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"Longing for individual recognition" – Pregnant women's experiences of midwives' counselling on physical activity during pregnancy

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ABSTRACT

Objective: The aims to explore among pregnant women were their experiences of lifestyle counselling provided by a midwife in antenatal care, addressing health promotion with special focus on physical activity during pregnancy, and factors influencing the trustworthiness of counselling conducted by a midwife.
Methods: This qualitative study collected data from 14 pregnant, primiparous or multiparous women in gestational week 35–36 using in-depth interviews. The data were collected in Sweden in 2015. Qualitative content analysis was applied.
Results: The theme *"Longing for fulfilment of individual needs and expectations"* emerged during analysis, including four categories; *"Being exposed to unsatisfying counselling"*; *"Appreciating supportive and trustworthy counselling"*; "Wrestling with cultures", and *"Dealing with physical activity in daily life"*. The results indicated that some participants experienced limited counselling that was characterized by lack of knowledge, support, and trustworthiness in the midwife. Other participants reported valuable encouragement and support by the midwife. Participants were longing for individual recognition instead of receiving general advice on physical activity that was designed for all pregnant women.
Conclusions: Individual counselling on physical activity during pregnancy based on the participant's individual needs was desired. On the contrary, the participants could experience the midwife as having her own agenda, insufficient knowledge and primarily focusing on medical surveillance. There is a need of increased level of knowledge among midwives in antenatal care, regarding lifestyle and lifestyle change during pregnancy. This may enhance promotion of a healthy lifestyle for the pregnant woman during counselling.

Background

Physical activity is generally considered beneficial and safe during pregnancy, and there is no evidence of increased risk of adverse pregnancy outcomes in an uncomplicated pregnancy [1]. In fact, physical activity may reduce adverse pregnancy outcomes and is beneficial for maternal cardiac autonomic control [1–5]. Furthermore, physical activity, especially aerobic exercise, enhances maternal health during pregnancy [5]. The international recommendations by the World Health Organization (WHO) on physical activity during pregnancy suggest that pregnant women should perform at least 150 mins (performed in bouts of at least 10 mins) per week of moderate intensity aerobic physical activity, or at least 75 mins per week of vigorous intensity aerobic physical activity, or a combination of both. Pregnant women should seek medical advice before striving to achieve these recommendations [6]. These guidelines have been adopted in Sweden [1]. Although positive health effects of being physically active are well known, pregnant women tend to lower their physical activity when they enter their pregnancy [7]. Lack of time, somatic pain, and changes in body size are well-documented reasons for being less active during pregnancy [8–10].

Pregnancy is an ideal opportunity to promote change of lifestyle that may benefit both the pregnant woman and her fetus [11]. The relationship between the caregiver and the patient relies on trust and confidence [12] and two-way communication with a person-centred approach are significant components in the relationship [13]. In Sweden, almost every pregnant woman attends free antenatal care (ANC) [14]. Counselling on a healthy lifestyle and medical surveillance during pregnancy are prominent work tasks for an ANC midwife [14]. Individual counselling and detailed information on recommendations for physical activity during pregnancy may encourage pregnant women to maintain their pre-pregnant leisure-time physical activity into their pregnancy [15–17].

However, the literature is limited regarding pregnant women's

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experiences of being counselled on physical activity and the significance of midwives' trustworthiness during counselling. Therefore, the aims to explore among pregnant women were: (i) The experiences of lifestyle counselling provided by a midwife in antenatal care, addressing health promotion with special focus on physical activity during pregnancy, (ii) Factors influencing the trustworthiness of counselling conducted by a midwife.

Methods

In this study, a qualitative approach was applied using qualitative content analysis (QCA), which enables a deeper understanding of the participants' lived experiences. QCA was thus the selected method aiming for a thorough understanding of the experiences of being counselled on physical activity during pregnancy. The manifest content (i.e., what the text says) as well as the latent content (i.e., the underlying meaning) were analysed using QCA [18].

The interview guide

A thematic interview guide was created by the authors that corresponded to the aims of the study. Some topics mirrored the topics in a previous study where the participants were midwives [19]. The interview guide was tested in a pilot interview and resulted in minor revisions of the guide. The pilot interview was included in the materials with the informed consent of the participant.

The following topics were included in the interview guide: Experiences of midwives counselling on lifestyle habits and life style change in general and physical activity in particular, the significance of lifestyle counselling in general, and the trustworthiness of the midwife in relation to the counselling.

Recruitment of study participants

Pregnant women were asked to participate in the study before their routine ultrasound examination, which is performed between 18 and 20 weeks of gestation. All participants were clients at a hospital-based Specialist Maternal Health Care Centre (SMHC) at a hospital in northern Sweden. Using purposive sampling, the study aimed for healthy, at least primiparous women who had a routine ultrasound examination indicating normal outcome and women who spoke Swedish or English. In addition, we aimed for a variation in age, country of birth, and body mass index (BMI) (i.e., normal weight, overweight, or obesity. We defined immigrant women as those who were not born in Sweden. All pregnant women visiting SMHC for their routine ultrasound examination were consecutively approached. The appointed midwife briefly informed an eligible pregnant woman about the study "counselling on lifestyle habits during pregnancy", and received permission for first author (ML) to contact the eligible participant for additional information about the study. The first eight pregnant women who were approached gave their verbal consent for further contact; the ninth eligible participant declined participation. The first author contacted all eight eligible participants by telephone, and all agreed to participate in the study and agreed on a date and place for an in-depth interview. During the course of the data collection, it was recognized a need of recruiting more immigrants and overweight or obese women in order to achieve the variation in the desired background characteristics. Accordingly, an additional recruitment process took place aiming for obese pregnant women (BMI $\geq 30\,kg/m^2$) and/or immigrant women. This recruitment resulted in six more participants, resulting in 14 total participants in the study. All participants were married or cohabiting, and their educational level was equally distributed between university and high school level. Most of the participants were born in Sweden and their BMI varied between 20.1 kg/m^2 and 38.5 kg/m^2 (mean = 27.5 kg/m^2) (Table 1).

Table 1
Background characteristics of the participants.

Variables	n (%)
Participants	14
Age (years)	
Mean	31.5
Min–Max	23–38
BMI (kg/m)	
< 25	6
25.0–29.9	2
30	6
Parity	
Primiparous	10
Multiparous	4
Marital status	
Living alone	0
Cohabiting	14(100)
Highest educational level	
University	7 (50.0)
Highschool	7 (50.0)
Compulsory school	0
Origin	
Sweden	11 (78.6)
Other countries	3 (21.4)

Data collection procedure

The gestational age at interview was selected with the purpose to gather as much information and experience of the present pregnancy as possible. The pregnant women were interviewed at 35–36 weeks of gestation (mean value: 35 weeks and six days; range: 35 weeks and two days to 36 weeks and three days). The participants determined the venue for the in-depth interviews. Nine participants requested that the interview take place in their homes, and five participants chose a private venue at the hospital. The first author performed all in-depth interviews. All eligible participants received written and oral information on the study and were informed that they could withdraw their participation at any time without giving any particular reason. Each participant signed a written consent form before the interview. The interviews were performed during January 2015 to August 2015 and lasted between 45 and 80 mins and the mean time was 50 mins. All interviews were digitally recorded and were transcribed verbatim into text by one of the authors (ML).

Data analysis

The analysis was performed using qualitative content analysis as presented by Graneheim and Lundman [18]. All transcribed data were read thoroughly by ML and IM. ML identified meaning units, condensed meaning units, codes, and emerging sub-categories and categories. ML and IM discussed the codes, sub-categories, and categories. The transcripts were then re-read to certify that no significant data were neglected. At this phase of analysis, the underlying latent meaning (i.e., the theme) emerged and the second author (MP) contributed to the analysis and discussion. Finally, all the authors arrived at a consensus regarding analysis and presentation of the findings.

Ethical considerations and approval

The study was granted approval by the Ethical Review Board, Umeå University (Dno. 2014-152-32M). All pregnant women should be counselled on lifestyle in the early pregnancy according to the national recommendations for antenatal health care [14]. Thus, the topic of the interviews should have been addressed by the midwife previously. The eligible participants were primiparous or multiparous pregnant women