and 60 years. The average time as a practising midwife was 20.8 years, with only three participants having less than ten years in practice.

Procedure

Data collection took place in 2010 for participants referring to the home-based service, and in 2012 and 2013 for participants referring to the community service. For both services, all community midwives who were eligible to refer women to the weight management service were approached by the project manager for that service or directly by the research team, to invite them to participate in the study. For both samples, purposive recruitment strategies were employed to ensure a geographical spread of participants across the area served by the relevant service. Recruitment continued until all eligible midwives had been offered the opportunity to participate. Accurate recruitment rates cannot be calculated due to incomplete data on the numbers of midwives eligible to participate at the time of data collection, however from the available data it is estimated that between 5% and 10% of eligible midwives participated. Informed consent was provided by all participants prior to data collection.

Midwives in the home-based group were interviewed face to face. Having experienced some difficulties in recruiting those midwives for a face to face interview, midwives in the community-based group were asked to take part in a telephone interview, as a means of making participation more convenient. Similarly, a single focus group was arranged at the hospital where midwives from the community-based group were employed, timed to coincide with a scheduled team meeting, in order to make it easy for midwives to participate in the study if they chose to. Five participants took part in the focus group. The same topic guide (see Fig. 1) was used to guide all interviews and the focus group in both participant groups, in order to facilitate comparison, although participants were encouraged to speak freely about any topic they deemed important. All interviews and the focus group were digitally recorded and transcribed verbatim.

Analysis

Analysis was conducted using a deductive, realist approach, reflecting that interventions take place in the 'real world' (Pawson and Tilley, 1997) and that emotions, beliefs and values are part of reality and therefore relevant to understanding and explaining the phenomena being studied (Putnam, 1999). A process of thematic analysis was