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**THE ANTENATAL CARE EXPERIENCES OF
OVERWEIGHT PREGNANT WOMEN IN THE UK**

MARIA E. IYEKEKPOLOR

A thesis submitted to the University of Huddersfield in partial fulfilment of
the requirements for the degree of Doctor of Philosophy

The University of Huddersfield

November 2016

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Abstract

The current position of the World Health Organisation (WHO, 2014) is that there is a threat of a global “obesity epidemic” (Boero, 2007, p.1); and existing studies in the UK report that a 5th of pregnant women are overweight. This has created increased scrutiny of fatness and weight, especially in pregnant women. The concern about obesity and pregnancy outcomes also contributes to the National Institute for Health Care Excellence (NICE, 2010), recommending that the antenatal care delivered to overweight pregnant women should be within the guidelines of a high-risk pathway of antenatal care. This has increased the medicalisation of the care for overweight pregnant women.

The aim of this study is to explore the experiences of overweight pregnant women in relation to their heightened medicalised antenatal care. Using a social constructionist approach and a Foucauldian interpretive lens, semi-structured face-to-face interviews were used to collect data from 12 women who were between 16 and 30 weeks pregnant, 6 midwives who provide antenatal care for them, and 3 obstetricians to whom women are referred. The data were analysed using thematic analysis. The findings show that pregnant women do not identify with being ‘obese’ and perceive themselves as being overweight but healthy. Key themes that emerged from the data describing women’s perception of heightened antenatal care are: their understanding of risk and risk perception, the power of science and how it constructs their maternal health and the power of obstetricians justifying medical interventions in pregnancy and childbirth.

This study creates and contributes to the awareness of how overweight pregnant women who are healthy experience antenatal care. It explores the need of overweight pregnant women, and identifies changes that need to be made to positively enhance how these women experience pregnancy and childbirth. These findings need to be considered by policy makers, individuals in practice and those with a role in educating health care practitioners so that overweight pregnant women are provided the appropriate antenatal care.

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Dedications

This work is dedicated to all my *bubus*:

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study and assisted me with recruitment and finally, a big thank you to all the women who found time to share their pregnancy experiences with me.

List of abbreviations

AIMS	Association for Improvements in the Maternity Services
ARM	Association of Radical Midwives
BBC	British Broadcasting Corporation
BMI	Body Mass Index
CMACE	Centre for Maternal and Child Enquiries (Formerly CEMACH- Confidential Enquiries into Maternal and Child Health)
DoH	Department of Health
DVT	Deep Vein Thrombosis
EBM	Evidence Based Medicine
EBP	Evidence Based Practice
GTT	Glucose Tolerance Test
IOM	Institute of Medicine
IRAS	Integrated Research Application System
NCT	National Childbirth Trust
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHS REC	National Health Service Research Ethics Committee
NMC	Nursing and Midwifery Council
NMR	National Maternity Review
RCM	Royal College of Midwives
RCOG	Royal College of Obstetrics and Gynaecologists
R & D	Research and Development
SOGC	Society of Obstetricians and Gynecologists of Canada
SRA	Social Research Association
SREP	School of Human and Health Sciences Ethics Panel
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

Chapter 1

Background to the research

Introduction

This thesis critically explores the experiences of women who are pregnant and have a high body mass index (BMI). BMI is a tool that is used to measure the relationship between an individual's weight in kilogrammes and the square of his or her height in metres and could be indicative of the amount of body fat carried by an individual. Excessive body fat has been reported to have a negative impact on an individual's health hence BMI is also a tool that is used to gauge the state of health of an individual (World Health Organisation (WHO), 2014; National Institute for Health and Care Excellence (NICE, 2014). This thesis will examine the experiences of pregnant women who have been categorised, using the BMI measure, as having a higher than 'normal' or 'expected' level of risk in pregnancy. The research study for the thesis explored the impact of being categorised as high risk on account of BMI only on the experiences of pregnant women as they navigate and receive antenatal care as provided by a Trust within the National Health Service (NHS). It is important to state here that this thesis will only explore the experience of pregnant women who, other than having a high BMI, would normally be provided midwifery led antenatal care, as they would be deemed to be healthy. This is because they have not presented with any other health issues or concerns. However, these pregnant women receive antenatal care from midwives with involvement from other healthcare professionals such as obstetricians solely because of their weight (NICE, 2010). To fully explore the experiences of overweight pregnant women as well as the factors that shape their experiences, the study will also explore their discussions with their antenatal care providers (mainly midwives and obstetricians). A review of the discussion between women and their care providers will also enable the researcher to explore

healthcare professionals' experiences of providing antenatal care for these women throughout the course of their pregnancies and to document their feedback on how they interacted with and felt about providing antenatal care for pregnant women with high BMI.

Traditionally, pregnant women are provided antenatal care by midwives, but when a woman's BMI is high, that is 30kg/m² and above, she is also deemed to have a higher risk exposure to her pregnancy and pregnancy outcome according to the National Institute for Health and Care Excellence (NICE 2010). The Centre for Maternal and Child Enquiries (CMACE,) and the Royal College of Obstetricians and Gynaecologists (RCOG, 2010) also acknowledged this position. To manage this increased risk to pregnancy and/or childbirth, women who fall into the category of high BMI are provided with a focused risk or a high-risk antenatal care (NICE, 2008) which is delivered through the shared antenatal care pathway.

The main reason for categorising women, using a BMI measure, is to evaluate the perceived risk to a woman's pregnancy and childbirth. NICE (2010) and the CMACE/RCOG (2010) recommended antenatal care for pregnant women with high BMI which may involve medical intervention. According to NICE, this antenatal care needs the involvement of a midwife and an obstetrician (NICE, 2010). A shared antenatal care is different to a midwifery led care and has been described as medicalised care (Nyman et al., 2010; Fuber and McGowan, 2011) which would indicate that pregnancy by women in this category have a medical condition. It is this view of weight and pregnancy that attracted my interest in the debate about the experiences of pregnant women receiving antenatal care and how this differs from traditional midwifery and obstetric care.

I was born in Nigeria and lived my childhood and early adult life in Nigeria before relocating to the Bahamas in the Caribbean where I experienced antenatal care and childbirth twice. In those two cultures, being fat was not

intrinsically tied to health risk. What was; and presumably is still, encouraged is an active lifestyle and healthy eating. Weight or fatness was also not the focus of antenatal care. However, media reports and my personal experiences within the first two years of my stay in the United Kingdom challenged that awareness of fatness. I found that the issue of 'obesity' and 'overweight' is a topical health issue and the media actively disseminated a negative view of weight and/or fatness to the public (NICE, 2014). I was aware of the health benefits of maintaining and managing individual body weight (NICE, 2014). I was also aware that excessive weight or being excessively underweight could be a predisposing factor in exposure to illness and medical conditions, but this did not in itself constitute sufficient grounds for categorising a person as having a medical condition. It is this conflicting view of weight as construed by my Nigerian and Bahamian background on the one hand and the British and most other Western media on the other that ignited my interest to explore the rationale for the perception of weight in the UK which also mirrored those of other Western cultures.

Initial enquiries indicated that the views actively put in the public domain by the media were a summary of epidemiological findings and conclusions presented in various research reports. There is an enormous amount of studies about the impact of high BMI on pregnancy and the unborn child (see for example Chu et al., 2007; Zhang, Bricker, Wray, and Quenby, 2007; Athukorala, Rumbold, Wilson, and Crowther, (2010); Begum, Sachchithanantham and Somsubhra, 2011; Smith and Lavender, 2011). The reports from these studies indicate poor maternal and child outcomes and claim that the number of women in this category of antenatal care is increasing (Kanagalingam et al., 2005; Lewis, 2007). These epidemiological studies also claim that the antenatal care provided for these women puts a huge financial burden on the NHS (Smith et al., 2012). There has been a pervasiveness of claims about the impact of high BMI on pregnancy. They

include claims that high BMI impact on the health and wellbeing of women of childbearing age, their unborn and young children.

Internationally, obesity is identified as a major public health issue (World Health Organisation, 2008, 2014). Reporting that obesity has more than doubled worldwide since 1980, WHO also confirmed that 39% of adult aged 18 years and above were overweight in 2014, and 13% were obese. In the UK the rate of obesity has been on the rise. In 1993 13% and 16% of adult men and women respectively were obese but by 2011 these values had risen to 24% for men and 26% for women (Baker, 2017). This represents a growth rate of 85% and 63% in obesity for adult men and women over 18 years from 1993; and an annual average increase of 4.7% and 3.5% of growth in men and women obesity. If this average rise in obesity is not reversed, by 2050 the proportion of adult men and women that is expected to be obese will be 47.83% and 47.67% respectively. This is a simple rather than a compound growth rate and is therefore consistent with the prediction that more than half the adult population will be obese by 2050 (Swinburn et al. 2011). A similar increase has also been reported in Canada and the United States of America (USA). In 2014 the obesity rate for adult men and women was 29.2% and 29.8% respectively for the USA while the corresponding values in Canada were 21.1% and 18.1% (Statista, 2017).

This growing rate of obesity has been documented to be equally evident among women of childbearing age. For example, it is claimed that a fifth of pregnant women seeking antenatal care in the UK are reported to be obese (Kanagalingam, Foroudi, Greer and Sattar., 2005; Morgan et al. 2014). It is against the overall growth rate of overweight and obesity in the general population and women of child bearing age in particular that the various long and short term health risks associated with being overweight and pregnant for mothers and babies (Leddy, Power and Schulkin, 2008; Marchi et al. 2015) has become a source of significant concern for national health

institutions and governments. Adverse risks linked to the unborn are unusually large babies, shoulder dystocia, meconium aspiration and distress (Davies et al. 2010; Vinturache et al., 2015). More risks acknowledged to be associated with maternal obesity and poor outcome to the unborn babies are congenital anomalies (Stothard et al. 2009; Magann et al. 2011), birth trauma, neonatal hyperglycemia (Manzanares et al. 2012), and lastly in the worst case scenario, increased risk of stillbirth and infant death (Torloni et al., 2009).

The Centre for Maternal and Child Enquiries, (CMACE, 2010) and Marchi, (2015) identified poor outcomes to mothers to include gestational diabetes mellitus (GDM), pre-eclampsia, operative delivery and increased risks during childbirth. Other increased risks attributed to maternal obesity which are linked to poor outcomes for mothers are delay in the first stage of labour (Mbah et al. 2010), general anaesthesia and wound infection (Marshall et al. 2012). In addition, healthcare professionals have indicated that obese pregnant women and their babies require significantly higher level of postpartum care (Heslehurst et al. 2007; Marshall et al. 2012) than normal weight pregnant women.

Although there is extensive literature that highlights the risks to the mother, the unborn and the baby's health as a result of being overweight during pregnancy, there are limited studies which have focused on exploring how these risks to pregnancy outcomes for overweight pregnant women and the added challenge that this poses to healthcare professionals impact women's experiences of being overweight and pregnant within antenatal settings. The few studies available, which draw participants from the overweight, pregnant women's population focus not on their overall experience of antenatal care services but on isolated issues such as women's experiences of body image changes in pregnancy (Fox and Yamaguchi, 1997), the beliefs of above average weight women in relation to weight gain during pregnancy

(Wiles, 1998), the transitions to motherhood and early family formation through the lens of food (Keenan and Stapleton, 2010) and women's attitudes to physical activities during pregnancy (Weir et al., 2010). While these issues may affect how overweight pregnant women experienced pregnancy and the care they received from healthcare professionals within the antenatal care settings, these studies do not focus on women's experiences and how their experiences may have been shaped or affected by weight-related factors.

The few studies that have explored the maternity experiences of women with a BMI of 30kg/m² and over, have not isolated the impact of weight from other factors such as having a medical condition. They also do not capture the data for their analysis until after the women were at the last stage of their pregnancy or had given birth. The resulting gap in time between the women experiencing the delivery of care by healthcare professionals and the excitement of having given birth or looking forward to giving birth in a few weeks may have affected the recollection of their experiences. Finally, existing studies gathered data from either pregnant women or the healthcare professionals who delivered care to pregnant women, but not both. For example, Nyman, Prebensen and Flensner, (2010), Fuber & McGowan (2011), Furness et al. (2011) and Mills, Schmied, and Dahlen, (2013), and recently, Bernecki Dejoy, Bitter and Mandel, (2016) all conducted their studies with women who were in the last stage (third trimester) of their pregnancy or had given birth. They also recruited women irrespective of their medical condition and risks. There was also a lack of diversity in the participants interviewed for these studies.

This study addresses these gaps in the literature on the study of overweight, pregnant women's experiences of antenatal care and childbirth. To achieve this objective, all the women recruited for this study had no known medical condition but were classified as high risk pregnant women only on account of their high BMI. In addition to the criteria for recruitment, women were

recruited from a diverse group, and were interviewed as their experiences unfolded.

The need to understand how fatness constitutes ill-health that is a medical condition, and which requires the medicalisation of pregnancy in women with high BMI is the main rationale for carrying out this research. It is as a result of this that the participants are only women who have the high-risk status on account of body weight alone. They have no other health issues. Another factor also contributed to the decision to explore and examine women's experiences, especially during pregnancy and childbirth, within the healthcare system. Thus, the knowledge that feminists have questioned why pregnancy and childbirth have become a 'risky' event since the 20th century (Oakley, 1984; Lupton, 1999; Wray and Deery 2008; Lupton, 2012a; Rothman, 2014). Women and commentators who challenge the medicalisation of pregnancy have also challenged the eagerness of epidemiological science to cloud pregnancy in risk. They claim that the weighing and screening of pregnant women from the onset of their first antenatal visit is further evidence of the desire to bring risk to the fore from the outset. Their claim is that women are drawn into a series of screenings, to ascertain whether the unborn baby is safe in the womb and find whatever justification to turn pregnancy into a medicalised event (Lavender and Kingdon, 2006). As a result, feminists and other sociological scholars (Lavender and Kingdon, 2006; Brubaker and Dillaway, 2009; McAra-Couper, Jones and Smyth,, 2012; Lupton, 2013) have challenged the medicalisation of pregnancy and childbirth in the health care system in developed countries. They emphasised that pregnancy was no longer seen as a healthy natural event but a medical condition that presents with either 'low risk' or 'high risk.' The ascribed risk is also now viewed as increasing with various factors such as a woman's age, her state of health and body weight (Wray and Deery, 2008; Lupton, 2013).

Sociological scholars, who also view pregnancy and childbirth as a natural event, have argued that the evidence that pregnancy is considered a risky event start from women's first or initial visit to seek antenatal care (Parker, 2012). During this visit, women have to undergo a risk assessment conducted by midwives. The sole purpose of this exercise, it has been claimed, is to gather evidence for categorising pregnant women into low or high-risk brackets and for healthcare professionals to be able to justify the risk ascribed to pregnancy as evidence-based (MacKenzie Bryers and van Teijlingen, 2010).

It is this propensity to seek out risk in all human endeavour, even in naturally occurring events like pregnancy that has made social scientists refer to our modern society as a risky one (Beck, 1992). The propensity to seek out risk means that, through science, there is the creation of order and control for modernity. It also began the excessive monitoring process of populations and individuals, and through an information system, this has now resulted in greater uncertainty within society (Giddens, 1991; Beck, 1992). The need for safety, therefore, drives the concept of risk, and this has been fundamentally linked to both the culture and organisational structure which exists within the NHS (MacKenzie Bryers and van Teijlingen, 2010). Risk classification or categorisation does not only exist in antenatal care setting but in other aspects of healthcare provision in the NHS (MacKenzie Bryers and van Teijlingen, 2010). Risk management in antenatal care, which began in the early 20th century, has been adopted as a part of the positive strategy to reduce maternal fatality, child mortality and morbidity rate. The adoption of risk management as a positive strategy is the reason why women's medical records and obstetric history is carefully scrutinised (Tew, 1998). The flaw in this objective and goal is in the excessive focus on the likelihood of negative outcomes. Records are analysed to identify probable statistical direction and outcomes, and its result is then used to establish probabilities of unfavourable or adverse

outcomes or in other words, the likelihood of negative outcomes for pregnancy and/or childbirth. In this assessment of risk, the risk ascribed to pregnancy and childbirth in women that are overweight or have high BMI increases. The view of sociological scientists is that if women's pregnancy, because of weight only, is categorised as risky, then either pregnancy or being overweight or a combination of both (as it is in pregnant women with high BMI) must be a medical condition. If this is not a valid deduction, then the medicalisation of pregnancy cannot be described as evidence-based. Also, the question of how fatness constitutes ill health in general and results in poor outcomes during pregnancy, especially when a woman does not have any medical or health-related issues, has been and will continue to be contested. This is because a conclusive causative link between fatness and ill health has not been indentified to date.

Epidemiological studies lay claims to poor outcomes for pregnant women with high BMI (see Catalano, and Ehrenberg, 2006; Leedy et al., 2008; Rauger-Martin et al., 2010; Knight et al., 2010), and use the summaries and conclusions of various study reports indicating poor outcomes to substantiate its claims and submissions. However, these poor outcomes only indicate an associative link with high BMI and this does not confirm a causative link which must be evident for high BMI to be accurately framed as a medical condition. The information published from epidemiological studies and reports is then picked up by both popular print and electronic media and used to shape perceptions, construe 'truth' and 'reality' as well as frame the impact of construed reality. The views put in the public and media domain by these reports which are framed as scientifically objective results are then used to construct medical knowledge about pregnancy and high BMI (Saguy and Almeling, 2008; Harper and Rail, 2012; Parker, 2012) in a repetitive and prolonged manner to ensure that both political and social perceptions embrace the view put forward. There are several reasons why feminist commentators argue that women's bodies and bodily events, for example,

menstrual cycle, pregnancy, childbirth and menopause have been construed by biomedical science as deviant, faulty or risky and as such should be subjected to medical intervention as well as self-surveillance (Vaz and Bruno, 2003). Feminists argue that there is a lack of validity in the conceptualisation of risk in the relationship between weight and pregnancy (Murray, 2008; Harper and Rail; 2012). They also challenge how the impact of weight is framed as a negative and presented in absolute rather than relative risk terms which convey a much higher likelihood of occurrence than is actually the case in discussion with women. The direction of a discourse such as this assumes that the outcome of risk is absolute and will be negative rather than the objective view of risk that indicates a probable chance of either a negative or positive occurrence. Social scientists have therefore rejected the strongly held cultural views that science and the biomedical model create “naturally unfolding scientific knowledge” (Lupton, 2003 p.26).

In general, society portrays individuals with high BMI as lacking the will to make healthy or good choices in their eating habits, and women who have high BMI receive a more critical assessment when they become pregnant if their BMI remains high (Puhl and Heuer, 2009). The print and electronic media presents individuals with high BMI as members of the society with gluttonous tendencies, who make poor food choices and find unhealthy lifestyles to be desirable (Saguy and Gruys, 2010). The media portray them as lacking the will, or consciously choosing not to search out appropriate and relevant information that will enhance their ability, to understand the choices and action needed to attain a ‘normal’ or a ‘healthy’ weight (Saguy and Gruys, 2010; Parker, 2014). Nettleton (2013) argues that this lack of knowledge about what is normal and abnormal weight gain has been purported to be a failing on the part of women, whom the media believe are not doing enough to take responsibility. They are therefore held to be responsible and even culpable for negative outcomes to their health and the

health of their unborn child (Keenan and Stapleton, 2010). According to Petersen and Lupton (1996) a healthy woman is a resource for the production and nurturing of future healthy citizens or generations, and Nettleton (1996) asserts that where there is a risk to this resource or role, the media and society is keen to blame women. As a result of the willingness and readiness of the media and society to ascribe blame to women, feminist scholars have drawn attention to how women's behaviour about eating and drinking during pregnancy is undergoing heightened scrutiny (Salmon, 2011). Also, society has increased maternal responsibility to achieve positive health outcomes for their unborn babies (Markens et al., 1997; Maher et al., 2010). The expectation of society that women should embrace their role in safeguarding the future generation is an integral part of the "discourse of reproductive citizenship" (Salmon 2011, p.168). As part of this discourse, modern public health messages lay emphasis on women's responsibilities to ensure they have a healthy pregnancy, healthy child, avoid engaging in unhealthy activities, such as, alcohol consumption, smoking and drugs (Salmon, 2011; Bell et al., 2009). The battery of advice given to women does have its impact on women vis-à-vis how they see themselves, especially women who are overweight but healthy. This doctoral research thesis contributes to these debates by exploring the experiences of women with high BMI who are pregnant, and considers what it means for these women who other than their weight or BMI are healthy to have the high-risk status ascribed to their pregnancy and be recommended a risk-focused classification of antenatal care on account of their weight alone. Additionally, the thesis will contribute to discussions on how these health-risk messages are communicated to pregnant women who are in the high-risk category of antenatal care. It will identify how women construct meanings from risks messages about their bodies and how this shapes the way they negotiate antenatal care options available to them. Such understanding will also highlight how women comply with or resist medicalisation of their pregnancy and the explanation for this.

Rationale

According to NICE (2010) guidelines, pregnant women should be categorised by their BMI and assigned to different antenatal care groups (NICE 2008). In line with guidelines, there are two groups under which pregnant women will receive antenatal care; namely, the traditional midwifery led pathway and the shared antenatal pathway. The literature reviewed for this study confirmed that there is a paucity of studies into the experiences of pregnant women assigned to the shared pathway of antenatal care. The rationale for this study is to fill the gaps identified in existing literature and to understand how the difference in the risk perception of high BMI impact the antenatal care services women receive and how they feel about it.

This study will also challenge the use of BMI as a tool for categorising pregnant women into antenatal care groups and differentiating between the treatment women receive on account of their body weight.

Gaps in existing literature

According to McPherson et al. (2007) 23% of the population are obese, and there is a prediction that more than half of the adult population will be obese by 2050. Heslehurst (2010) has also reported that obesity is a growing problem for women of childbearing age (Heslehurst, 2010), and about a fifth of pregnant women in the UK are obese (Kanagalingham, 2005; Morgan et al., 2014). Against this background, there is concern that the literature review has identified that there is the lack of individualised antenatal care for pregnant women with high BMI. Also, honest and clear communication of how high BMI could impact pregnancy and antenatal care experience for women in this classification have also been emphasised as 'lacking' (Fuber and McGowan 2011; Furness et al., 2011; Heslehurst et al., 2013). In addition, an extensive search for a study on experiences of pregnant women in antenatal care settings (at the time this study commenced) did not find

any research study with a particular focus on how pregnant women with high BMI experienced antenatal care. The review for this study also identified a lack of personalised or individualised care for pregnant women with high BMI. This study, therefore, intends to explore why there is a lack of individualised antenatal care for pregnant women that are overweight as well as the form and content of communication between health care professionals and pregnant women with high BMI. It will also initiate and contribute to the effort to redress the lack of research studies with a primary focus on how pregnant women with high BMI experience antenatal care in NHS facilities and so, contribute to finding new ways of working with women in this category of antenatal care.

Aims and objectives

Aims

To understand the experiences of pregnant women with a high BMI with regards to the antenatal care they receive.

To identify and examine the impact, if any, that the body weight of pregnant women has on how healthcare professionals deliver care for pregnant women and how this impact has shaped how healthcare professionals communicate and interact with pregnant women with high BMI.

Objectives

To explore the perspectives of pregnant women with high BMI about their pregnancy and their experiences of maternity services.

To critically explore the perception of healthcare professionals regarding the impact of high BMI on the antenatal care they deliver to pregnant women.

To investigate the advice that healthcare professionals give to pregnant women with a high BMI about body weight, particularly about communication around the risks that high BMI poses to their pregnancy and how this might happen.

To identify ways in which antenatal and midwifery care for pregnant women with high BMI might be enhanced.

Research approach

The researcher used a qualitative approach which encompasses an in-depth interpretive analysis for this study. Several factors were considered before adopting a qualitative methodology, including the main purpose of the study; which is to examine women's perception and feelings about their experiences of antenatal care. It was, therefore, necessary that the approach adopted would allow these women's experiences as well as those of their healthcare providers to be captured, analysed and presented as findings. To achieve this goal, the researcher first decided on whether to adopt a quantitative or a qualitative approach. The literature reviewed for this research set the framework for the study by giving a thorough description of research activities and methods adopted by other researchers that have carried out research into the experiences of women in similar or related situations. Although the philosophical positions of quantitative methods respond to research with the aim of providing numerical data for the purpose of describing events and outcomes, it is not suitable for a study which transcends the identification of causative or associative relationships. The aim of this study transcends causative or associative relationships to the acquisition of a fair and relatively accurate understanding of the phenomenon that is studied and the probable impact on people within groups or the wider society. The ability of qualitative methodology to accommodate both objective and subjective variables is the main reason a

qualitative approach was adopted. Also, the philosophical position of qualitative research is one that provides details, the opportunity for examination and the tools for explanations based on words and feelings, the perceptions of individuals and the context of participants' experiences (Silverman, 2013; Silverman and Marvasti, 2008). These are some of the issues that this study will explore.

Furthermore, a qualitative approach is more suited for exploring beliefs and perceptions. It will also facilitate effective engagement with the participants of this study regarding how they assessed their experiences, the factors that shaped the assessments as well as any other rationale behind the range of perceptions and meanings expressed by pregnant women. These attributes of the qualitative methodology will afford a deeper and more robust understanding of the phenomenon that is studied. Also, qualitative methodology embraces a broad spectrum of approaches to data analysis, and the specific approach adopted for this study is the thematic analytical approach. According to Braun and Clark (2013) thematic analysis enables the researcher to identify, analyse and report patterns or themes within data. The thematic analytical approach also helps to interpret the data regarding the different aspects of the research topic. This ability to cope with different themes or aspects is helpful because literature review identified a multiplicity of issues including a lack of individualised antenatal care for pregnant women with high BMI along with a lack of clear and effective communication with women in this classification. Also, this study intends to contribute to finding new ways of working with women in this category of antenatal care.

A methodological interest of this research is to evaluate why fatness is perceived and framed as a negative and to present an alternative view of fatness as perceived by overweight pregnant women. To do this, the study

will include discussing the source and impetus for the popular notion or constructs of fatness as a state that is detrimental to the health of women in general and particularly pregnant women. This study will also use face to face interviews to capture how pregnant women perceive and make meaning of their experiences of antenatal care. It will place significant attention on the women's own words as they describe their experiences and how they perceive things through social interactions which is key to how women construct reality. The data collection and analysis for the study is guided by social constructionism and Foucault's concepts of power/knowledge, governmentality, and the gaze of others through medicalisation (Foucault, 1972, 1973, 1976, 1980). These concepts have the efficacy to influence the views and experiences of pregnant women with high BMI. The main focus of social constructionism is the representation of the construction of meanings by individuals and the understanding of the personal influence that underlies the individual constructions of meanings (Pieterman, 2007). As mentioned above, there is a paucity of study around the experiences of pregnant women with high BMI but who do not have any other health issues. This research will add to the growing number of studies exploring the experiences generally, of women who have had to access care delivered by the National Health Services (NHS) and draw attention to how healthy pregnant women with high BMI experience antenatal care services as delivered by the NHS.

Terminologies

Throughout this thesis, the term 'above average weight', 'overweight', and 'high BMI' will be used to describe women in this research. All of these descriptions refer to a BMI that is greater than 30kg/m², and the medical term for this category of women is 'obese', a term that I prefer not to use due to its clinical connotations. Literature suggests that women have expressed an aversion to the term as it denotes ill health (Murray, 2006) and the participants in these studies do not have any health or underlying

health conditions. The researcher's initial interactions with pregnant women within this research strongly indicated that the use of the term obese or obesity with them evokes strong and sensitive emotions. Other terms such as 'fat' and 'fatness' will also be considered throughout the thesis because literature from 'Fat studies' use these terms. BMI will be used throughout in this thesis to indicate a relationship between a person's weight in kilogrammes, and the square of the individual's height in meters and overweight or high BMI will indicate a measure of $BMI \geq 30 \text{kg/m}^2$. Fat or fatness will not refer to a measurement of BMI but a state of body variation. The use of the term healthcare professional will encompass midwives and obstetricians who are directly involved in the delivery of antenatal care to pregnant women with high BMI who are in the shared antenatal care pathway.

Thesis structure

This thesis contains nine chapters. The first chapter provides background knowledge about the research. Chapter two gives an insight into the constructions of high BMI as a risk factor in antenatal care. Its focus is to carry out a review and evaluation of biomedical constructions of high BMI and its impact on pregnancy and childbirth. This chapter also examines the role of the media, particularly how the media presents high BMI in pregnancy, accepts the construct of high BMI as a risk factor and the construct and presentation of BMI to pregnant women with high BMI, contrary to the assumptions and attributes recognised by the quantitative approach used in developing the BMI model as a measuring tool. It will also discuss how the role of the media has contributed to the construction of high BMI as a risk factor and how this is used to validate the medicalisation of childbirth. The chapter concludes with a critical examination of the effects of

medicalised antenatal care provision on the overall experiences of pregnant women. Chapter three outlines the political context within which discourses of high BMI, its risk to pregnancy and pregnancy outcomes and the necessity for intervention, take place. The researcher argues that this discourse, which is dominated by biomedical knowledge, currently determines the content and direction of antenatal care policies in the UK. In this chapter, the researcher argues that risk perception in Western culture resulted from a mechanistic view of the body. The chapter offers a deconstruction of presumed relationship between inactivity, gluttony and fatness, by drawing on Foucault concepts of medicalisation, the gaze of others (clinical gaze), surveillance, governmentality, and power and knowledge to explore the manner in which obesity discourse operates. Chapter four describes the methodological approach employed in carrying out this research and considers the impact of being an insider or an outsider as perceived by the participants. Chapters five, six and seven present and analyse the empirical findings relating to risk framing and how healthcare professionals communicate risk to women. Also in these chapters is, the discussion of how women perceive and understand risk framing, the consequences of using BMI as a criterion for ascribing risk to pregnancy, decision making concerning women's antenatal care, and the choices available to them. In addition, chapter six also highlights the ways in which women use their knowledge to seek a position of power to negotiate, question and challenge the options presented to them. Chapter eight presents a brief reflection on my experiences of carrying out the study and chapter nine concludes the thesis of the study and provides an understanding of pregnant women with high BMI and their perception of wellbeing. Chapter nine also demonstrates the potential benefits of using semi-structured interviews in the research study with a focus on the experiences of pregnant women with high BMI. It also highlights the constructed nature of knowledge and emphasises the ways our perception of some issues shift with time, place, and are socially and politically situated.

Also, it presents a discussion about how the theoretical underpinning and methodological perspectives that shape the research was achieved as well as its potential implications for the findings that the study will make. Any reference to names in the thesis other than cited references have been used as pseudonyms for participants in the study (see table 1).

Chapter 2

Biomedical constructions of maternal fatness

Introduction

The objective of this chapter is to carry out an in-depth evaluation of the biomedical representation of maternal fatness, and in so doing deconstruct how fatness is portrayed. Maternal fatness is held to be detrimental to women of childbearing age. This position is based on reports which are disseminated through scientific and medical literature as well as published health policies. The content of these reports, because they are judged to be scientific, are not subjected to scrutiny by the media and the wider society. The justification for construing maternal fatness as detrimental to pregnancy and the unborn child relies heavily on results from epidemiological studies. This reliance has resulted from the ease of access that the work of epidemiological scientists has to popular electronic and print media which it uses as a conduit to disseminate information to health professionals and the public.

The view that maternal fatness is a negative gained wide acceptance because of the access of epidemiological scientists to the media, which allowed them to place their findings in the domain of healthcare professionals, healthcare regulators, leading social and political leaders and commentators. This detrimental view of fatness, in the population generally and in women of childbearing age in particular, also greatly contributes to how risk is viewed and assessed in pregnant women with high BMI. These risks are therefore assessed in antenatal care and are used to make recommendations on how to screen women with the aim of identifying those that can be ascribed higher than 'normal' or 'acceptable' risk in pregnancy. The higher risk profile justifies the decision to assign these women to a shared antenatal care pathway. The process used by healthcare professionals to differentiate between the levels of risk to pregnant women

who share a similar health profile other than a difference in BMI is indicative of how BMI is perceived and framed by healthcare professionals. If the health profile of two pregnant women in all areas, including height, are the same, but they have different weight, and the one with a higher weight was adjudged to have a higher risk, then weight and risk are deemed by healthcare professionals to be synonymous. The use of the higher risk profile as justification for segregating women into different categories of antenatal care has its roots in the strength of epidemiological assertions about maternal fatness. It is this risk assessment, which is shaped by biomedical science that provides the support for the medicalisation of fatness and directly influences the antenatal care that is delivered to women who are pregnant with high BMI. Medicalisation creates room for increased surveillance and intervention for the purpose of; “just in case something goes wrong” (MacKenzie Bryers and van Teijlingen, 2010, p.492), though such categorisation, surveillance and medicalisation usually diminishes a woman’s ability to exercise choice. This chapter will also explore the potential for risk categorisation, surveillance and medicalisation to diminish and in some cases erode women’s ability to exercise choice.

Antenatal care offered to pregnant women with high ‘BMI’ in the UK

The National Institute for Health and Care Excellence suggest women, should be weighed when they first access their midwives for a booking visit (NICE, 2008, 2010, 2016). The weight recorded should be used to calculate BMI for assigning women to a category of antenatal care pathway (NICE, 2008, 2010, 2016). Antenatal care for women in the UK symbolically begins with this initial or first booking appointment with a midwife. At this visit, an initial risk assessment of the pregnant woman is carried out. The main purpose is to ascertain the type of antenatal care to offer to pregnant women. While a risk assessment is desirable, it has to be rigorous and

comprehensive when it is used to make decisions regarding the type of care a pregnant woman will receive. It should include assessing the physiological, emotional and mental health status of the pregnant woman to be considered comprehensive and to be able to deliver compelling evidence for gauging risk to pregnancy.

The risk assessment done during women's initial or first booking appointment is not comprehensive. It is limited to the collection of some lifestyle information, past personal and family health information, socio-demographic information and a measurement or reporting of the woman's height and weight. It is therefore not surprising that women feel that using their body weight measurement along with vague historical and socio-demographic information as justification for ascribing risk to their pregnancy and categorising them as in need of care that inherently includes medical intervention is aimed at medicalising their pregnancy (Lupton, 2012a, 2012b). It is important to note here that the NICE (2010) guideline also states that the antenatal care for women with an uncomplicated pregnancy is to be provided by midwives and General Practitioners (GPs) (NICE, 2010). This position would seem to conflict with the recommendation; that midwives and obstetricians should provide antenatal care for pregnant women with high BMI but with no health or medical conditions that could be considered a complication (NICE, 2010). The conflict from NICE (2010) recommendations comes from the fact that it clearly asserts that a pregnant woman with high BMI, but with no medical complication, should be provided with the same care as other pregnant women with a known complication. In so doing, NICE (2010) confirms that its view of overweight, pregnant women, is only formed through the lens of fatness as presented by the media. This is because NICE (2010) implicitly acknowledged, even when there is no evidence to support it, that there is a causative link between fatness and disease. Still, another explanation is plausible. That is the apparent conflict only exists because NICE (2010) did not intend its

guidance to be a rule-based framework but rather, to establish a principle-based regime, which both allows and encourages professionals to make judgements based on robust evidence. Assigning women to a shared care pathway just because they have high BMI, only categorically equates higher BMI with higher risks to pregnancy and fails to acknowledge the evidence that high BMI has only been found to have a higher probability of association with adverse medical conditions (Harper and Rail, 2012). This does not represent professional decision making as described above. Framing high BMI as high risk and using such framing to secure the support of the NICE (2010) guidelines in caring for pregnant women with high BMI in the same manner as women with various known medical conditions will undermine the purpose of NICE (2010) recommendations which amongst other recommendations is to safeguard women's ability to exercise choice.

NICE (2008, 2010) guidelines categorise women with BMI of 30kg/m² and above as 'obese' and women with a BMI of 40kg/m² and above as clinically 'obese', and stipulates that healthcare professionals give them information about diet and healthy eating by trained staff. This recommendation assumes that these women do not have healthy eating practices. It fails to use the opportunity to secure a better understanding of the whole range of reasons for fatness which includes amongst others, genetics and activity level. So, the antenatal care for women with high BMI sets off with a risk classification that resulted from the superficial understanding, knowledge of, and framing of high BMI. Medical doctors across various national borders have criticised the use of a BMI measure as a marker of risk, but health care regulators continue to use it internationally in guidelines for assessing and delivery of care. One of the reasons for the criticisms is that it uses arbitrary boundaries and features which affect the classification of individuals at the borderlines between these categories (Heyman, 2010a).

A critical understanding of Body Mass Index (BMI)

Some local authorities and Trusts have acted to address the growing trend of increasing body weight in the population generally with a particular focus on women of childbearing age and children. The recently introduced 'Monday Clinic', for example, was initiated to encourage women who are pregnant with high BMI to engage with services (NICE, 2011). The goal of the initiative is to help women to make positive and healthy lifestyles choices throughout the antenatal period and to support women to sustain positive lifestyle choices made during antenatal care even after childbirth (NICE, 2011). Doncaster and Bassetlaw Hospitals, an NHS Foundation Trust, took up the initiative to pioneer changes in the lifestyle and eating habits of women during pregnancy. They use teams led by midwives who are referred to as 'Healthy Lifestyle Midwife' to deliver the services in the schemes. The services or activities they provide consist of diet education and advice, counselling, aquanatal activities (swimming for pregnant women) and some exercise sessions for women (Williams and Garland, 2014). According to the report, Doncaster and Bassetlaw have provided this service since 2009 and have, as evidence of achievement, a dossier of success rate in the successive years. However, the service that began by working with pregnant women who have a BMI of 30kg/m^2 or higher has recently confirmed that following a review of clinical outcomes, it only now considers women with BMI of 40kg/m^2 or higher. This new focus on only pregnant women with a BMI of 40kg/m^2 or higher further strengthens the challenge of those who question the efficacy and effectiveness of using BMI on its own as a tool for assessing the health risks of individuals. This shift by Doncaster and Bassetlaw is also evidence-based as it was the result of a clinical review of historical clinical outcomes. Whilst the research for this thesis, and this thesis itself, does not suggest that BMI should not be used, as part of a cluster of variables, to gauge individual health position or status, it does challenge using BMI on its own to make a decision about individuals' health status. As a result, solely relying on the use of the BMI measure as a means

for calculating health risk, and wrongly framing such risk, in a narrative that suggests that high BMI represents actual rather than relative risk, cannot be presented as evidence-based practice as healthcare professionals currently do. While Doncaster and Bassetlaw did not discuss the nature of the review and the clinical outcome which supports the decision to move the BMI threshold for their Healthy Lifestyle programme (Williams and Garlands, 2014), the decision suggests that they no longer consider that the risk to health and health outcomes is significant enough to justify intervention if BMI is less than 40kg/m². The alternative argument is that financial constraint may have been a contributing factor for raising the applicable BMI threshold. Whether or not the outcome of clinical review or financial constraint is the reason for the change, there are many questions that the decision to change the BMI threshold did not answer. Did the review suggest that the risk associated with a BMI range between 30kg/m² – 39.99kg/m² is no longer cause for concern to justify intervention? Are pregnant women in this range and their unborn child or children no longer likely to suffer significantly higher risk exposure during pregnancy? What makes the risks of a BMI of 39.99kg/m² to pregnancy significantly less than the risk from a BMI of 40kg/m²? These questions are equally applicable to the accepted range set and use in delivering antenatal care to women in NHS sites. What is evident in this shift of the application of BMI as a clinical tool for assessing individual health conditions is that it is subject to the perception of those deploying it for clinical decision-making. As a result, the fluidity and arbitrary nature of the obesity classification cut-off points (Ross, 2005; Evans and Colls, 2009; Heyman, 2010a, 2010b; Jette and Rail, 2012) weaken the claim of evidence-based practice made by medical professionals who rely on the BMI level for categorising pregnant women. In a similar context, Health Canada (1999 cited in Jette and Rail, 2012, p.414) changed the cut-off points for pregnant women from an upper limit of 27kg/m²; usually perceived to be normal BMI for pregnant women; to 24.9kg/m². The aim was to ensure a match with the Institute of Medicine (IoM) guidelines

(Rasmussen and Yaktine, 2009). This change moved women who were previously in the normal BMI range of 25, 26, and 27kg/m² to the overweight classification, and they were advised to lose 10kg to fit into the classification of 24.9kg/m² or lower (Jette, and Rail, 2012). Jette and Rail (2012) queried this outcome and asked if it was evidence-based given that the initial classification was recommended and used for assessment which produced an outcome that was described as based on “valid and reliable evidence” (Jette and Rail, 2012 p.414). Marking women as having a higher risk factor on account of weight, has a tendency to create both personal and social pressure for women to get out of this risk-status position (Heyman, 2010b). Also, this may force women into a position where they apportion blame to themselves despite the fact that factors outside their control such as their genetic makeup may, in fact, provide the explanation for their body weight (Joffe, 1999; Heyman 2010a) and/or the cause of their weight gain. Healthcare professionals use the BMI measure for the sole purpose of calculating risk to or for profiling the risk of body fat to a woman’s pregnancy, and to establish whether or not to intervene medically. As a result, healthcare professionals use the BMI measure to make a categorical pronouncement about the existence or otherwise of a medical condition in women with high BMI. It is this perception and framing of weight and the pressure that comes from the pronouncement of highly regarded national institutions which support this perception and framing that healthcare professional draw strength from to justify the treatment of pregnancy in women with high BMI as a medical condition. As already stated, NICE (2008, 2010) guidelines require midwives and obstetricians to work in collaboration and provide additional care to pregnant women with a BMI 30kg/m² and over. The additional care is in the form of screening, monitoring or medical intervention that other pregnant women do not receive. This thesis argues that, the pregnant participants in this study were cared for differently because of their high BMI, which the guidelines and healthcare professionals construed as a medical condition or a state of health that is indicative of the

existence of or the onset of a medical condition. This suggestion fails to recognise that there is no universally agreed range of BMI which is indicative of probable health outcome. The lack of agreement is evident in the contradiction in the guidelines given by health regulators in different territories; for example, the difference between healthy BMI range for pregnant women in Canada and the UK, (Davis et al., 2009; Lowell and Miller, 2010). Thus, there is no agreement on the use of BMI as a marker of risk to health outcomes. Along with this lack of agreement on the validity of using BMI to gauge health risk, there are also differences regarding the thresholds within which risks apply. As a result, the manner in which BMI is currently used to categorise 'obesity' may capture both individuals who may or may not experience any health issues (Heyman, 2010b) and present them as either exposed to or safe from higher risk when this is doubtful.

The cut-off produced by BMI is such that it creates anxiety in women, who desire to be cared for within the traditional midwifery-led antenatal setting, to achieve an approved body weight before considering pregnancy. As a result, women push to be fit and to achieve a 'normal' BMI before considering procreation (Jette and Rail, 2012). NICE (2010) guidelines for women before, during and after pregnancy shows an intention to direct healthcare providers on 'best practice' as they provide care for women to address pregnancy and weight gain in the clinical context (Evans and Colls, 2009). Similarly, in Canada, guidelines set out to guide the antenatal care for pregnant women who are overweight was produced by the Society of Obstetricians and Gynaecologists of Canada (SOGC, 2010). Its purpose is to address and manage weight gain in women with weight related issues. The guidelines, Murphy Paul (2008, cited in Jette and Rail, 2012, p.408) argued, was created in light of concerns that pregnancy in overweight women is a key contributor to the purported "obesity epidemic" in the West (Boero, 2007, p.1). However, according to Wray and Deery (2008) there is no agreement on what constitutes 'fatness' or its impact on health. Besides the

picture of ill health, attributed to an obese state, which is currently offered to the public, there is the contention that it is not as precise and certain about the link between obesity in women of childbearing age and the obesity epidemic, (Boero, 2007). The healthcare and medical community has considerable concern about claims of links to numerous health risks, for both mother and the unborn child during pregnancy with a high BMI (Institute for Medicine, 2009; McKnight et al., 2011). This is because of the lack of clarity in the link between maternal obesity, the obesity epidemic and medical or health outcomes for the unborn child. Also, the use of BMI as a tool of health indicator has been criticised, because it does not make provision for differences between ethnic groups (Gard and Wright, 2005; Evans and Colls, 2009). Further, the use of the BMI measure as a healthy weight indicator was questioned by Bagust and Walley (2000) who advocated a different standardised weight-for-height measurement. Bagust and Walley (2000) believe that standardised measurements of body weight for stature, as used in BMI, has an attribute of frame dimension rather than just adipose tissue. As a consequence, BMI has a tendency to underestimate the prevalence of overweight and obesity among the tallest individual and over-estimate it among the shortest. This alternative proposed by Bagust and Walley (2000) has been used nationally or internationally. Just as BMI is used to gauge health status in pregnancy and childbirth, it is also used as an indicator of women who should qualify for fertility treatment (Pasquali et al., 2007; Brewer and Balen, 2010; NICE, 2013). The rationale for using BMI in this way is because NICE (2013) guidelines recommend explaining to women that if their BMI is 30kg/m² or over, they are more likely to take longer to conceive. As a result, women with high BMI are informed to lose weight to increase their chances of conception (NICE, 2013). Also, the British Fertility Society (2007) also concurred with this view stating that all women seeking their service are advised to achieve weight suitable for their height before thinking about conception. These pronouncements and guidelines serve to put huge pressure on women with high BMI even when there are questions

about the use of BMI as an indicator along with its arbitrary application between times and boundaries; as in Canada and UK (Doncaster and Bassetlaw Hospitals).

The purpose of this research is not to dispute the claim that there may be risks factors associated with high BMI generally and during pregnancy. Similarly, this thesis does not refute the counter claim that there might be risks associated with very low BMI for health and wellbeing generally and during pregnancy. However, the study advocates carrying out a critical evaluation of the use of clinical guidelines that puts women into high-risk classification only because of high BMI, and so shape how they navigate and experience antenatal care services throughout their pregnancy and childbirth. Although NICE (2010) asserted that they only use validated evidence in published guidelines, they remain greatly problematised because the evidence used is questionable. As a result there is continuing challenge to the objectivity and reliability of BMI as a measure of bad body fat or an indication of health risk (Campos, Saguy, Ernsberger, Oliver and Gaesser, 2006).

Despite these challenges to the accuracy and effectiveness of BMI as a measure that indicates health-risk and outcomes from within the medical and social science disciplines, the guidelines published by national regulators of healthcare such as NICE (2010) and SOGC (2010) continue to use BMI as a key health marker. The recognition accorded to BMI as a marker of health risk has resulted in healthcare professional being able to categorise pregnant women with high BMI as being at greater risk and subject them, their pregnancy and childbirth to medical surveillance (Davis et al., 2012). Feminist commentators have asserted that monitoring and scrutinising the weight of women as part of reproductive health assessment is an exercise of power over women's bodies (MacDonald, 2004; Weir, 2006). They argued that the current effort to focus on the pregnant body in response to the

medical profession and societal concerns regarding excessive weight gain during pregnancy may not be coincidental. This claim is consistent with Foucault's (1997) assertion that the pregnant body is an ideal site for the administration of what he described as bio-power. Furthermore, he explained that the transformation in the exercise of power emerges with the birth of liberalism and the idea of a government that must control the life of, and achieve better management of, the labour force (Foucault, 1997). According to Lupton (2013) liberalism depends on their citizens to adopt their injunctions voluntarily rather than through the use a punitive power to maintain social order and to increase production. Thus, Foucault (1997) uses bio-power to refer to modern political states' new focus on life by monitoring its citizens through the subjugation of bodies, for example, regulation of habits, family life, sexuality, wellbeing and health promotion. Apparently, the pregnant body is an appropriate avenue for the implementation of tools, expertise, techniques, and means intended to produce a healthy and approved social body for women of childbearing age to secure a healthy future generation (Jette and Rail, 2012; Lupton, 2013). Research scholars have challenged the use of BMI to categorise pregnant women and place fat bodies into 'normal' and 'not normal' pregnant bodies. They asserted that the categorisation of women in this way is used to justify and enforce intense monitoring for the purpose of mitigating against risks to women and their unborn child, as well as to achieve an uncomplicated childbirth (Lupton, 1999, 2013; Weir, 2006).

Risk construction within healthcare/practices

Most dictionaries define risk as the possibility of incurring misfortune, loss, or hazard. According to Renner, Gamp, Schälzle, and Schupp, (2015) the way risk is perceived is a prerequisite for taking action. They assert that, because of the fundamental role that perception plays in response to risk, it is important to understand how risk is perceived. It is also important to state that risk perception in healthcare is related to health outcomes and

wellbeing. Risk, in healthcare, is the chance that someone will encounter a specific adverse health outcome with undesirable impact, for example, disability, or in the worst case scenario, death (Lupton, 1999; Heyman, 2010b). The general and healthcare definition of risk acknowledges that it is merely a chance or possibility of something going wrong. Risk is, therefore, an indication that something might go wrong without any quantifiable certainty (Lupton, 1999). Risk does not suggest that something is likely to happen; in statistical terms it acknowledges a probability that an event may happen.

The perceptions of those actively measuring risk can shift the phenomenon of risk from a state of possibility to that of probability, and this then requires action to mitigate the likelihood and impact of undesirable occurrence. NICE (2010) guidance that recommends that pregnant women with high BMI should be provided a risk-focused antenatal care, confirms their framing of high BMI as a probable risk that requires action to manage and mitigate. Actions to consider, as part of the effort to mitigate health risk, are discussed with women as a result of their BMI. They are therefore provided risk focused antenatal care under a shared pathway which requires the involvement of a midwife and an obstetrician. The discussion also includes information about the types of surveillance monitoring women will undertake as a result of high BMI so as to prevent any uncertainty. Women by the end of the discussion are provided with a string of information about their care, which Heyman (2010b) has argued, is a form of risk information packaging for women. Heyman (2010b) also asserts that risk management closely follows the provision of risk information. The contemporary concept of risk is a result and phase of the modern development of society. Scholars have explained that in this modern day society, individuals, social and political groups created by the force of modernisation, increasingly avoid adverse outcomes and the impact of risk, by using the control and protective institutions of the industrialised society (Beck, 1996).

Further, Joffe (1999) argued that maybe there was less emphasis on risk in the pre-industrialisation era. This may have been the reason for the acceptance of what was considered a natural event in the pre-industrialisation era, as a risky event but as occurrences which were not indicative of threat. That view of risk has since changed, and it is now the norm to discuss threats of adverse outcomes and their impact as a calculable risk which can be managed, mitigated or eliminated to reduce or avert the worst from happening (Heyman, 2010a, 2010b). This desire to mitigate the occurrence and/or impact of risk is in line with the modern mission to promote rational control in every aspect of life. According to Beck (1996) risk is a social construct which is defined strategically and sensationalises within the public sphere with the huge help of scientific resources delivered for the purpose. Beck (1999) and Giddens (1991) asserted that because risk identification and calculation requires expert knowledge and skills, lay people will rely on their assessment. Also, lay people will ask for advice from experts on the prevalence of risks and how to avert them as in the case of pregnant women when they consult their healthcare professional during antenatal visits. In the broader healthcare environment, interest in risk discourse has increased, with the claim of 'evidence-based' as a justification for it (Symon, 2006). Healthcare professionals use this evidence-based claim as justification because of the recognition it is accorded in the hierarchy of medical and scientific research. It is therefore used by healthcare practitioners to give credence to why risk classification has to be considered to avoid harm in healthcare settings (Symon, 2006).

The use of 'evidence' in modern science has generated a sophisticated body of knowledge with regards to claims of the most effective methods of treating diseases (Alaszewski, 2010). It is within an environment where evidence-based or expert knowledge are highly rated, that healthcare practitioners were socialised. As a result, the model used for healthcare

planning is driven by statistical data, and this produces categories based on data and these are then used to inform healthcare management (Symon, 2006). Lupton (2006) argued that as healthcare practitioners rely heavily on expert knowledge of science and medical evidence for their practice, they cite it as a defense for risk classification. As a result of this absolute reliance on risk experts by healthcare and medical professionals, the knowledge, and perception of the individuals using healthcare services (such as pregnant women) about risk is completely ignored (Lupton, 1993, 2006). Meanwhile lay knowledge may, in fact, have greater validity than scientific or medical knowledge of risk, and the risk-assumptions healthcare professionals make to exert control over service users' behaviour, (Lupton, 2006) maybe invalid. Thus, pregnant women with a high BMI may either conform to this control or try to resist it.

Perceptions of risk within antenatal care

In contemporary Western countries, most women enjoy healthy and straightforward pregnancy, labour and childbirth (Lee, Ayers, and Holden, 2012). However, some women still experience complications during pregnancy and at delivery. As a result, NICE (2008, 2010) recommend providing specialised or risk-focused antenatal care for women who may experience a complication. The focus of high risk antenatal care is therefore different to the traditional midwifery-led antenatal care. The shared care pathway and the midwifery-led pathway are the description given to the antenatal care delivered to pregnant women with potentially high-risk and low-risk (NICE, 2008, 2010) pregnancy and pregnancy outcomes respectively. The shared care pathway is a risk focus antenatal care.

NICE (2010) identifies two types of pregnancy; a high and low-risk pregnancy in its recommendations, it is therefore necessary to define low and high risk in pregnancy. On the one hand, low-risk pregnancy is one perceived to be without any unexpected complications; and the guidelines

suggest that midwives and GPs should provide the antenatal care for women who fall into this category with ad hoc involvement of obstetrician and other specialists if additional care is needed (NICE, 2008, 2010). The alternative is a high-risk pregnancy. That is a pregnancy that is perceived to be in need of additional routine care outside the care provided by midwives and GPs. This may be because women have encountered problems in previous pregnancy or have pre-existing risk factors. For example, diabetes, hypertension, epilepsy, severe asthma, HIV, obesity (BMI 30kg/m² and over), multiple births, or attainment of the age of 35 years or above. An additional indicator of increased risk for placing women in the high-risk category of care is “complex social factors” (NICE, 2010. No page) for example substance misuse, being recent migrants, asylum seekers or refugees, lack of English language fluency, age under 20, domestic abuse, poverty and homelessness (NICE, 2010). Other circumstances that have led to the high-risk classification of pregnancy includes physical conditions, being a member of an ethnic minority (the UK and the USA), and having low-income status. The reason for the inclusion of the last two factors is because low-income populations are the ones that are more likely to die from pregnancy-related issues than Caucasians or those in higher socio-economic groups (Amnesty International, 2010; CMACE, 2011).

The Centre for Maternal and Child Enquiries (CMACE 2011) re-echoed their previous recommendations (Lewis, 2007, CEMACH), and advised that antenatal care should be accessible and friendly to overcome barriers women face and to improve the outcomes for the health of women and newborn health. An appraisal of the treatment of pregnant women, as they navigate access to antenatal services within NHS sites, reveals that there is a strong appetite for healthcare professionals to categorise pregnancy as high-risk with the objective of medicalising pregnancy. This is evident in the interaction between healthcare providers and pregnant teenagers as well as pregnant women who are over 35 years. Though there is no specific guideline from health regulators about pregnancy under the age of 20, and

there are no evidence-based clinical findings that suggest greater risk to pregnancy and childbirth with women under 20 years, NICE guidelines categorised these women as high-risk, (2010). As a result, these women experience the shock that their pregnancy has been categorised as high-risk when they access antenatal care. It is the same experience for women who are over 35 years of age. Healthcare professionals replicate this arbitrary classification which allows healthcare professionals to intervene and monitor pregnant women medically even when they do not have any known medical condition (Heyman, 2010b). Wray and Deery (2008) and Lupton (2013) challenged the arbitrary definition of risk to pregnancy which is predicated solely on a BMI measure that is not accepted or recognised to be able to produce certain and reliable measure or indication of bad fat. Also, BMI does not indicate the existence of or identify the location of bad fat (Heyman, 2010b) in the human body. Wray and Deery (2008) and Lupton (2013) also questioned why weight constitutes a problem during pregnancy and childbirth.

According to Bayrampour, Heaman, Duncan, and Tough, (2012) women's perception of risk is influenced by several personal characteristics such as age, the woman's support network, her ability to control her circumstances, whether or not she is in a relationship, has a job and her general state of health. Their experience of antenatal care is also perceived differently, this too also depends on the manner in which her midwives and or obstetrician communicate and discuss risks classification and the way forward with women (Lee et al., 2012, Lee et al., 2014). In Lee et al.'s study, women who are considered high-risk during pregnancy found it a difficult situation, hence they sought ways to acquire knowledge about the risk category they had been ascribed, to make sense of the situation. They sought knowledge and evidence from outside their interaction with the antenatal care team to weigh the odds of the risks mentioned by healthcare professionals happening to them (Leichtentritt, Blumenthal, Elyassi, and Rotmensch.,

2005). In most cases, women responded with fear and showed anxiety and frustration and struggled to hold on to hope, and the emotions that they showed were affected by their personality and social-cultural background (Lee et al., 2012; Lee, 2014). Similarly, reports suggest that the risk perception of pregnant women with high BMI depends on how healthcare professionals communicated risks to them (Lee et al., 2012, Mills, Schmied and Dahlen , 2013). Nyman et al. (2010), Keely, Gunning and Denison (2011), and Mills et al. (2013) asserted that pregnant women understood their weight to be a possible risk factor that could impact on themselves and their unborn child negatively. However, that awareness was not acquired before they became pregnant. For example, pregnant women with a BMI of 40kg/m² and above had awareness about 'obesity' as a risk factor but only developed such awareness at the beginning of their pregnancy (Keely et al., 2011). Other studies have also reported that women do not have any knowledge about the relationship between excess body weight and risks (Keenan and Stapleton, 2010; Keely et al., 2011; Heslehurst, 2011; Heslehurst et al., 2013). Lee et al. (2012) argued that, given the relative lack of risk awareness and/or the different risk perceptions by women, that the use of improved communication should be used to achieve a better understanding for women categorised as having a high-risk pregnancy. The improved understanding may then contribute to a positive experience for pregnant women.

Risk information sharing and communication have a significant impact on how risk is perceived (Edwards, Elwyn and Mulley, 2002; and Keller and Siegrist, 2009). Keeler and Siegrist (2009) asserted that the use of various graphics and numerical data, irrespective of whether the data is representing a positive or negative outcome, could impact how the recipient of data perceive the concept of risk that is conveyed. Over-emphasising risk and its consequences make those who are the subject of the potential hazard to be more receptive to suggestions of options proposed for mitigating identified

risk. MacKenzie, Bryers and van Teijlingen (2010) have asserted that information given by doctors is sometimes used to exert control over women. The result is that it leads to women expressing informed compliance rather than making informed choices (Jordan and Murphy, 2009). Also, Lupton (1993) asserted that the communication of risk in a manner that shapes perception may be used to exert control over behaviour by encouraging the concept of social cohesion. The ability to use communication to control behaviour may explain why medical conditions that are associated with high BMI are over-emphasised, but the types, attributes and actual implications of risk are not. A good understanding of risk, which will include an awareness of the differences between relative and absolute risks as well as the attributes of relative and absolute risk will enable women to understand the risk communication. The understanding will empower women and other stakeholders in maternal health to assess the safety of pregnancy and the likelihood of negative outcomes.

Pregnancy and childbirth are believed to be safe for women in wealthy countries, but it continues to be perceived by medical professionals in these countries to be risky (Jette and Rail, 2012; Lupton, 2013). Technological advancement that is designed to improve the safety of pregnancy and childbirth through sufficient information about the state of the woman and unborn child may have created concerns that required a medical response (MacKenzie, Bryers and van Teijlingen, 2010), which in turn, evoked more intolerance of risk. The result is the belief that there is a professional responsibility to minimise or eliminate all level of risks (Jordan and Murphy, 2009). Enkin (1994) and Handwerker (1994) drew attention to the fact that doctors' practices which includes the discussion of risk may be affected by an awareness of this responsibility and a fear of litigation rather than medical consideration.

Handwerker (1994) argued that risk status is more likely than not to be amplified than lowered during pregnancy; and Enkin et al. (2000) asserted

that there is difficulty in explaining the degree of association of variables such as high BMI, to adverse conditions for women during pregnancy. The task of identifying the role of the factors or variables is even more challenging where there are multiple risk factors associated with pregnancy because of the challenge of assigning values to the variety of factors before integrating them into a single risk score. When healthcare professionals who deliver care to this category of pregnant women assess how BMI as a factor engenders threat in pregnancy, they ignore the limitations that are inherent in assigning values to a variety of factors that impact the overall measure of risk. They treat BMI as the sole, rather than it being a part of a multiple of, factors that should be used to identify a single risk score. This construction of BMI and the danger it ascribes to positive health outcomes, is the reason healthcare professionals feel able to categorise women solely on the evidence of their BMI measure. Also, this construction of high BMI and the risk it represents is used to recommend a medical option without considering other options that may be more appropriate such as social intervention.

The social construction of risk, according to Lyerly et al. (2009) provides an indication of how risk advice can be applied, in a non-interventionist approach to maternity care with the aim to change behaviour. For example, a pattern of risk perception reversal which is believed to be possible between pregnancy and childbirth is elaborated by Lyerly et al. (2009). They assert that throughout pregnancy, physicians' advice tends to be about urging women to abstain from any behaviour that is perceived to be risky; hence women are instructed to avoid certain foods and medications, exposure to radiation, and restrain from participating in certain activities. However, they reported that in the management of pregnancy and childbirth, an interventionist approach was used because the risks to pregnancy and outcome of failing to intervene are assessed to be more significant (Lyerly et al., 2009) by healthcare professionals than pregnant women. For example, pregnant women offered descriptions of vaginal birth were prepared to

endure a much higher level of risk to themselves to accomplish natural childbirth, than their physicians (Turner, Young, Solomon, Ludlow, Benness, 2008). Another example, drawn from a qualitative study conducted to ascertain risk perception in high and low-risk pregnant women, found that women with high-risk pregnancies were more likely than those in low risk to distinguish the perceived risks and link them to themselves rather than linking the risks to the baby (Heaman et al., 2004).

Healthcare professionals perceive risk differently, and this depends highly on the two models of care; social and medical models of care (Graham and Oakley, 1986; Lee et al., 2012) that shape the content and form of their training. The medical model, on the one hand, tends to focus on anticipating pathology which is promoted by obstetricians, and this dominates antenatal practice in the UK and most developed countries today (Graham and Oakley, 1986). This model will be unpacked by looking at the biomedical interpretation of risk perception in antenatal care, demonstrating how language and 'authoritative' knowledge is used to perceive, frame and reinforce risk. The medical model, backed by its technocratic model of birth and medical culture, and its understanding of human biology controls the criteria of acceptability when it comes to risk perception in pregnancy and childbirth (Lippman, 1999; McLaughlin, 2001). Given that obstetricians determine risk through various factors such as physical, medical history, obstetrics and pregnancy-dependent risk factors, the concept of risk is therefore inextricably entwined with pathology and puts pregnancy and childbirth along a continuum of risk (Murphy 1994; Honest et al., 2004).

This practice views pregnancy and birth as events that require medical control and monitoring to avoid harm and guarantee safety. MacKenzie Bryers and van Teijlingen (2010) assert that it is the preferred position of the medical model to enforce intervention at the earliest indication of pathology. The rationale for this is explained thus "childbirth is normal only

in retrospect" (Mason, 2001, No page). This construction of risk requires obstetricians to proactively diagnose risk factors so that they can develop appropriate plans for risk management. Obstetricians are trained to proactively see pregnancy, labour and delivery as unsafe before the achievement of a safe birth (Brooks, 2006) and this belief shows in their interaction with pregnant women receiving antenatal care from them. Further, Foucault's (1972) concept of 'authoritative scientific knowledge' explains how the medical construction of risk and its use of that construction, which obstetricians perceive to be objective, influences their practice. The belief that the framing of fatness is authoritative knowledge has far-reaching influence on individual obstetricians and their interpretation and communication of risk. Edwards and Murphy-Lawless (2006) argued that risk construction may be, entirely, dependent on scientific thought. This position presupposes that science alone can be the evaluator of risk and that science alone can objectively define and accurately measure risk. This belief fails to link the numerical measure of risk to the impact of actual occurrence and also ignores the real factors, including individual and group experiences and circumstances that shape the impact of the adverse event.

Ortendahl (2007) in an assessment of the way the medical model uses risk language, claimed that there are those who believe the explanation that the use of risk oriented language by obstetricians and their construction of risk is for the benefit of women and their unborn children. They believe that it is intended to safeguard the health and wellbeing of women. As a result, risk language is about danger and pathology, and this imposes a particular worldview on women and their families (Symon, 2006). According to Ortendahl (2007) the medical worldview reinforces the emotions of fear and uncertainty in pregnancy and birth, whilst at the same time, elevating the biomedical structure to a point where it holds the authority and power to reduce risks and fear through intervention.

A social model which is used by the midwifery profession, on the other hand, emphasises the importance of a woman's birth space. Some scholars believe that the most successful and safest births are births that occur in an environment which the woman creates for herself as it affords her a feeling of safety and being in control, and affords her less apprehension (Graham and Oakley, 1986). The foundation of the social model is the principle that the childbearing process is a natural event; a concept that midwifery training promotes and perceives to be true. Midwifery believes in the natural ability of the woman's body to carry out its childbearing function and support the expectation that most pregnant women will have a normal and safe childbirth with little or no biomedical intervention. Women who are expected to have complications; on the evidence of how their pregnancy is progressing not BMI; can be predicted, selected and supported (Oakley, 1999). This social model, which midwives promote, works with the tenet that identifies three factors that are most significant to women in the childbearing process namely choice, control and continuity of care usually referred to as the 3Cs (Walsh, 2006). As choice is central to how women experience antenatal care and childbirth, the Rational Theory of Choice and related concepts such as egoism, was used in analysing data. This Theory was used in addition to the concepts of power and knowledge, to analyse the interaction between women and obstetricians regarding choice (Scott, 2000).

Systematic reviews have demonstrated that midwifery care and its focus on the 3Cs results in positive outcome for mothers and their children (Hodnett, Gates, Hofmeyr, Sakala and Weston, 2011, Hodnett, Gates, Hofmeyr, and Sakala, 2013). Midwives' view of the childbearing process as a normal and healthy process, however, does not rule out the fact that midwives acknowledge that there are potential risks inherent in pregnancy and childbirth (Graham and Oakley, 1986). The influence, of the social model, upon the training of midwives, places less emphasis on virtual risk. As a

result, they make a conscious effort to observe women, identify their needs, encourage and support the physiological process of pregnancy and childbirth and at the same time be attentive to any indication of abnormalities (Hodnett, 2007 et al. and Hodnett et al., 2013). These factors place the midwife in a knowledgeable position where her skills and experiences are used to view risk, through ways of knowing, and connecting with women to give them control and support them when they challenge the definition of biomedical risk (Chadwick and Foster, 2014).

To conclude on the biomedical and social perception of risk, what is evident is that the medical community emphasises the notion of risk as a concept that can be objectively measured and used to guide practice and mitigate potentially adverse outcomes. This belief is grounded in the findings of epidemiological research that are reported in medical articles and media reports and from which the medical profession draw authority to support its claim of evidence-based care. This claim of evidence-based care is the medical practice highest claim to a superior knowledge in childbearing (Edwards and Murphy-Lawless, 2006). They do this to exert authority and power over women and midwives in antenatal care services. In the end, the medical perception of risks in pregnancy and childbirth and intervention can be complex. However, a thorough understanding of the social model and its emotional context can enable a different approach to risk perception in pregnancy and childbirth.

To halt the media reliance on epidemiological reports as the only source of truth forming or knowing about fatness, proponents of the social model such as the Nursing and Midwifery Council and feminist groups must do more. Additional efforts could include greater support for research into the social framing of fatness and engaging more with media to put the outcome of such research efforts in the public domain.

Media constructions of fatness

“Women who are obese before becoming pregnant 'are at TWICE the risk of their baby dying in infancy” (Parry, 2015, unpaginated). Parry did not discuss what the risk of a child born to a woman that is not obese is of dying in infancy. The risk could be any value between zero and one; zero if there is absolutely no chance of a child born to a non-obese woman dying in infancy and one if it is certain that every child born to a non-obese woman will die in infancy. The statement emphasised 'TWICE' without indicating that it is still within zero and one, which is hypothetically the same in real terms though more concerning in statistical terms. So, the use of 'TWICE' is an example of how the media hype up the significance of risk which may not be meaningfully different for various groups by employing relative rather than absolute risk measures.

This section of the chapter will look at the popular media and the “obesity epidemic” messages they send to the public (Boero, 2007, p1). To do this, the report will discuss, briefly, how information is accessed for printing and disseminated to the public. Also, this thesis will explain the way medical knowledge about fatness during pregnancy has been communicated to the general public through print and electronic media, and how the media present a view of maternal responsibility. There will also be detailed commentaries on a review of news about increasing birth to unusually large babies and lastly a review of stories regarding the impact of the 'obesity epidemic' on the NHS, (Boero, 2007).

The popular media is a major contributor to the determination of and the definition of what constitutes public health issues or social problems (Maher, Frazer, and Wright, 2010). Public health concerns made popular in the news media includes fatness (presented in news media as the 'obesity epidemic'), teenage pregnancy, drug use, alcohol, domestic violence, and so on. The press is able to frame the social problem as health and illness related issues

because of the general acceptance that the media only reports opinions of experts, scientific and medical evidence and assertions about realism and 'truths' (Lupton, 1998). This notion that the media only reports objective expert opinion, which is accurate, genuine and transparent is embedded in the subconsciousness of individuals and groups within societies. This belief is backed by the perception that media reporting is based on reliable scientific and medical evidence which has been objectively presented, are unbiased and represent valid claims to realism and truth. This perception of the media by the public is also internally manifested by the press's almost complete reliance on research reports; especially those published in peer-reviewed journals. This relationship between the media and the society which is the recipient of the outcome of media activities, is an endless cycle which compels the media to constantly seek out authoritative sources that may not be accurate, objective, complete or transparent in their perception, construction and framing of realism or truth. The finding of van Trigt, de Jong-van den Berg, Haaijer-Ruskamp, and Tromp, (1994) from a study of the sources of medical information reported by journalists disclosed that all journalists utilise professional medical journals and press releases from pharmaceutical companies. The staff of these popular media also confirm using sources from universities and conferences, governmental organisations and contacts with researchers. However, journalists in the study confirmed that consideration is mostly given to the medical journal as the most reliable source of information; this is because medical research is peer-reviewed and perceived to be independent and a source of legitimate knowledge (van Trigt et al., 1994).

A concern expressed by Harrabin, Coote and Allen (2003) is the fact that medical reports relayed to the public by popular media which should be without bias and in an appropriate manner to avoid misinterpretation by the lay public, is now being manipulated. In addition, modern media now have reality shows focussing on lifestyles and health and operate as a healthy

arena which encourages surveillance of bodies, both by self and others, especially with regards to the putative 'obesity epidemic' (Rail and Lafrance, 2009; Warin, 2011; Rich, 2011; Boero, 2007). Often, media discourse is aligned with governmental health documents and health promotion discourses, which Saguy and Almeling (2008) argue is the interconnected role of science and medicine news that shapes the way 'obesity' is framed as a social problem. For example, the phrase from WHO (2000), which declared obesity as a "...serious disease" (WHO, 2000, p.4) and gave the recommendation to limit the "...global obesity epidemic" (WHO, 2011 not paginated) is aimed at extracting a response toward addressing the problem of weight or obesity. According to Hilton et al. (2012) media interest in fatness stemmed from concerns raised by WHO, and information from its reports and other epidemiological studies, are picked up by journalists to play in the framing of obesity as a public health and social problem (Hilton et al., 2012). Saguy and Almeling (2008) have queried the manner in which news media frames these by asking questions which includes whether they sensationalise information that they report to the public, do they paint morally neutral scientific explanations with moral overtones or are journalists simply reflecting the moral condemnations of 'obesity' in the original medical science report. As I conducted this research, I was interested in how women situate themselves according to information about 'maternal obesity' and being pregnant with high BMI. I was keen to know how they negotiated popular media discourses pertaining to pregnancy with high BMI as reviewed literature indicated that such navigation or negotiation of media discourse is affected by audience reception, which may include acceptance of media intended meanings, or total rejection of these media representations (Gill, 2008).

According to Hilton, Patterson and Teyhan (2012) the focus of the media on pregnant women who have high BMI has been a part of why the wider 'obesity epidemic' is thought to be on the increase and referred to as co-

morbidity if women are pregnant with high BMI and if there is a prognosis suggesting that pregnant women are diabetic. Explaining this, Hilton et al., (2012), asserted that popular media are of the opinion that the increasing prevalence of gestational diabetes mellitus and type 2 diabetes mellitus is as a result of the increasing rate of 'obesity' in the society. A number of social scientists (Boero, 2007; Saguy and Almeling, 2008; Monaghan, Hollands, Pritchard, 2010), have shown interest in the manner in which fatness is portrayed in the media, but they have not paid particular attention to the issue of maternal fatness or being pregnant with high BMI which is the focus of this research. Scholars have questioned the rationale behind media focus on the role of overweight mothers whom they perceive as unconsciously contributing to the raising of a generation of unfit and unhealthy children as 'fat' women raise 'fat' children. The media involvement in shaping opinion and belief regarding maternal overweight is not restricted to the print media.

Media and Epidemiological Reinforcement of Stigma

The media act as a social station for the communication of information to the public. The different medium used in disseminating information ranges from television, radio, newspapers, magazines, journals and the Internet. (Boero, 2013). The media is a conduit for the generation of assessment criteria on results of health issues and it is also used to produce and disseminate scientific facts or truth to the public (Wray and Deery, 2008; Boero, 2013). Thus, media coverage of obesity news evokes debates and these debates inform policies (Ries, Rachul, and Caulfield, 2011). Explaining this, in their comparative study of media framing of obesity, Ries et al. (2011) argued that different countries frame policy differently given their own country's context. Boero (2013) also asserts that the media coverage on obesity does impact policy. A key outcome of the impact of media discourse on obesity is its capability to shift the construction of obesity from a social to a health or wellbeing variable or issue, and focus more attention on demographic groups

within national and or global population. As a result, obesity is often qualified, for example childhood obesity or maternal obesity. However, the potential for these anti-obesity campaigners to unintentionally increase stigma amongst overweight people has been highlighted (Puhl, Peterson and Luedicke, 2012). Puhl and colleagues assert that with the constant focus on 'fat' bodies by various media of communication, and the call for the public to embrace the urgent need for intervention, 'obesity' continues to evoke a feeling of stigma. Boero (2012) argues that the media get information about obesity from scientific authorities; they then use the information to present 'obesity' as a problem and portray the problems as health concerns and economic anxieties. Anti-obesity commentators then coin words to amplify these concerns and anxieties. These emotive descriptions for example 'obesity time bomb' or 'fatness is a problem of epidemic proportion' are adopted and recycled between the mass media as they push for actions that will urgently tackle obesity. As usual, the Government respond to the concerted effort of the media by initiating and evolving policies to support proposals aimed at reducing 'obesity' (Puhl et al. 2012). For example, the imposition of soft drinks levy by the government following experts' endorsement though members of the public voiced strong opposition to the levy. The reason provided for the soft drink levy, per the UK.GOV website, is that the UK has one of the highest obesity rates among developed countries, and it is a growing problem (GOV.UK, 2016).

Davis Floyd (2004) adopting an anthropological approach, argues that obstetric practices and 'rituals' that take place in Western maternity settings are highly sophisticated and occur in technocratic environments. This environment adopts a scientific perspective of the human body and its functions and treats the maternal body as a machine. In this context, childbirth is a mechanical process rather than a normal life event. The medical model mirrors masculinity and so devalues the experiential knowledge of women as well as that of their midwives. Reed (2005)

also alludes to an extended aspect of continuous patriarchy within maternity settings in the West. He cites an example of the role of men in the birthing process and argues that birth is perceived as a biological process of women's bodies, which men must meet with their masculinity, given their strength, rationality and objectivity are to counteract the natural 'weaknesses' of the female mindset. Reed (2005) added that putting the father in a role of objective partner and superior manager who directs and commands the woman to relax during childbirth is indicative of the perception of men and women.

Whilst the media seek to strengthen the justification for presenting obesity as a major threat to the health of women of childbearing age, a group that hold alternative beliefs to the position of the popular media has evolved. The group known as Health At Every Size (HAES) is challenging the current 'knowledge' as espoused by science. They are challenging the rationale for demonising obesity as disseminated by the media. HAES argues that fatness does not constitute ill-health (Bacon and Aphramor, 2011). HAES offers an alternative to the current popular and dominant discourse on weight, and criticises the dominant medical view of weight and its classification as ill-health (Brady, Gingras and Aphramor, 2013). This new movement challenges the value of dominant health promotion measures of weight loss that focuses on eating behaviours and argues for the consideration of a focus on a weight-neutral approach (Bacon & Aphramor, 2011).

HAES emphasises the shift away from the hegemonic thinking about body size packaged in moral obligation of right or wrong choices, individual lifestyle and in the light of self-care (Brady et al. 2013). HAES asks for a multi-dimensional view; including the relationship people have with food, eating, body size and the relationship people have with knowledge, health, their environment and one another; to be considered.

In addition, HAES adopts the position that the aim of their interventions is to help individuals to reconceptualise the body/mind dualism; to identify,

irrespective of fatness, what counts as healthy or unhealthy and right or wrong. Their objective is thus to re-modify hegemonic assumptions that exist in the Western society (Brady et al. 2013) about the way fatness is perceived or portrayed.

Accounts of maternal responsibilities

In a recent television report on ITV News (Nannar, 2015), Professor Dame Sally Davies; England's chief medical officer, warned that obesity should be responded to as a top priority given that obesity is the biggest threat to women's health. Then more information was rolled out to women on national television, on averting risks to reinforce healthier lives for women and their families. The Mail online also quotes Professor Sally Davies about 'bursting the myth' and strongly advised that before pregnancy; women should achieve a healthy weight and exercise regularly to give their babies the best chance at life (Packham, 2015). A recurring theme from the media framing of maternal overweight or high BMI in pregnancy is that it places a large element of responsibility on mothers and women who are overweight during pregnancy. As the title of the news item suggested, women have to stay within a particular weight range to give their babies the best chance at life. This claim suggests that women who are overweight during and after pregnancy stand to put the lives of their children in danger and are also responsible for creating a fat generation. This assumption, McNaughton (2011) argued, is moral-laden, and it is the result of an uncritical medical framing of overweight as bad, risky and detrimental to the future generations.

This focus on pre-conception, pregnancy, and childbirth is another means or opportunity for surveillance, regulation and discipline of the woman's body (McNaughton, 2011). TV programmes such as 'Honey, we are killing the kids!' (Govic, 2007), 'Jamie Oliver food revolution' (Food Revolution, 2010)

as well as past years' series of Jamie's Ministry of food, (Jamie Oliver's Ministry of Food, 2008) targeted families and the role of mothers in the kitchen as she prepares meals for her family. It implies that more ought to be done within the mothers' domain to ensure the provision of nutritious meals which equates to a healthy family. As much as they achieved high ratings, when aired for viewing by the general British audience, and demonstrated an intense level of interest which is consistent with the public obsession with displays of weight loss from ordinary people just like them (Lupton, 2013), the various TV programmes mentioned above, demonised mothers. It depicts overweight children in households as the consequences of feeding habits which the general public view as poor. These TV programmes placed the blame for the situation on failings by parents whom they accuse of poor parenting regarding food preparation. Families that are judged to be failing regarding their feeding habits are subjected to intervention in the form of follow-up with dietary advice and are asked to embrace better exercise habits in the family. In some cases extreme measures, such as involvement of a physician and a psychologist may be used to carry out the examination and analysis of the children's eating habits as well as physical activities (Govic, 2007). These measures are similar to those adopted in the case of pregnant women with high BMI who are referred to obstetricians for intervention after risk assessment and discussion.

This view of demonising and pronouncing sanctions on women for being overweight and those of members of their family is widespread. For example, Jamelia; a pop musician and a Loose Women talk show panellist; suggested that plus size clothes must not be available in high street shops (Boyd, 2015). Although it sparked a row afterwards, it demonstrates how keen individuals are to police overweight individuals in the society. She then defended her position in a newspaper interview, asserting that unhealthy living lifestyles led to people becoming overweight (Corner, 2015; Shenton

and Corner, 2015). The media make these assertions without consideration for vulnerable individuals, such as teenagers, pregnant women and others with underlying medical conditions who may become pressured by such statements and starve with a detrimental impact on their health. The attitude of the media undoubtedly demonstrates a reflection of a culture that is fat-phobic where, seemingly, there is something culturally revolting against the fat body (Lupton, 2013).

Finally, popular media in Western countries, through its total and uncritical acceptance of the medical assumptions and framing of the 'obesity' discourse, provided a new terrain and compelling medium for airing concerns about the care for children which is a burden on mothers (Boero, 2007). This notion that the responsibility for children's welfare and wellbeing is gender-induced, pulls responsibilities from the family as a unit to mothers in the families. The responsibility includes her eating habits pre and post pregnancy, and what she feeds her children and her entire family. Shifting responsibility to mothers in this way creates a diversion of attention from problematic issues and concerns of the state, including the lack of adequate resources for mothers and for children, that could be or should be the responsibility of the state (Maher et al., 2010). Arguably, media framing highlights and broadens maternal responsibilities for the bodies of their children as well as defining and extending women's roles as the manager of their children's wellbeing while disproportionately apportioning blame to mothers for childhood 'obesity' (Maher et al., 2010).

Risk discourse: the birthing of large babies

A critical view of media coverage of the rise of big babies or 'sumo babies' as the Guardian (2008) suggests, is a shift from maternal overweight to the problematisation of babies born to women who are overweight over the course of the last decade. The article began its discourse of the new trends

by emphasising that there has been a rise in the number of bigger babies that weigh 10 pounds or more. Thus reaffirming the assertion that an increased frequency in the number of bigger babies has changed pregnancy

and labour (Groskop, 2008). In 2015, a Mirror headline read: 'Britain's biggest baby arrives as mum gives birth to hefty 15lb 10oz tot' (Mccrum, 2015). The article reminded readers of medical experts' warning that there would be a rise in the number of big babies, apparently born to overweight mothers. This reference to expert medical warning indirectly shifts the blame for the growing trends on overweight mothers (Maher et al., 2010; Warin et al., 2012). Eager to buttress its point to readers, Mccrum (2015) picked information from Tam Fry of the National Obesity Forum who asserted that "obese mums-to-be are likely to have fat children whose health may be severed from the day they are born" (Mccrum, 2015, unpaginated). A more recent article, by the Guardian newspaper, had this headline "overweight mothers have larger babies, research ..." (Press Association, 2016, unpaginated). This article directed its discussion to readers and provided a dossier of complications and risks associated with a big baby, for example, children developing diabetes later in life. In one of its claims, it stated that very high or very low birth weight in babies might expose them to type 2 diabetes later in life. In addition, it provided an analysis of how the characteristics of the mother can play a significant role in this outcome and offered suggestions on how tailored management routines should be put in place to reduce the number of babies born too large. In the same vein, Spencer (2016) discussed the issue with a similar focus asserting that "fat mothers do have bigger babies and could be condemning them to a lifetime of ill health" (Spencer, 2016, unpaginated). The perceived ills of having a fat baby presented to the reader, appeared scary and could evoke feelings of anxiety and worry in parents, and arouse self-blame in mothers. By supporting claims with sentences from experts, the media seek to give

credibility and validity to the information they put out by framing them as very authentic for it to be valued and bought into by readers.

The reaction to the trend was and is still to reverse the direction of movement in the birth of larger babies. Because of the attention the birth of bigger babies received, it has now been framed and recognised as a medical problem requiring medical intervention. As a result, The UK NHS proudly reported that a solution that allows treatment of larger babies had been discovered (Barnes and Macrae, 2012). Although the drug for the proposed treatment is in the trial phase, it is supposed to be used to halt the 'obesity' epidemic. It is expected to be in widespread use in five years; that is from 2017 if successfully tried and implemented (Barnes and Macrae, 2012). Thousands of overweight unborn babies and mothers-to-be will be drugged yearly to ensure that when their babies are born, they fit into the prevailing range approved by biomedical science, if the trial is successful.

Overweight pregnant women – a “Burden on the NHS?”

In 2007 Heslehurst et al., (2007) undertook a study of the impact of maternal obesity with regards to its burden on the NHS maternity services. The study instigated many headlines re-emphasising the burden maternal 'obesity' is to the NHS (Independent News, 2007; BBC News 2014; Clarke-Billings, 2016). These reports highlighted the financial impact of overweight, pregnant women on the NHS maternity services, by drawing attention to the increasing costs of providing effective and safe antenatal care for overweight, pregnant women. The financial impact includes the cost of ensuring that hospitals have an appropriate number of senior staff on the wards to attend to women. The extra staff are needed during labour, to carry out the extra scans women undergo, to perform the increased number of caesarean sections that are likely as a result, and to acquire specialist equipment needed for their care, for example, reinforced theatre tables, beds, large cuffs for blood pressure monitors and wheelchairs. Reports (Morgan et al., 2014; Public Health England, No Date) also focused on the

costs of the extra care overweight women require during postnatal periods due to more chances of infection, and the need for support with

breastfeeding. The clear message from these reports is one which demonstrates civic irresponsibility on the part of overweight, pregnant women and mothers, as they take up a large share of scarce public resources. The media in this sense do not only present maternity care for overweight women as a massive economic crisis but also imply that the growing cost of maternity care for overweight women threatens the financial viability of the healthcare systems. These views present overweight women of childbearing age; and indeed other overweight individuals; as irresponsible, social liabilities and convey societal expectations for overweight women to respond to a moral imperative for action to prevent an individual and national health disaster, for the good of all (Gard and Wright, 2005; Beausoleli and Ward, 2009).

The social construction of 'obesity' as a problem that has reached an epidemic proportion (Rich and Evans, 2005) is directly linked to the mass media's heavy reliance on findings from medical and science discourses (Boero, 2007) which is the key source of both lay and biomedical 'obesity' knowledge.

Communicating risks in antenatal care

In the UK midwives are the lead healthcare professionals in the care team of pregnant women (NICE, 2008; Shribman and Billingham, 2009; Fuber and McGowan, 2011). Midwives are responsible for assessing women at booking appointments and offer advice about the antenatal care women will receive in the antenatal care pathway they are assigned. As part of this assessment, women receive advice about diet and lifestyle; healthy food choices, exercise, smoking and alcohol consumption during pregnancy and after childbirth (NICE, 2008; Shribman and Billingham, 2009). Pregnant women

with high BMI that is over 30kg/m² receive care under a high-risk antenatal care pathway. It is the responsibility of midwives, at this stage, to explain to women the high-risk categorisation and all that their antenatal care provision will involve in the subsequent months, up to childbirth. Besides the midwives who give high-risk information to women, other healthcare professionals who will provide antenatal care for women who are overweight, and who will also discuss risks with women, include obstetricians and sonographers.

Communication is a significant aspect of antenatal care provision generally, and pregnant women look forward to the discussion, with mixed emotions which ranges from excitement to trepidation. Despite the mixed emotions that women go through as they attend their initial booking appointment, women view it as a valuable phase in their pregnancy journey, irrespective of how they receive key information which could be verbal or written (Keely et al., 2011). Some women are aware of the risks linked to being overweight and pregnant and the increasing negative publicity that it receives from various societal platforms, from media to political commentators (Lupton, 2013). This awareness may evoke feelings of guilt in women with high BMI for being in a high-risk antenatal care category. Also the added anxiety that comes with the discussion of the probable effects and the need for medical intervention (Puhl and Heuer, 2009) could undermine the wellbeing of pregnant women. The emotion that women feel may be the result of the social stigma ascribed to individuals who are perceived to be different from the norm (Puhl and Heuer 2009). Previous studies with pregnant women who have high BMI have reported that healthcare professionals find it challenging to discuss weight issues and risks associated with being pregnant while having a high BMI (Heslehurst et al., 2007; Heslehurst, 2010; Oteng-Ntim et al., 2010) with women. Healthcare professionals have expressed difficulty in broaching weight-related conversations with pregnant

women (Heslehurst et al., 2007; Oteng-Ntim et al., 2010; Heslehurst et al., 2011; Furness et al. 2015), because they are mindful of the societal stigma associated with body weight-related issues (Rogge et al., 2004; Brown, Thompson, Tod and Jones, 2006).

Midwives are reluctant to raise concerns about women's BMI or label women as 'obese' as specified by policy and protocol due to complaints from pregnant women with high BMI in the past. Consequently, there has been a deliberate acceptance of the need for more sensitive risk-communication to mitigate the uneasiness about discussing weight issues (Heslehurst et al., 2007; Schmied et al., 2011; Heslehurst et al., 2011; Heslehurst et al., 2013; Furness et al., 2015). Healthcare professionals are reluctant to discuss the risk of high BMI because, the unintended outcome of 'high-risk' discussion is that pregnant women may feel uncomfortable and dissatisfied with the care pathway they are assigned. However, they may not express this as they are conscious that it may be viewed as denial (Furness et al., 2011) since the general perception is that women do not identify with being obese (Mills et al., 2013). Although this study does not dismiss the suggestion that there may be risks associated with obesity in pregnancy, it recognises the position of women who are concerned that BMI is being used to classify them into categories and also that women are adamant that it situates them in 'buckets' (Mills et al., 2013. p.318) which they see as unhelpful. This study also observed that the risks associated with insufficient gestational weight gain (Mills et al., 2013) is not as emphasised as the risk of high BMI. Women continued throughout the study to assert that the blanket use of BMI to ascribe risk to their pregnancy is unhelpful. Pregnant women with high BMI criticised the use of BMI in previous studies conducted by Nyman et al. (2010), Fuber and McGowan (2011), Mills et al. (2013) and Heslehurst et al. (2015). The women asserted that healthcare professionals hide behind the measure and terminology (Mills et al., 2013).

The studies also emphasised the need to be sensitive to the language used. Similarly, other studies have looked into the use of terminologies in healthcare settings, for example, Taylor and Ogden (2009) found that overweight patients do not like the term 'obese,' and advised healthcare practitioners against using it. They suggested using a euphemism instead, such as 'overweight.' Similar studies by Dutton et al. (2010) and Gray et al. (2011) also suggested that understanding the need to use particular terminologies with patients is an important initial step to ensuring that communication is effective. Women have asserted that they are placed under scrutiny and monitored (McNaughton, 2011) and scholars such as Jette and Rail (2012) have argued that it may not be a coincidence that the pregnant body is currently the focus of medical gaze. They suggested that the link between negative pregnancy outcomes and the weight of pregnant women is deliberate. Linking negative outcomes to weight makes the pregnant body an ideal site for the administration of what Foucault referred to as 'bio-power' (Foucault, 1972). The attention accorded women of childbearing age as the custodian of future generations and a key player for sustaining human existence as we know it means the knowledge of biomedical science and the power it legitimises can be used to safeguard women's bodies and mitigate or eliminate risks to unborn children (McNaughton, 2011; Parker, 2014).

Governance and the medicalisation of pregnancy and childbirth

Medicalisation is the process through which non-medical issues are not only defined as problems but construed as a medical problem to be treated with medical interventions (Conrad, 1992). According to Nettleton (2013) the medicalisation of various aspects of life is a way of expanding the application of the power gained by the medical profession. The result is that medical scientists often extend medical jurisdiction and this has become a major

concern to social scientists in recent years (Nettleton, 2013). Arguing, Conrad and Schneider (1980) stated that drivers of medicalisation operate as a powerful institution of social control by claiming expertise in areas of life that did not previously need medical understanding, for example, ageing, pregnancy, childbirth, alcohol consumption and childhood behaviour.

Regarding pregnancy and childbirth, the acceptance of the power of medical practice, which derives from its claim to knowledge and expertise, has legitimised the ability of the medical profession to set the boundaries and standards regarding pregnancy and childbirth. It is the authority achieved through the use of an array of medical technologies which have been used to identify and define what is outside the boundaries set by the medical profession as a medical problem (Nettleton, 2013). Feminist critiques in the domain of medicine, for example, Oakley (1980, 1984); Doyal (1995); and Marshall and Woollett (2000) have challenged the pathologising of pregnancy and childbirth. They argued that it has used the persuasive campaign of safety by the medical establishment to reduced home births as a result of this herald of clinical safety. The immediate impact of this campaign is that women were encouraged to have their babies in the hospital, though evidence now indicates that most women had safer birth at home than in hospital. The evidence supporting safer births at home has not lessened the desire to medicalise pregnancy and childbirth or weaken the argument pushing forward the medicalisation process; rather, it has increased it (Oakley, 1984; Tew, 1998; Nettleton, 2013).

A further criticism of the medicalisation of pregnancy and childbirth by Oakley (1984) and Doyal (1995) is the failure of the medical profession to take into consideration the whole person. Medicalisation focuses excessively, almost exclusively, on pregnancy and childbirth, to the point that it sees women as 'mindless mothers' (Barry and Yuill, 2013. P.52) and frequently ignores their experiences and knowledge. Various interpretations and

reasons that justify medical intervention during pregnancy and childbirth are given to women to secure a pregnant women's acceptance of the medicalisation of their pregnancy and childbirth. For example, advising women that they would benefit from a pain-free birth (Oakley, 1984).

Sawiski (1991) and Lupton (2013) argued that cultural, technological and medical practices have positioned the pregnant body in the public domain for surveillance, which creates anxiety and leads to women having to take a seat of civil rather than personal responsibility. Weir (2006) posits that with the introduction of the concept of 'infant mortality,' unborn personhood was discursively established. Various forms of representation of the unborn child, particularly, the popular and increased use of ultrasound scans and its images are observed to have underpinned the personification of the unborn child and contributed to the demands for rights for the unborn child (Oaks, 2000; Kukla, 2008).

One of the major efforts to reverse the male dominant medical obstetrics practice that is non-relenting in its intent to continue with the medicalisation of pregnancy and childbirth is the actions of maternity-focused pressure groups. The group actively lobby for the rights of women to experience natural births and to ensure women have all the information they need to make informed choices (DoH, 1993; DoH, 2007). According to van Teijlingen (2005) the role of the medical profession regarding birth is about power and control; he emphasises that one of the reasons obstetricians use machinery may be because they do not believe in the capability and ability of women's bodies (van Teijlingen, 2005). Meanwhile, feminists emphasised that women faced with such circumstances feel as though they have failed at being women (Oakley, 1984; Moore, 2011).

Midwives in the maternity setting provide care for pregnant women irrespective of the classification women are in (DoH, 1993; NICE, 2008;

National Maternity Review, 2016) (NMR). In an environment where the dual ideologies of normal and high-risk exist, which set the threshold for medical control, midwives have the challenge of alleviating the fears of women categorised as high-risk pregnant women. As a result, midwives do what they can to make them believe in the ability of their bodies to carry out one of the physiological functions of the woman's body (van Teijlingen, 2005). Although some midwives have experienced a shift in belief, from a social to a medical model (which does not make them less effective midwives), they should be inclined to promote pregnancy and childbirth as natural events and should help pregnant women to understand medical advice from 'knowledgeable' obstetricians. The onus, however, is on women to comply or resist advice given by obstetricians who accept that BMI is a source of increased risk to pregnant women. However, because women feel responsible for their unborn child, they will readily concur with advice from their healthcare providers to mitigate the fears of the unknown and to be perceived as good mothers (Maher et al., 2010). The desire of women to protect their unborn child makes them amenable to medical advice even when they have reservations. So using risk to make pregnancy and childbirth an event to govern and pathologise, changes the way women perceive the birthing process and therefore, make them lose confidence in their ability to give birth naturally (Bergeron, 2007). The loss of confidence in the right, ability and capability to control ones birth experience is potentially a way of disempowering women (Lowe, 2004; Lothian, 2006).

This study, because of the central role of empowerment and the exercise of choice by pregnant women, will explore how women discuss and negotiate their decisions based on the information they have received from their healthcare professionals. It will also consider how the information they receive affects their intention and ability to make a choice about the birth they intend to have in the climate of the medicalisation of pregnancy and childbirth.

Choice and birthplace in antenatal care

Choice in pregnancy is a significant aspect of antenatal healthcare, as delivered by the NHS in the UK and most developed countries, and it has received much interest from feminists' scholars and commentators as it has been considered in studies focusing on various topics, such as being a mother (Sevon, 2005), breastfeeding (Crossley, 2007), reproduction (Thachuk, 2007) and childbirth (Stockhill, 2007). According to Brocklehurst et al., (2011) and Hollowell et al., (2011) planned birthplace is described as the woman's intended place of birth at the start of labour. Birthplace for pregnant women is an aspect of the pregnancy and childbirth journey that women look forward to, and this is mostly influenced by the social, cultural and political context in which women and their family live (Grigg et al., 2015). When women's pregnancies are pathologised, it raises obstacles to natural childbirth, dis-empowers them and makes them reliant on 'interventive' care and technological practices instead of their own inherent skill, knowledge, and birthing ability (Tew, 1998). In the 1980s, women complained about a lack of choice, control and continuity of the care they received and claimed that they were made to believe that the care that was provided to them must be the best for them. Today, women have a choice to make regarding their birthing place but when a choice is offered to women without adequate information to appraise it, or when the information provided to women is not complete, accurate or transparent or morally neutral, they choose whatever is on offer (Porter and MacIntyre, 1984). This makes the offer of choice a token gesture rather than a real response to women's call and desire for choice. Therefore, pregnancy and childbirth pathologisation and the intervention practices which were the order of the day has not been reversed by the promise or offer of choice but has continued and has gradually moved 90% of births from home to the hospital (Davis, 2013).

The dramatic shift of childbirth from home to hospital from the 1960s up till the 1980s in the UK called for reconsideration of the birthing process and for childbirth to be perceived as a normal physiological event for women, instead of the disempowering event it has become through medicalised antenatal care (Davies, 2013). Responses from the UK government resulted in policies which recommended changes in the sense that women now have options of the place of birthing their babies following the woman-centred care (DoH, 1993) favoured by the DoH. Although the government policy on 'Changing Childbirth,' promises women 'choice' it is only prepared to offer women little options of choice in the largely consultant-led maternity units (Beech, 2007). Beech reported that despite the positive promises of the various policies on the need for women to be empowered and to actually be allowed to exercise choice, there were still complaints from women regarding actions which exclude them from making a choice. For example, the study by van Teijlingen et al. (2003) on women's views found that women were dissatisfied with childbirth matters, which contradicted government propaganda that claimed satisfaction on the issue. Beech (2002/3) also noted that the situation had become one where what constitutes normal birth was confusing to women. She observed that women now accepted some form of routine intervention such as the use of forceps, drips and epidurals, as an integral part of normal birth because of the frequency of their use in childbirth. This routine intervention in the natural birthing process and how it has been framed and communicated to women has not only changed women's perceptions of the natural birthing process but has reshaped women's belief in the physiological function of their body. To keep up with promises to women and their families, the DoH document (1993) was followed up with a new document, the National Service Framework for Children, Young People and Maternity Services (NSF, 2004). This document was produced to build on the recommendations of the 'Changing Childbirth Report.' The publication provided for a ten-year plan and aimed to improve national standards of care for children, young people,

pregnant women, and mothers. This document contained a vision for the provision of a more modernised, woman and family-focused, maternity services for women, and emphasised some core statements from the Changing Childbirth Report with a bid to be woman-centred (DoH, 2004). Above all, it reiterated the issue of choices, asserting a new resolve to its position to ensure pregnant women are given adequate information about their care and allowed sufficient time to reflect on it and make an informed choice. This publication was intended to address areas that the Changing Childbirth Report was failing in, but Dimond (2004) and Newburn (2006) asserted that without adequate funding, its aims might not be realistic.

The NSF (2004) was followed by another document, Maternity Matters (DoH, 2007). At this time, the publication centred its commitment to the family, and took the view that women and families should be offered choices of where and how women want to give birth, which, the document purported will lead to a flexible, responsive and easily accessible maternity services (DoH, 2007). Although this document underlined choice as a core area to address, it stresses, however, the overriding importance of safety in relation to place of birth and whatever women's options are, implying that what is considered the safest for her will determine the final choice. This position effectively shifted power from women to expert medical teams who provide women's antenatal care and allow medical experts to exercise more power to limit the options available to pregnant women.

Recently, a publication 'Better births, improving outcomes of maternity services in England' (NMR, 2016) has emerged; championed by Baroness Cumberledge, the same independent chair of the 'Changing Childbirth Report' of 1993. The publication has seven key recommendations (NMR, 2016) and each of these is a recommitment to women, babies, and families. The review, a five-year forward-looking document of maternity care services, promises more personalised care for women. The publication

recycled and re-echoed key issues from the Changing Childbirth Report (DoH, 2004) which makes them mere sentiments from past policies about maternity care. The publication promises that maternity care will be “centred on the woman, her baby and her family, based on her needs and their decisions” (NMR, 2016, p.8). It also promised genuine choice that is informed by unbiased information. What seems to be novel in this review is that it promised that women will now be in control and exercise their choices through a personal budget that is the “NHS Personal Maternity Care Budget” (NMR, 2016, p.8). Apparently, maternity services are constantly being reviewed and scrutinised by policy makers. The results and direction recommended by the review of maternity services in every one of the last three decades have essentially remained static. In each of these publications, clear commitments have been made to women regarding the form of maternity services they can expect including details of what is feasible regarding choice and what is not. However, the same themes and commitments, including woman-centred care, woman-focused care, and choice; continue to feature in these documents as a key future target for the last three decades, is evidence that previous policies have been ineffective in practice.

Ensuring that there is the availability of choice for women regarding birthplace of their unborn child is now an entrenched target for those charged with reviewing and assessing the performance of maternity services. The elusiveness of choice for women is the result of the dual and conflicting view of pregnancy. While the view of pregnancy as a natural event placed a premium on choice as an important goal, a medical perception of pregnancy supports intervention and eliminates choice. It is this conflict that has made the delivery of choice to pregnant women with high BMI an elusive objective. So, the availability of choice continues to be relevant as an objective because of the way pregnancy is perceived and the

use of technologies that gives visual privilege to the invisible, to facilitate heightened medical surveillance during pregnancy and childbirth (Foucault, 1973). Women are provided heightened care despite their reluctance to be subject to it in the guise of avoidance of harm to the baby (Narayan, 2015). To give the impression of empowerment for women, they are encouraged to make birth plans in the contented expectation that it will be respected; however, evidence suggests that women who complete birth plans are still likely to end up with interventions (Newburn, 2009). There is very little information about healthy pregnant women with high BMI to date but current guidelines suggested that pregnant women with BMI of over 35kg/m² should give birth in a consultant-led unit (CMACE and RCOG, 2010). This guideline effectively takes choice away from women with high BMI and women in this category of antenatal care are not expected to complete a birth plan for the choice of place of birth because by default they only have access to consultant-led birthing units (NICE, 2008; RCOG, 2010). When choice is taken away in this manner, as in the case of women with BMI of over 35kg/m², it confirms that pregnancy in this group of women is completely medicalised (Kerrigan, Kingdon and Cheyne, 2015). The result is that these women do not feel treated as individual, instead they feel marginalised and treated as a member of a pool. A more proactive and positive guideline on antenatal care for pregnant women with high BMI is needed (Kerrigan et al., 2015) to make them feel the positive emotions of pregnancy and childbirth. This will also reverse the current situation where choice is limited to what individual Trusts and staff decide to offer women (Beech, 2005). This is despite the findings by the Birthplace study that giving birth at home or in a midwifery-led birth centre is as safe as going to the consultant-led unit (Brocklehurst et al., 2011) which most Trusts offer to women with high BMI.

Brocklehurst et al. (2011), in their explanation of a study, asserted that experiences for women vary between hospitals and other birthing sites.

According to them, this is because women who planned to give birth in a midwifery-led unit or at home and began their care on these sites, were far less likely to have assisted childbirth such as forceps, caesarean section, and epidural for pain relief. Also, more than 11% of women whose childbirth started in the hospital had caesarian section compared with 2.8% of those who started at home. In the hospital, 6.8% of births were by forceps compared with 2.1% at home (Brocklehurst et al., 2011; Hollowell et al., 2011). These findings were from studies that involved only women with low-risk pregnancies. As a result, one might wonder what the statistics will be for women perceived to be high-risk as a result of a high BMI measure. Commenting on this finding, the spokesperson for the National Childbirth Trust (NCT), Mary Newburn stated that women perceived to be healthy and who are expected to have a straightforward pregnancy should be advised to give birth at the midwifery-led birthing unit. Also, she reiterated that the new findings supported the opening of more birth centres to create more positive choices for more women. It is therefore, important for policymakers to use the findings to inform their decisions about service provision and commissioning (Boseley, 2011).

So, if the risk of high BMI continues to be perceived, framed and communicated in their current form, access to an effective or free choice of a place of birth will only be an illusion for pregnant women with high BMI. The assessment or measurement of the risk of high BMI is currently framed in relative rather than absolute terms. Also, the risk of high BMI is construed as representing a probable rather than a possible chance of occurrence of an adverse event. This perception and framing of risk and how it is assessed and presented will continue to support the position that without medical intervention, high BMI will lead to an adverse or negative outcome for women or their pregnancy. This view of risk wrongly amplifies the threat of high BMI to women and their pregnancy by failing to report the absolute risk of BMI (Beech, 2005) but instead over hypes the relative risks which are

dressed up as absolute risks. The focus on risks in the childbearing process demonstrates a culture of worry which is a common concern in modern life (Kringeland and Moller, 2006), and which is also a reflection of Beck's (1994) 'risk society.' Relating this perception, framing and construction of risk to pregnancy and childbirth, this will potentially lead to a complete absence of maternal choice as the need for risk-management and mitigation will always be used to justify the medicalisation of childbirth and achieve what the experts in medicine suggest as being 'safe' (Cahill, 2001). In their argument, Kringeland and Moller (2006), asserted that healthcare professionals use security and protection from risks to gain control of the birthing environment. They asserted that the medicalisation of pregnancy has increased in line with increased sophisticated technologies in ultrasound scans that are used for surveillance and interventions. They argue that medicalisation has grown alongside a growing societal concern about risks (Beck, 1994). Along with the heightened concern about risk awareness, is the persistent call for greater freedom of choice for women about childbirth. These two positions, heightened concern about risk and call for women to have greater choice, are in constant conflict and constitute a barrier to the attainment of optimal conditions for a positive childbirth experience for women. Baker, Choi, Henshaw and Tree, (2005) and Houghton et al. (2008) found that women identified inadequate information, poor communication and the lack of the prospect to exercise choices as contributing factors to a negative experience. Baker et al., (2005) also observed that the process of choice in childbirth is dependent on, but is not encouraged by medicalisation and the asymmetrical information relationships between healthcare professionals and the lay public. They concluded that common practices such as "obstetric hegemony with its philosophy of pathology", a "fetocentric environment" and a "paternalistic model of care" (Baker et al., 2005, p.21) all constitute barriers to the ability of women to exercise choice or make an informed decision. Antenatal care is provided by healthcare professionals within patriarchal cultures that fully subscribes to risk consciousness as its

central feature (Knaak, 2010). So, choice for women is likely to continue to produce results that are more of the outcome of coercion than the exercise of free will because it is surrounded by paternalistic ideologies and practices (Baker et al., 2005).

Conclusion

In this chapter, a review of maternal overweight was undertaken and involved reviewing public health and medical science literature. The chapter also discussed risk perception in the antenatal setting as it affects pregnant women with high BMI, how risk is perceived and how the context of series of health regulatory guidelines impact the care provision that pregnant women with high BMI can access. Also considered, is the role media play in the construction of fatness as illness in the Western cultures, particularly, how they source and select what they consider newsworthy to disseminate through their platforms to the public which includes members of the healthcare profession. The review and discussion of media involvement in the perception and framing of fatness showed that the media has actively contributed to tipping public opinion against fatness, without acting as an unbiased umpire in verifying and validating the perception and framing of fatness, it vigorously sold to its reading and viewing public. The media, while presenting findings from research reports, may have acted and continue to act in good faith but it failed to consider the influence by those who have a particular interest in research outcomes or findings. They have not been similarly mindful of their ethical responsibility to ensure that the quality of the report they put in the public domain meets the threshold of completeness, accuracy, objectivity, transparency and rigour that the public expects or believes media reports to have met, when they accept media reports as objective truth. The media use reports published in articles to make commentaries about maternal responsibility, women's pregnancies and outcomes, and to comment on the financial threats facing the NHS,

the health of future generations and the perceived failings of overweight, pregnant women regarding their civic duties to other members of the society. Furthermore, the chapter considered how the perception and framing of fatness and the contribution of the media and acceptance by health supervisory and regulatory institutions such as NICE (2008, 2010) might have contributed to the framing of the risk of high BMI. It explores the use of the risk framing that is determined by the media in discussion and communication with women and examined the choice of words and their context in the discussion of increased risk with women by the healthcare professionals who care for pregnant women with high BMI. This thesis supports the opinion of commentators who believe that the perception, framing, and communication of risk to pregnancy in its current form is aimed primarily to make pregnant women accept the medicalisation of pregnancy and childbirth. This chapter considered the issue of choice of birth place in the management of maternal overweight. The chapter also explores how weight is used as a filter to determine where and how women should give birth by categorising them, and how the categorisation disenfranchises women by taking away their right to be involved in decisions-making about their pregnancy, the care they receive and their unborn children. Finally, the chapter considers how the diminished choice and the categorisation of women into the shared antenatal care pathway negatively affects women's experiences of pregnancy and birth.

Chapter 3

Body size and antenatal care: Power, Knowledge and Surveillance

Introduction

This chapter examines the political context of being overweight in the general population with a focus on pregnant women. The chapter will include a critical evaluation of dominant discourses on maternal fatness, and included in this evaluation is an objective appraisal of the notion of normality regarding body size which in turn necessitates and calls for measuring body weight and height for the BMI calculation. It also explores the existing modern day notion of increased risks in pregnancy and childbirth and how these have placed additional moral responsibility on the woman regarding the safety of the unborn child and her family in general. Further, it examines the cultural perception of fatness, and food consumption in the West and elsewhere. These discussions use, as a guide, Foucault's (1976) concepts of power, knowledge, governmentality, bio-power, surveillance and the gaze of others (clinical gaze).

Understanding the political context

The responsibility of the modern state and what constitute an effective government, as shaped by the paternalistic view of political leaders and political commentators and which the public has unconsciously endorsed, is that all aspects of the safety of all individuals within a defined national border should be a top priority for the government. It is therefore in the interest of the government to posit its health policies in a manner that align with health warnings given by the scientific community. This action of policy makers ensures that policies receive the endorsement and the seal of scientific approval, which is celebrated as unbiased, comprehensive and transparent by the media and welcomed by the educationally, economically

and socially privileged members of society. The interest of the government in health-risk, therefore, is to complement its policies on expanding risks in areas of life that would otherwise be normal. The interest of government is consistent with the preference of the modern day state policy of policing every aspect of life and living including pregnancy, where any risk however little is described theoretically as being inherently too great (Lupton, 2013) to be ignored. Government policies in their desire to discharge the responsibility of government use findings from medical and scientific consensus to respond to health warnings (Kersh and Morone, 2002; Lupton, 2012a). These health warnings come with self-help tools which are used to encourage people to try and adopt a healthier lifestyle (Herrick, 2007). Lupton (2012a) has argued that public health and medicine are intertwined institutions of authority with huge influence in the manner in which individuals understand, perceive and experience their bodies through information provided by government funded public institutions that provide supervisory and regulatory functions for public health. The remit of these institutions have gradually blurred the boundaries between social and medical issues, and towards the end of the last millennium both were already accepted as an integral part of the human experience (Bordo, 1993; Campos et al., 2006; Colls and Evans, 2009).

In this context, individual bodies are the target of biomedical discourses and practices, and public health is expected to take up and re-enforce this medical knowledge and make it a focal point for public health groups to deliberate on (Herrick, 2007). On the other hand, politicians take established statements from the public health discourses which rely on a set of clear definitions, based on accepted etiological and epidemiological contributions and the relationships between the two (Herrick, 2007). The focus on individual bodies is evident in the shift from the population to individualised responsibility, and several individually targeted series of state-sponsored strategies are deployed to achieve this. The state-sponsored programmes

include amongst others, the British 'Change4life' campaign (DoH, 2010), American Michelle Obama's 'Let's Move' campaign and President Obama's task force on childhood obesity. That Michelle and Barak Obama launched their programmes on the same day is strong evidence of the state determination to force individualised responsibility. Other similar initiatives include the Australians 'Swap it don't stop it' in early 2011' (Swap it don't stop it.gov). Governments set up initiatives that go as far as monitoring what their citizens eat, the choices they make and why. For example, the UK White Paper contends that campaigns must recognise what different population groups need, as well as take into consideration why they make the choices they do (DoH, 2004b). Brown and Duncan (2002) argued that it is necessary to know a disease incidence, prevalence, and mortality rates so that interventions such as health promotion initiatives mentioned above can be used to reduce them.

This need for knowledge relies heavily on statistical evidence; a phenomenon Foucault (1976) acknowledged in his assertion, that statistics have long been fundamental to the growth and development of public health, given that they offer the courses of action and a measure of success. Though statistics is a powerful political tool (Herrick, 2007) used to provide quantitative proof of governments' success in improving the wellbeing of its citizens, statistical figures are also a means of exposing the limits of the government when it comes to reducing the risk of and vulnerability to conditions such as 'obesity'. Governments are therefore keen to adopt models and frameworks that have the support and approval of biomedical and statistical culture. This need for approval of the scientific community may explain the state's interest in monitoring and surveillance of the health of its citizens at population-level, to identify 'at risk' sub-groups for individual attention, as recommended by biomedical-statistical analysis. The recommendation would, therefore, ensure that citizens are doing what is necessary to regulate their bodies in the interest of maintaining good health

(Lupton 1995, Petersen and Lupton, 1996). This monitoring of individuals encompasses the whole population including children, men, and women of all categories.

Constructions of power in a clinical healthcare setting

Power and Knowledge

Foucault (1973) believes that power and knowledge are linked, and that power generates knowledge and knowledge brings about the effects of power. According to Foucault (1973) power and knowledge are intertwined, and the quest for power and knowledge is a motivation of human interest. His notion is that power can shape knowledge and truths which, in turn, mould individuals' thoughts, conduct, and views of the world (Lupton, 2012a).

Foucault's (1973) view is different to the traditional perception of power as an authoritative and oppressive force that controls the actions and behaviours of others. Power, within the context of healthcare, does not employ the same force as dictatorial regimes but uses subtle means including the exhortation of scientific knowledge to shape the truth. By so doing, knowledge and the power that it exerts sets the boundaries of what is right and wrong, acceptable and unacceptable (Lupton, 2012a). This ability to set boundaries is the source of the authority of the state and the medical profession in their use of power to define what is healthy and unhealthy, normal and abnormal, right and wrong (Wray and Deery, 2008; Lupton, 2012b).

Power and knowledge empower professionals and place them in a position of moral superiority over service users. The knowledge constructed by obstetricians and researchers within their medical communities are often

exemplified by their various professional journals and then passed on to popular media which then convey such information to the general public (Saguy and Almeling, 2008; Saguy and Gruys, 2010). Consequently, the knowledge conveyed is interpreted and reinterpreted in different ways as understood by the public. Fleck (1979, cited in Lowy, 1988. p.2) asserted that scientific facts are always in a state of constant evolution and are therefore subject to ongoing reinterpretation. Epidemiological information is regarded as scientific but contrary to the assertion by Fleck (1979, cited in Lowy, 1988.); the media presents epidemiological information as absolute truth. The stance of the media does not entertain the possibility of another view of fatness which may also be true. The media and epidemiological scientist that present epidemiological findings as pure knowledge rather than the result of the interaction of social, political and cultural factors, do so to undermine the inherent evolution in scientific facts. It is this view of science as value-free by the media that serves to add credence and status to the medical discourse on fatness (Wray and Deery, 2008). Hence, its acquisition of the status which normalised it as the only truth rather than views it as being a part of various discourses (Foucault, 1990) used for identifying the truth. The media and anti-fat commentators view maternal obesity through a scientific and medical lens and use the claim to science to ascribe credence to their position. They then employ the position in defining obesity as one of the major medical challenges facing maternity settings in the UK and elsewhere (Kanagalingam et al., 2005; Heslehurst, 2010; Knight et al., 2010).

Medical knowledge, therefore, has the power to shape the way that the maternity care provided for pregnant women with high BMI is viewed and understood by healthcare practitioners (Cheek and Porter, 1997). Medical research knowledge shapes power, and this power shapes the perception of maternal obesity, the understanding of risk in pregnancy, and the need to

build medical safeguards into and around maternal obesity care. This power or authoritative status of medical knowledge provides a justifiable premise for subjecting above average weight, pregnant women to surveillance and technological intervention from their healthcare providers.

Surveillance

Describing health surveillance, Armstrong (1995) asserts that through the triumph of medical theory and practice in the hospital, a new concept of medical surveillance, based on the surveillance of the healthy individuals, has emerged. Notably, health surveillance involves the use of any tracking or monitoring of health-related data, whether in an organised fashion or not (Fox et al., 2009). According to Armstrong (1995) when this concept of monitoring individuals is applied to their health status and wellbeing, it is referred to as 'surveillance medicine.' He stressed further that surveillance targets everyone, as it brings the healthy and the sick into the field of visibility. Describing it as the new vehicle for exerting power, Armstrong (1995) submitted that surveillance medicine has redrawn the boundaries between health, illness, and disease to promote a regime of total health. It is a concept that others have referred to as a means to engender the objectives of medicalisation (Illich, 1976) or healthism (Crawford, 1980). Surveillance regime does not only subject individuals to the technologies of medical surveillance but also expects individuals to partake in the practice of self-surveillance (Earle, Foley, Komaromy and Lloyd, 2009). Medicalisation is therefore, consistent with health surveillance or surveillance medicine for overweight, pregnant women to be placed under surveillance because their weight is considered a risk factor which places them and their unborn babies in a perpetual at-risk state (Earle et al., 2009). However, because BMI, universally, has not been accepted as an efficient and effective marker of higher risk, the use of high BMI to subject women to medicalisation is constantly challenged. As a result, the subjection of women to surveillance,

though accepted by surveillance medicine, is also fraught with failings for the woman who would otherwise not be in need of further screening. Surveillance medicine, as Earle et al. (2009) emphasised, does not only influence how the individual can experience health and illness or communication about their health, but becomes a dominant mechanism for the production and regulation of knowledge about health and medicine.

The practice of medical surveillance has both intended and unintended consequences. Its intended effect creates documentary evidence which powerful actors can use as leverage to enact exclusionary and discriminatory policies. In other words, identifying and putting people into 'risk communities' (Gagnon and Guta, 2012). It also emphasises the central role surveillance play in the creation of normality and abnormality as perceived by individuals (Gagnon and Guta 2012). Gagnon and Guta (2012) also suggested that the internalisation in individuals of the sense of being normal or abnormal is a principle unintended consequence that may lead to the avoidance of or refusal to seek healthcare. As a result, surveillance medicine maps out an unlikely kind of identity which is not naturally occurring since its monitoring gaze sweeps across new spaces of illness potential (Armstrong, 1995). However, Gagnon and Guta (2012) have also suggested that medical surveillance and self-surveillance may not be entirely negative, as its concept is useful when one reviews the outline of patient safety.

Bio-Power

According to Lupton (2012b) bio-power stems from bio-politics and it refers to the tools of expert knowledge which represent and discipline human embodiment. Its focus includes self-governance carried out by the individual and external governance implemented by agencies of the state or other institutions. These bodies issue minimum guidelines and standard expectations to ensure the realisation of what the medical and political

authority agree is a desirable body size and weight relationship for members of society, especially pregnant women. Bio-power and bio-politics create the perception and concept that guides and influences the kind of care provided by maternity services, and which expects that women should attain a certain body weight to be called normal.

The clinical gaze

The clinical gaze invokes and interprets the language that describes visual outcomes and integrates it into knowledge (Foucault, 1973). Health professionals involved in the care of pregnant women with a high BMI adopt a way of seeing these women's weight. They also adopt words to integrate what they perceive as knowledge, and this gives them the power to create their version of the 'truth'. Seemingly, the development of the gaze and the language helps to describe visual images, transforms the unnoticeable into the noticeable, and has created a new alliance between words and things which also makes it possible to see, to say (Foucault, 1973) and to some extent to become judgemental.

A modern example is the classification of body weight into healthy and unhealthy weight categories by using BMI. The individuals who deviate from what the health and medical society recommend as the norm or acceptable, such as not being in the healthy weight category (BMI 18-25kg/m²) as measured by BMI during pregnancy, are singled out, monitored, and subjected to scrutiny by their healthcare providers. According to Rothman (1989) and Hubbard (1990) the need to place women's bodies under a continuous clinical medical gaze to ensure adequate monitoring, stems from the patriarchal desire to protect their offspring even if it leads to devaluing women's bodies. Another reason for monitoring is the willingness to perceive

unborn babies as secondary patients, who are separate from their mothers and so justifiably in need of protection.

The dividing or differential practice, in the delivery of care to women with above and below a particular BMI threshold, demonstrates how above average weight pregnant women are objectified and regulated on account of their weight through the authority of the gaze. According to Rabinow (1984) this act of manipulating people into classified categories results in social exclusion.

Many feminist scholars such as Doyal (1985) and Annandale (2014) have drawn on the medicalisation of women's bodies as a demonstration of social control by the patriarchal medical profession (Matthews, 2015). The inherent attributes of masculinity in medicine make it patriarchal. One of these attributes is being in the present (Phoenix, 2015). By being in the present, Phoenix meant doing things in the present and the moment; that is being very attentive to the immediate circumstance of a person or event as it is deemed fit at the time and precludes speculating. This ties into the observed practices by obstetricians in antenatal care settings. They work to current guidelines as issued by their professional bodies ignoring any personal or social mitigating circumstances of pregnant women. Grounding oneself, in reality, is another male and patriarchal feature. According to Phoenix (2015) it is a sign of masculinity and enables the capacity and ability to resist pressure and events around the individual. Hence, in the antenatal setting when women are in labour for example, obstetricians make judgements about women based on what they see and perceive. They make the decision to intervene medically based on the immediate reality irrespective of the pressure from pregnant women or midwives. This response from obstetricians may have informed the claim that patriarchy devalues the experiences of women and midwives. The attributes of being in the present and grounded in reality are consistent with being focused and potent, hence

the latter two attributes are considered masculine. According to Phoenix (2015) whilst being focused is a feature of masculinity, and demonstrates the ability to be absorbed into the tasks at hand and not be distracted by any other occurrence, the potent aspect of masculinity portrays strength and shows the ability to be in control.

Phoenix (2015) describes feminine characteristics as being free, spontaneous, intuitive, accepting and nurturing. Freedom enables openness and engenders the ability to be part of everything whilst seeking all avenues to resolve a challenge. This characteristic is embedded in the philosophy of midwifery. A typical example is when midwives support women in labour in the midwifery-led units to do whatever makes them comfortable as they give birth. Spontaneity describes situations when a person reacts to a circumstance using emotional intelligence and intuition to make decisions. Often these decisions are influenced by other than pragmatic evidence; they are in part affected by the innate feelings we have and our past experiences which are outside prescribed guidelines and rules.

Spontaneity and intuitiveness are often intertwined and have been described as an attribute of femininity. These attributes were observed more with midwives than other medical professionals such as obstetricians, as midwives aim to make women's situations better. When a midwife assesses a woman and notices that there would be a need for medical intervention, s/he would take appropriate action, which maybe intuitive and open but not dictated by the rulebook that is often rigid. It is therefore not considered to be based on knowing within the sphere of dominant knowledge. Midwives in most cases will moderate their knowledge of the rules and evidence of science with their innate experiential knowledge of women and the social context they exist in to make decisions. As a result, midwives in most cases, act according to their innate sense and because of their experience of having

worked with women for a period of time, they are able to intuitively make valued judgements of situations and act upon it.

Both accepting and nurturing has been described as feminine characteristics (Phoenix, 2015). They encapsulate the philosophy of midwifery, for example, midwives in this study accepted women's circumstances and did not dwell on women's weight while providing antenatal care for them. Midwives in Fuber and McGowan (2010), Schmied et al. (2011), Furness et al (2015) (also see, Nyman et al. 2010; Smith et al. 2012; Foster and Hirst, 2014) provided antenatal care for women and accepted their fatness without drawing the women's attention to weight-related conversation to gain their trust. They did this to make women feel comfortable with their midwives. An example of a nurturing behaviour is showing compassion and helping people in our care to see that they can be involved in decisions and actions that lead to their desired outcome. Nurturing is a concept that is synonymous with midwifery, midwives nurture women in their pregnancies by ensuring that they become better informed about their needs, the needs of their unborn and the entire family. Midwives used these attributes of femininity in their interaction with women by being good and active listeners which encourages women to express themselves in the way they deem fit (Foster and Lasser, 2010).

Maternity system culture

According to Tew (1998) pregnancy and childbirth was once 'women's business'. Women managed all aspects of giving advice to pregnant women and assisted with childbirths, hence the name 'midwife' in old English, which literally means 'with woman'. Tew (1998) explained further, that before 1700s, childbirth was customarily a domestic affair that was attended by female friends, relatives, neighbours and local women who were experienced in supporting women during childbirth. The knowledge and experience of supporting women during childbirth was passed from woman to woman

through narratives and experience from one generation to the next as part of the normal interaction and exchanges of the social community, hence childbirth was perceived as a normal part of life (Oakley, 1993; Kitzinger, 1997). However, all this changed from around the 1700s when a more technical approach to childbirth was introduced, and it became popular in the UK, and other Western countries, for men to be involved in taking birth. This opened up the path for men to gain entry into this women's affair, and with time, also gained dominance (Tew, 1998). The men soon became referred to as 'professional medical men' and took charge of the affairs of childbirth. Over time, midwives lost their status and were portrayed as unenlightened, unhygienic, and entrenching childbirth practice in superstitions and folklore. Professional medical men were later referred to as man-midwives who were also known as male doctors, and became patronised by the wealthy folks, because families who could afford their high fees, increasingly used their services (Tew, 1998). At the time, midwives became unfashionable, outdated and associated with working class families. This shift in childbirth continued and progressed into the 1800s and 1900s, and in the 20th century, obstetrics developed and there was a gradual movement of childbirth into hospital from homes for high-tech management (Tew, 1998). During the same period, the gradual medicalisation of pregnancy and childbirth started and childbirth began to be perceived less and less as a natural life event. These developments led to childbirth being characterised with risks, and viewed with the lens of pathology to be managed with technology (van Teijlingen, 2005). Increasingly, familiarisation of hospital birth, led to a remarkable increase in medical intervention which consequently, reduced midwives' autonomy, skill and activity in birth (Robinson, 1989).

Medicalisation, in sociological terms, is perpetuated by the opportunities offered to the medical profession to make claims over a fundamental physiological event that other professions such as epidemiologists and

society now consider a deviation from a normal phenomenon (Ireland and van Teijlingen, 2013).

On the one hand, sociologists recognise the negative effect of medicalisation as disempowerment of women and creating a perception that women lack control of their bodies at this crucial time in women's lives, especially when there is a belief that women do not have the capability to give birth naturally (Downe, 2006; van Teijlingen and Ireland, 2013). The negative of medicalisation alluded to by sociologists is not recognised or accorded the same level of significance by medical professionals who subscribe to the bio-medical model of health. The medical profession does not recognise the negative effect for women arising from monitoring the childbirth process alluded to by sociologists. The view of medical professionals is that such monitoring helps to ensure the safety of the unborn baby and mother. Where the impact of monitoring is acknowledged, it is claimed that the benefit of monitoring, in terms of the elimination of risk or mitigation achieved in ensuring a safe pregnancy and childbirth is worth the impact of monitoring. This is the rationale for perceiving every pregnancy to be potentially risky and for the expectation that pregnant women should be in medical units where they can be monitored (van Teijlingen, 2005). A medical unit is deemed an appropriate place for pregnant women because it ensures that they are closely monitored using high-technology and affords the opportunity for obstetric interventions. The medical or bio-medical model of health focuses almost exclusively on biological factors, and within this model much emphasis is made of the medical model of disability which focuses on disability purely as an impairment of biological function. To avoid the impact of probable impairment in individuals, the medical model believes that pregnancy is only safe in retrospect (van Teijlingen, 2005).

Midwifery philosophy, on the other hand tends to be embedded in the social model of health. This model unlike the bio-medical model focuses on a broad range of factors such as environmental, economic, social and cultural

influences. It has therefore been described as a holistic model (Davis- Floyd, 2004). Using this model, midwives who work in midwifery-led units can promote normality (Downe, 2006). The holistic approach encompasses facilitation of the woman's natural experience of pregnancy and birth without excessive focus on time. Labour can follow women's own body rhythms and the pain of childbirth is perceived as an integral and acceptable part of childbirth. Other aspects of the holistic model that midwifery is embedded in, is the view that birth is a life natural event, an activity a woman accepts, with the help of a skilled midwife guiding her to respond to her body, as she brings new life to the world (Davis-Floyd,2004). Midwives can facilitate normal birth in a midwifery-led unit thus; Gould (2000) contends that a midwifery meaning of normal birth is where the woman's innate ability to give birth physiologically is respected and promoted.

While it is clear from the two models of childbirth that they have conflicting perspectives, it is not to say that all doctors are fully supportive of the medical model and all midwives advocate the holistic or normal birth. For example, midwives who work within a consultant-led unit are in a dilemma because they do not have autonomy to make decisions since they have little or no input in the decision-making concerning women in the unit (Walsh, 2010). The main reason for the inability of the midwife to be in control of childbirth in a consultant-led unit is because of how the hospital is structured (Keating and Fleming, 2009). Keating and Fleming, (2009) is of the opinion that a hierarchical structure exists in hospital institutions which places the consultants at the top, situates midwives lower and puts women at the bottom of the hierarchy. Keating and Fleming (2009) demonstrated in their study that midwives working within consultant-led units could become victims of patriarchal control and so, adopt a medical model of birth. Other studies (Keating and Fleming, 2009; Walsh, 2009) that have examined this category of midwives assert that though they (midwives) are committed to facilitating normal birth in the hospital labour wards, it is a difficult and an

uneasy atmosphere within which to carry out their duties (Keating and Fleming, 2009; Walsh, 2009). Midwives are in most cases required to conform to the medical system, instead of paying attention to the individual needs of women (Fleming, 2009; Keating and Fleming, 2009; Walsh, 2009). In addition, senior midwives that have practiced midwifery for a long period of time within a medical unit, may cooperate more with medical policy rather than advocate and support midwifery practices (Keating and Fleming, 2009). Keating and Fleming (2009) stressed that some midwives discretely contest the justification for medicalisation of pregnancy and childbirth with the intent to maintain a non-medical approach to birth, but this was difficult within the constriction of hospital practice. This inability of midwives to employ their midwifery experiences and skills within obstetrics units is a source of frustration and distress for them (Shallow, 2001; Russell, 2007).

There is paucity of existing studies about the experiences of midwives supporting normal birth in consultant-led units. However, the few studies found argued that this category of midwives find themselves in situations where there is conflict between them and doctors. According to Keating and Fleming (2009) the medical model is guided by scientific knowledge, where principles of active management of labour during childbirth is within the meaning of normal. Russell (2007) also reaffirms that the patriarchal control that exists within hospitals makes it difficult for midwives to exercise power within consultant-led units. However, Russell (2007) in her study found that some midwives use individual strategies and tactics to delay medical intervention with women during labour, and such midwives have been labelled 'mad' by conforming midwives or 'bolshie' by doctors (Russell, 2007). However, Russell (2007) suggested that these 'mad' or 'bolshie' midwives are confident in their own abilities and can use covert strategies to delay or prevent medical intervention. In consultant-led units, doctors are the most influential staff members as they can overrule midwives' clinical decisions concerning normal birth.

The act of decision-making within the consultant-led units in hospitals is entrenched in power and existing policies, and the regulatory framework in place is supportive of medicalisation which is contrary to midwives' approach to childbirth. Midwives are thus, forced to work by these rules that are outside their beliefs and perspectives (Walsh, 2009). The notion of power that is pervasive in consultant-led units could be described as the one Foucault identified as operating, covertly, in majorly hierarchical organisations (Fahy, 2002). Foucault explained that this kind of power is not perceived as a repressive force, but one which is neutral and necessary for an organisation to maintain social function, however, this has been dismissed by Lukes (2005). As he argued that power relies heavily on people (individuals and groups) who can make decisions and policies which mirror their values rather than the values of those at the bottom of the hierarchy (Lukes, 2005). This is manifested in consultant-led units in hospitals where the medical approach prevails rather than the midwifery-led holistic approach. In addition, Luke (2005) also asserted that individuals with power, control the framework and agenda of what is to be discussed and implemented. Foucault's theory (1976) also acknowledged that knowledge and power are closely connected, and as a result, those individuals or groups who hold the intellectual resources inhabit a site of power and use it (Bradbury-Jones, Sambrook and Irvine, 2008).

Stigma

According to Puhl and Heuer (2009) weight stigma is the exhibition of prejudiced attitudes, for example, ascribing negative labels including but not limited to lazy, unintelligent, or irresponsible to those who are perceived to be different from the norm. It includes discriminatory actions towards an individual based on their weight and body size alone. Stigma is a social construct influenced by social and cultural factors which alienates an

individual who is perceived to be different from the norm due to one or more undesirable attributes (Puhl and Brownell, 2003; Lindhardt et al., 2013). The negative experience of being 'fat' is not only located in everyday social interactions but is structurally situated in a person developmental, economic and personal spheres of living such as education, employment and health (Brewis, Hruschka and Wutich, 2011).

It is apparent that the attributes which are stigmatised vary from one social context to another and between time periods. However, common amongst them are the social consequences that develop. They include amongst others, avoidance, rejection, and marginalisation (Puhl and Brownell, 2003). In the context of the variety of deviant labels created by society and the negative effect of being stigmatised, Goffman (1963) noted how the stigmatised victims might cope with their 'spoilt' identity. The above average weight woman, for example, cannot hide her stigma because it is obvious but Goffman (1963) asserts that the affected persons develop a coping mechanism which will help them to deal with the stress in social interactions. However, Yoshino (2006) submits that coping strategies may be supportive for women, but they depend solely on the woman's personal sensibilities.

Maternity care policies

In the UK maternity care policies have continued the tendency of re-focusing maternity services more towards a social model, which recommends midwifery-led care for low-risk women (MacKenzie Bryers and van Teijlingen, 2010). The policy also suggested a team approach for complex needs and as far as possible, birth in local communities is to be encouraged (NICE, 2008). Since the publication of first major policy (DoH, 1993), there have been several publications, but the goal has remained essentially the same, indicating that the implementation and the realisation of the objective of the initial policy have been slow. The lack of visible progress has led to

some commentators seeking an explanation for the inability to achieve some of the key objectives in the initial and successive policy documents. As a result, one of some of the recurring questions have been “could it be as a result of risk theories and dominance of governance in maternity and healthcare systems?” (MacKenzie Bryers and van Teijlingen, 2010, p.493). Although birth policy advocates local births for low-risk women, clearly, it is not always feasible in practice because it is challenged by the care aspect of ‘what might go wrong?’. This means that both professionals and women are more likely to choose to give birth at the consultant-led unit, just in case something happens. When the level of anxiety about risks is raised like in the case of pregnant women with high BMI, it heightens the level of risk-perception by the maternity care system (Davies, 2013) and shifts decisions to obstetricians.

If midwives are to be the lead professionals in low-risk pregnancy, and other low technological surroundings such as home births (Walsh, 2007), it means the policy is ready to implement ‘woman-centred’ care, as it has proposed (MacKenzie Bryers and van Teijlingen, 2010). In the case of pregnant women with high BMI, evidence suggests that what women need during pregnancy and birth of their babies is support. Hodnett et al. (2013) indicates that women allocated supportive companions, were more likely to have a spontaneous vaginal birth than women who were not. They emphasised that women should be aware of this, especially those who have been ascribed the high-risk status.

Continuity of midwifery care, as offered by community midwives has been applauded, because it improves the outcome for women and babies (Sandall, Soltani, Gates, Shennan and Devane, 2013). A systematic review by Sandall et al., (2013) found that, high-risk women who were allocated this kind of care were more likely to have a normal birth than women who were not. On the contrary, Fleming (1998) asserts that pregnancy and

childbirth can be described as a process of self-exploration, and some women seek to share and understand this with their community midwives. Community midwifery is a model of care that offers an increased continuity for women and their families by ensuring that the same or known midwife is responsible, as far as feasible, for the delivery of care and support through pregnancy, birth and postnatal stage (McCourt et al., 2006; Williams Lago, Lainchbury and Eagar , 2010). Midwives in this model of care provide care for women in both high and low-risk categories of care. Community midwives provide care across hospitals and community service boundaries (McCourt et al., 2006; Williams et al., 2010). Also, this approach of care has been one that develops a partnership between women and their midwives throughout the period of engagement. Therefore, the relationship that is created and nurtured between women and their community midwife has been described by women as special, and many women felt that it is like a personal relationship albeit, not identical to friendship (Walsh, 1999; Pairman, 2006).

Although it is effective because of the positive outcomes that have been derived from it (Sandall et al., 2013), many women are still not able to access community midwifery care due to the shortage of midwives and organisational constraints (Pairman , 2006). Further, Walsh and Newburn, (2002) contend that if the NHS continues to employ midwives who are based in consultant-led units, where childbirth is highly managed using an obstetric model, an expected change to the social model of care will take time. Walsh and Newburn, (2002) stress that many midwives who practice in obstetrics units have now adopted the shroud of medicalisation that exists in obstetric units. So, for a social model of care to thrive in the NHS, Walsh and Newburn (2002) argued that midwives should work more in community-based settings and practice in an environment that is more strongly aligned with that of social care workers.

Although studies have reported that women have expressed the desire to have control over their experience of childbirth (Lothian, 2006; Begeron, 2007; Parry, 2008; Munro et al., 2009) there is still a huge presence of the medical dominance within the NHS maternity care system (Walsh, 2010). Walsh (2010) maintains that in this context of medical dominance, it is difficult for midwives to meet the desire of pregnant women for a change or to facilitate choice and control for women, when they have not been able to achieve or acquire or exercise midwifery control over decision making-within their practice (Walsh, 2010). This lack of capacity, not ability, to act as independent professionals regarding judgements or decision-making in areas they have been trained in, may explain why midwives have been seen as resisting change when different models of care are introduced. It can be argued that midwives entered the profession, not to be disadvantaged by medical professionals, but to be able to contribute within the remit of their professional duties and responsibilities, which though independent of the medical model will be able to contribute to the delivery of care by using expertise and professional knowledge (Walsh, 2010).

Clearly, midwives have a major role to play in supporting women to access adequate information, to build their knowledge and to empower women as they make decisions about their care. However, women are now resorting to readily available information which may not be accurate on the Internet. Through their peer networks, women believed they became relatively self-sufficient about knowledge acquisition which enabled them to resist medical dominance (Lorentzen, 2008). The reason for women turning to the Internet which provided general, rather than individually targeted, advice and information or guidance may be because midwives were not able to advise them sufficiently and as openly as women wanted.

Shaw (2013) also confirms that power dynamism has arisen due to the oppression of midwives by the organisation within which they practice,

largely by the dominance held by obstetricians. For example, Keating and Fleming (2009) explored midwives' experiences of promoting normal birth in an obstetrician-led unit in Northern Ireland. They observed that midwifery care in Northern Ireland was dominated and characterised by obstetricians who engaged in the medical model of care and were highly interventionist in attempts to speed up and control births (Brodsky, 2008). According to Keating and Fleming (2009) senior midwives in this setting had been exposed to and embraced the medical model of care, but the newly qualified midwives expressed frustration and felt disempowered at their failure to support women to achieve normal birth, or offer evidence-based care.

This evidence suggested that older and newly qualified midwives are influenced by power dynamics as they strive for a professional position between themselves and their professional colleagues within a predominantly medical environment (Pollard, 2011). Midwives in this situation will accept different models in how they deliver care and support and this has the potential to shift if the midwifery profession perceives itself as being accorded less recognition and freedom to exercise professional judgement, as other groups that operate within a more entrenched medical model. As a result, this thesis argues that midwives who operate within a predominantly medical environment cannot be faithful to their traditional philosophies and values of the social model of care. Rather, midwives accepted change because of their desire to achieve a recognised and respectable status as medical colleagues, rather than the expectations of pregnant women. Consequently, they now freely adopt medical and technological approaches to maintaining prominence in their profession (Shaw, 2013).

The acceptance of the medical culture also involves the use of technical language to maintain the image of an expert. This is a significant shift from their traditional role of empowering women through information sharing

(Poat et al., 2003). This change in the attitude of midwives may further worsen the asymmetrical relationship between the pregnant women and her antenatal care team as midwives begin to achieve greater recognition but only because of their acceptance of the medical view of pregnancy and childbirth. Fahy and Parratt (2006) infer that midwives can use this power to persuade women to accept their advice. This shift will threaten midwifery's influence over how antenatal care is delivered for women who are not deemed to need medical intervention. It will also undermine their role as guardian of traditional care for pregnancy and childbirth and erode the notion that one of their main focuses is the protecting of the birthing environment to enable the woman to use her 'integrative power' so as to experience an uninterrupted labour and childbirth (Fahy and Parratt, 2006). Therefore, there needs to be a move from a hierarchical relationship, where obstetricians and midwives have power over women, to a healthy partnership relationship which protects the interest and aspiration of pregnant women to exist in this continuum. Such a move will ensure a state where women and their healthcare providers share their collective knowledge and skills and thus, share power and control (Gallant, Beaulieu and Carnevale, 2002).

Culture perceptions of fatness (obesity)

Moral panics about obesity in Western nations have occurred alongside changing images of normative femininity in pregnancy (Warin, Moore and Davies, 2011; Nash, 2012). According to Nash (2012) negative comments from healthcare professionals regarding women's high BMI are often embedded with assumptions about its dangers to pregnancy. This further legitimises the control that healthcare professionals assume when upholding the knowledge of what is normal and not normal.

Murray (2008) argued that the fat female body has been framed as a place where numerous discourses integrate, including those raising concerns on normative feminine beauty and sexuality, health, pathology, morality, and the continuous projection of self-care. A culture where maternal obesity has become a source of concern for health professionals (Dodd et al., 2011), only create anxieties in women deemed to be overweight. Such a culture shifts the focus from women's pregnancy to the maintenance of an ideal weight during pregnancy, which is usually not advised (NICE, 2010).

According to Nash (2012) most pregnancy guide books have advice on how much weight women should gain during each trimester. Such guidance may put women under pressure to be on a diet while pregnant in an attempt to conform to the ideals of the society. According to Bordo (1993) who carried out a comprehensive examination of why women suffer from body image woes, a major reason is the urge to conform to popular media culture which equates slenderness to healthiness. She asserted that the representation of pregnant bodies in the social and biomedical environment generates anxiety that women's bodies are constantly under scrutiny. Women's internalisation of the Western cultural ideals accorded to thinness, sometimes erases the consideration of alternative body sizes (Nash, 2012; Lupton, 2012b).

Rules on women's pre-pregnancy body size, acceptable size during and post-pregnancy have been developed in the light of claims that being fat and pregnant is a contributor to the obesity epidemic in Western society (Paul, 2012). Historically, fatness and thinness have varying significance in various cultural settings (Broom and Warin 2011) and across times. Sobal (1995) reiterated that in the 20th century, thinness usually signified disease and poverty while being fat was an indicator of health, wealth and a cheerful disposition. However, as food became cheaper, abundant and readily available, fatness was a less consistent marker of wealth and distinction since everyone could easily access food. The increased abundance resulted

in a greater percentage of the population putting on weight. According to Sobal (1995) fat shifted gradually from its historical perception as a marker for identifying health and wealth in traditional societies, to being seen as a bad and ugly outcome in modern societies.

This change from a positive to a negative perception of heaviness or fat in recent years has become a symbol of failure, and it is now actively viewed by the medical communities as unfavourable and even linked to a lack of will, indiscipline and moral weakness. The negative view of weight forms part of the moral gauge for categorising women and mothers as 'good' and 'bad' mothers (Maher et al., 2010).

Constructions of maternal responsibility

This moral concept is evident in dominant obesity discourses which highlight a woman's inability to control and maintain a healthy weight before conception and therefore put their unborn baby in danger (Dodd et al., 2011). Pregnant bodies are not only under medical scrutiny, but they are scrutinised from other social spheres (Nash, 2011). As Nash (2011) has observed in contemporary Australia:

"Women must 'work' very hard to achieve a pregnant body that conforms to social expectations of good motherhood" (Nash 2011, p.1).

Emphasis on fitness during pregnancy is an additional pressure on women to remain thin through weight loss programs or to exercise at a time in their lives when they are expected to add weight and when some exercise activities may pose an additional risk. The possibility of risk from exercise has been picked up by a few studies that have examined the role of exercise in pregnancy which has raised concerns about the risks involved (Poudevigne and O'Connor, 2006; Watson and McDonald, 2007).

The imperative requirement for women to achieve a pregnant body that conforms to social expectation of a good mother imposes on women and mothers, as carers, an exceptional responsibility for their unborn children's health and wellbeing, thus creating a new area of maternal responsibility (Maher et al., 2010). This novel responsibility for women and mothers is an offshoot of discourses on obesity in pregnancy which suggests that maternal obesity has a strong link to childhood obesity. According to Maher et al., (2010) these frames of maternal responsibility draw heavily on bodily linkages between mothers and children and Lewis (2001) framed this increased responsibility as the individualisation of the gendered care burden that exists in Western societies.

Crossley (2004) argued that the rising obesity rate, if indeed it is the case, is a social issue and not simply a reflection of the body weight of mothers. It is a reflection of society and its choices in general. Concurring with Crossley (2004), Maher et al. (2010) stressed that a comprehensive understanding of childhood obesity is required rather than suggesting a simplistic link between childhood obesity and women's overweight, because childhood obesity requires due consideration of the complex social intersection of several variables rather than a focus on women's weight.

Conclusion

The framing of body size in modern society and its perception as a source of risk to the medical wellbeing of individuals, has been created with 'evidence' from epidemiological review studies. The impetus for this framing has been provided by the political context of modern state that ascribes responsibility to the state for the health outcomes and the wellbeing of citizens. As a result, the state responds to this responsibility within its traditionally paternalistic environment that has been shaped by paternal, political leaders and political commentators and endorsed by the society and the media.

The chapter evaluated the role of power and knowledge in creating the social, political and scientific support for the manner which overweight is perceived, construed and framed as a negative, with real threats to the health of individuals. The use of Foucault's (1976) concept of knowledge and power highlight how the claim to superior knowledge by epidemiologists and their backing by the media has galvanised the political establishment in several Western territories, to adopt the views of epidemiologists as presented by the media to create and fund several initiatives that both set and legitimise the boundaries of what is right and wrong, acceptable and unacceptable (Lupton, 2012a).

Following up on how knowledge has empowered the state and the media to categorise issues, occurrences or events that were previously construed as social issues, which society did not frown at, as present problems with adverse medical or political consequence engendered the advent of surveillance, monitoring and control. This chapter explored how power and surveillance activities that evolved from the perceived superior knowledge of epidemiologists was integrated into the healthcare delivery system and its impact on service users especially overweight pregnant women exposed to both bio-power and health surveillance activities that are deplored under the medical gaze of the medical profession. This gaze actively supports medical intervention in naturally occurring events such as menstruation, pregnancy, childbirth, menopause, and ageing.

The chapter also considered how the strength of the paternal culture in maternity settings and the social consequence that results from the stigma of being overweight erodes the confidence of overweight pregnant women. Overall, the chapter highlights how the construction of overweight, the surveillance, stigma and the feelings of reduced self-worth that surveillance and stigma create, impacts the experiences of pregnant women.

Chapter 4

Methodology

Introduction

This chapter commences by giving details of how the research design evolved and was carried out, the challenges encountered, and the thinking and rationale behind the decision to adopt a qualitative research method. The research approach section gives a detailed account of the research journey. The account includes a description of the activities carried out to gain access; the sampling approach used and actual gathering of primary data. Also discussed in this chapter is the use of in-depth, semi-structured interview style, in the interviews of pregnant women, midwives, and obstetricians. The purpose of planning is to secure efficiency and effectiveness in the deployment of resources and the execution of processes. So, also discussed is the use of topic questions and field notes which were used to guide interviews and optimise the effectiveness of interview outcomes for the benefit of the study. Pregnant women with high BMI are the primary participants in the study, and they are vulnerable members of society because of the physical strain of pregnancy and the emotional burden that emanates from the way society responds to overweight particularly in pregnancy. This study will ensure compliance with the strict ethical standards to safeguard the pregnant women who participate in it. Consequently, this chapter also includes a detailed description of the ethical approval process, and the steps taken during data transcription, coding or indexing and the analytical approach to ensure the researcher's position within the insider/outsider continuum is clear and preserved. The chapter also discusses details of validity, generalisation and evaluating criteria used in this study to deliver compatibility with qualitative research.

Research Approach

The researcher considered several factors before adopting an appropriate methodology for this study. The main purpose of the study is the examination of women's perspectives about their experiences of antenatal care. So the approach adopted is the one that will allow these women's experiences as well as those of their healthcare providers to be captured, analysed, evaluated, giving opportunity for clear patterns and/or findings to be extracted. It is important to explain the rationale, here, in the interest of exploring the beliefs, perceptions, and experiences of healthcare professionals who deliver care to overweight, pregnant women in a study whose sole objective is the exploration of the experiences of pregnant women with high BMI. Healthcare professionals, as used in this study, is an umbrella category for midwives and obstetricians who provide antenatal care for pregnant women with high BMI. Midwives and obstetricians jointly provide care for these women because their high BMI is deemed to expose their pregnancy to higher risks.

One of the major reasons for including healthcare professionals as participants in this study is the suggestion by various articles reviewed. The articles suggest that the beliefs and perception of healthcare professionals, regarding the risk of BMI to pregnancy, is in part shaped by how the media has framed fatness and overweight, which in turn may have influenced how healthcare professionals care for overweight, pregnant women. It also impacts how they relate with and communicate with pregnant women that are overweight or have high BMI. Since these beliefs, perceptions and experiences directly affect how pregnant women experience antenatal care, exploring them will generate insight that will enhance the understanding of pregnant women's experiences.

To be able to explore these variable human attributes of beliefs, perceptions, and experiences; a decision on whether to adopt a quantitative or a

qualitative approach first had to be made. The literature reviewed in chapters two and three set the framework for the study by giving evidence of instances where qualitative methodology has been used previously in an efficient and effective way to explore experiences or other social issues within groups or society. The literature reviewed also highlighted gaps (see section on the gap in existing research above) concerning the perception and experiences of overweight, pregnant women and the antenatal care they receive. As argued above, because the beliefs, perceptions, and experiences of healthcare professionals also impact how they deliver services to pregnant women and, how pregnant women experience the care they receive, the perspectives of midwives and obstetricians will be considered so as to gauge any impact they may have on pregnant women's experiences. As a result of the issues raised by women and midwives in previous studies, qualitative research methods are the best approach to explore these human attributes. The philosophical positions used within quantitative research methods aim to provide numerical data to describe events and predict the outcome. However, the philosophical position underpinning qualitative research is one that provides detailed examination and explanation based on words, feelings and individual perception and the context of participants' experiences (Silverman, 2013; Silverman and Marvasti, 2008). As a result, qualitative research is more suited to address the aims and objectives of this study. Also, I chose to use qualitative research because its data collection and analysis of health and social care issues, offers the means for meeting the threshold of rigour, creativity and transparency (Green and Thorogood, 2004) which are criteria used for assessing the quality of qualitative research (Mays and Pope, 2000). Qualitative methods also enable thorough exploration of how participants view their experiences, and the rationale behind their views. This will highlight details and the range of pregnant women's perceptions and meaning and provide a deeper understanding of the phenomena being studied.

Inductive thematic analysis was used to analyse the data because it provides a comprehensive process for identifying numerous cross-references between evolving themes in the entire data (Hayes, 1997, Braun and Clark, 2013). Inductive thematic analysis also provide the opportunity for theoretical freedom. It involves a process of coding without trying to fit into a pre-existing code frame or the researcher's analytical preconception. However, this does not mean that the researcher is free from an epistemological perspective because data are not coded in an epistemological vacuum (Guba and Lincoln, 2005). Data in inductive thematic analysis, to some extent is shaped by the researcher's standpoint and disciplinary knowledge (Braun and Clarke, 2013). These attributes of inductive thematic analysis makes it most useful in understanding women's perception, experiences and how women in the study make meanings of their social world and interpretations, and also provides a systematic process to data analysis. Thematic analysis also gives the researcher an opportunity to understand the potential of any issue more widely. Above all, Braun and Clark (2013), assert that it is flexible. In addition, it enables the investigation of the reality of being overweight from the participants' perspectives, through an exploration of their experiences and the meanings they attach to them, and at the same time, incorporates a broader view of society's role in the construction of being overweight as this contributes to and shapes the participants' understanding and meaning-making. This is important to the study as an understanding of the philosophy that underpins each paradigm and how they manifest themselves within various methods and methodological frameworks enabling a qualitative researcher to acquire a better understanding of research questions, research activities and reports.

Philosophical underpinnings

Crotty (1998) summed up philosophical underpinnings of research as frameworks that are known as paradigms which reflect interrelated beliefs

about the worldview and how this is perceived and interpreted. These paradigms are made up of:

Epistemology, the link between study and knowledge, and which offers the vehicle for knowing and framing reality;

Ontology provides the means for answering the question; what is reality or what exist?; and

Methodology, which encompasses the consideration of concepts and theories which underlie methods used (Crotty, 1998; Denzin and Lincoln, 2003) in the execution of the study.

According to Appleton and King (2002) and Weaver and Olson, (2006) a researcher should ensure that the research paradigm and the research purposes formed are complimentary, as this will enable the confirmation that the inquiry is integrated and methodologically sound. Jaccard and Jacoby (2010) also added that there is no chain of command in research paradigms, and one is not fundamentally superior to the other, though one may be more suitable for a phenomenon than another.

My philosophical beliefs and intentions are aligned with a constructionist/ interpretive ontological position. Constructionism denotes an alternative paradigm which is a break away from ontological realism. For Guba and Lincoln (1994) ontological realism denotes a stance that reality exists independently of human insight and experiences. Ontological realism aligns with the positive stance and modernist thought, which developed from the Enlightenment period which is also the period that traditional scientific methods originated (Lincoln, Lynham and Guba, 2011). On the contrary, a relativist position differs fundamentally to constructionism, and it contends that reality exists only in the context of a mental framework used in its

discourse or thinking around it (Denzin and Lincoln, 2003; Berger and Luckmann, 1966).

There are two different terminologies found in the literature, which is constructionism and constructivism. According to Blaikie (2007) constructivism focuses on perceptions that have a connection with cognitive processes undertaken by a person's mind when making meaning. On the contrary, constructionism tends to focus on the shared generation of communication of perceptions, procedure and meaning (Blaikie, 2007). Given these varying elements, there is an upside to social constructionism for the research aim and objective. It tends to focus on social inquiry (Blaikie, 2007) and is, therefore, better aligned with the aim of my research which seeks to capture, explore and analyse the connecting network of meanings from women, midwives, obstetricians and myself using a subjective perception and construction of variables. A constructionist paradigm is subjective in the sense that it embraces the intimacy of those involved in the construction of knowledge, and this includes the researcher in a socio-context, as the researcher is unable to completely separate self from the meaning-making process of social issues as perceived and construed by society (Denzin and Lincoln, 2003). Within the constructionist/interpretive paradigm, the meaning of social reality is constructed and interpreted by individuals through the day to day interactions involving thought processes, the external world and people (Lincoln, et al., 2011; Schwandt, 2000; Blaikie, 2007). Such meaning creation is particular, time and context bound. Hence, constructionism does not claim to uncover the truth or generalisable theory but contributes to what is perceived and construed as truth. Thus, truth as a relative construct is more aligned with qualitative analysis rather than a quantitative framework which uses a more objective analysis model or framework. Constructionism accepts that truth is relative and that a network of meaning is flexible and subject to change depending on human social experiences

(Charmaz, 2000; Schwandt, 2000). As a result, meanings are constructs which are inductive in the data and may have some transferability (Lincoln, et al., 2011). Constructionism is consistent with the philosophy of this study. It supports the study of women with high BMI, allows their experiences of antenatal care and how midwives and obstetricians who care for them communicate risks to be explored and analysed. According to the constructionist, the participants' (women's) 'truth' is considered to be relative and constructed by each woman depending on how she perceives her situation (Schwandt, 2000).

The uniqueness of the nature of women's reality is highlighted and validated by constructionist assumptions, and in this current study, the intention is to represent these women's experiences in that way. As the study progressed women's construction of meaning and beliefs, as shaped by their interactions within the social and cultural situations, and which also influenced or shaped their experiences of receiving antenatal care in the health service, received greater recognition and value.

Following the social constructionist perspective on how people make and construct meanings to their life experiences, my theoretical framework is shaped by the experiences and perceptions of overweight, pregnant women (Guba and Lincoln, 2005). As part of the social constructionist perspective, I drew on the work of Michel Foucault (1977, 1980) to focus on the process and relevance of constructions of reality while highlighting women's voices. In addition, it is important to highlight the role of power as women negotiate the meaning of the antenatal care they receive within the NHS antenatal settings. The focus of my study are the thoughts and everyday experiences of pregnant women who are classified as overweight and thus are high-risk pregnant women. Using social construction helps to illuminate the notion that meaning production is an intrinsically linked micro and macro sociological phenomena; that is women's experiences, meanings, knowledge

and social institutions. The work of Foucault on the 'body', his elaborate and critical views about knowledge, power, medicalisation, and surveillance influenced the study from the beginning. The literature reviewed, highlighted his critiques of social institutions and how they make the 'body' docile to enable constant monitoring, surveillance, and regulation. Foucault's concepts were also considered during the data collection process, as this allowed questions regarding how overweight, pregnant women and healthcare professionals perceived the 'body'.

Research Process

The literature search undertaken for this study was an ongoing process for the duration of the study. The study commenced with a review of several published reports from epidemiological studies. The objective of the initial review of the literature was to identify and examine the references they contained for further use. The rationale for this action is that most epidemiological reports are evidence-based and provide data, analysis and conclusions or recommendations which are later used to develop policies. Also being pregnant with a high BMI is a key focus for epidemiological scholars such as Yu, Teoh and Robinson (2006), Cedergren (2006) Guelinckx, Devlieger, Beckers, and Vasant, (2008) and Li et al., (2013). They all aimed to provide a research briefing based on evidence drawn from various studies they have conducted.

The literature identified as relevant and related to the objective of this study was read carefully to identify issues and questions that other researchers and commentators had previously raised, and which if effectively answered, would contribute to answering the research question raised in this study. The other rationale for reading, reviewing and evaluating existing literature was to identify gaps in the topics, which have not been addressed or fully explored by previous research or scholarly reviews of women's experiences of antenatal care and childbirth. The objective of reading existing literature

to identify gaps was to develop relevant research questions, objectives and aims for the study, as these will provide effective guidance and focus on the actual research activities, from developing interview questions, conducting the actual interviews to data sorting, grouping, and analysis and interpretation of data.

Gaining access

Flick (2014) posits that qualitative research raises crucial questions about access to the field which requires special attention because of the demands it makes on both the researcher and the participants in terms of time, intensity and depth of disclosure. Right from the planning stage of my study, strong recognition was given to ethical principles and processes, such as confidentiality, consent, acting in good faith, protecting the participants and integrity. Every aspect of the proposed research, including the methodology and methods proposed, reflected these ethical principles (DoH, 2005; University of Huddersfield, 2015). It was clear that there was direct access to pregnant women and their midwives through NHS antenatal settings after discussion within a supervision team meeting. It was, therefore, necessary to apply to gain access to the setting through its gatekeeper; the NHS Research Ethics Committee (NHS REC).

Initially, I had meetings with the head of midwifery services in the Trust where I planned to undertake my study and asked for written permission to conduct the study within the Trust once I had received the NHS ethics committee's approval. At this point, the head of midwifery services promised to discuss my study in the then forthcoming management meeting. It was also necessary to seek approval from the University's School Research Ethics Panel, so I completed and submitted the application for the approval of the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel (SREP). The School of Human and Health SREP is an integral part of the University's Research Ethics Panel. Feedback from the panel was

particularly helpful, and it was used to ensure that the information sheet and leaflet introducing the research to prospective participants was written clearly and was accessible to the women who would participate in the research (See supporting document in Appendix 1). Following some minor adjustments, the University of Huddersfield, SREP granted ethical approval for the study to commence.

As a researcher, from a social scientist background, the NHS ethical approval application process was especially challenging. I had to be very proactive regarding finding out how the application process worked. The review of the application by the University's Research Ethics Panel helped as their feedback was used to review the application and ensure that relevant details, in appropriate depth, were included before the Integrated Research Application System (IRAS) application form was submitted to NHS REC.

I was concerned about the justification I had to give as a sociologist applying for ethical approval through a system which operates with a more medical model of research. The more I read about how the system operates, the more apprehensive I became because my study did not seem to fit with some of the drop-down menu options on the ethics form. I was concerned about the influence the committee's decision would have on the outcomes of my proposed study. In particular, I was very aware of the strict timescale for completion and submission of my thesis. However, following preparation for meeting with the committee, including a discussion of likely questions I felt more confident to respond to questions from members of the committee. The confidence that resulted prepared me and put me in the position to be able to justify my study, not only in ethical but also in methodological terms. My ability in justifying the credibility of my methodology was a key step towards ensuring that I could convince the committee that the research was 'doable' while remaining ethical. The goal and objective were and remain relevant throughout the study period and after, making it a worthwhile study

with participation from both NHS midwives and clients. Despite this confidence in my ability to espouse the quality and benefits of my proposed research, I was still concerned about the position the committee would take. My fears and worries were confirmed when I received a provisional opinion on my application. For a summary of the committee's concerns (see Appendix 2).

The main concern raised by the committee was the issue of the language and terminology used in the research information sheet which introduced the study to potential participants. The committee objected to the choice of the term 'high BMI' rather than 'obesity'. They insisted that the medical term for the BMI threshold indicated for the study is obesity. The committee queried the omission of the term 'obesity' and the use, in its place, of descriptors such as 'high BMI,' 'above average weight' and 'overweight' as the preferred terms for the study. I explained the rationale behind these choices to the committee during the review meeting. I explained that the decision not to use the term 'obesity' was made because women had expressed disapproval towards the use of the term in previous research (Nyman et al., 2010, Fuber and McGowan, 2010, Furness, et al., 2011). However, my response was not accepted, and to meet the time frame for gaining approval, I had to use the term 'obesity.' The committee granted the approval to conduct the research on the NHS Trust sites the same week I agreed to use the term 'obesity' as opposed to my preferred term.

The researcher adopted a reflexive approach to the process used in applying for approval to conduct interviews on NHS sites. During the reflection which was part of my ongoing reflexive activity, I realised that the process of application and the committee's assessment is exclusively rule based. As a result, it requires very specific details in a more or less rigid form about what a researcher proposes to do. Given that the current study is about exploring maternal overweight, it is important to use the interpretivist

constructionist perspective. This is because, it involves multiple realities which emphasise individual's experiences (Braun and Clarke, 2006). My experience indicates that combining a principle-based approach with the rule-based framework that was used by the NHS REC panel in assessing my IRAS application will accommodate the fluidity inherent in sociological research. To some extent, I felt that the specifications in the IRAS application process made it very difficult to obtain approval due to its rigid approach to research design which was intended mainly for quantitative study. The lack of willingness to be flexible, demonstrated by the NHS Research and Ethics committee created challenges to the inherent fluidity and responsiveness required when conducting non-quantitative research with human participants. The challenges, especially in research involving a face-to-face interviewing approach and where there is uncertainty about how aspects of the research will develop, makes it unadvisable for a researcher to commit to a rigid framework in conducting research that is inherently fluid as it may halt the progress of the study or prevent its completion.

The stalling impact of rigid requirements was evident in the areas where the committee specified that I would need to submit an amendment to them for review if I wanted to change any of the documents submitted to them and which formed the basis of the approval they had given. The refusal of the committee to allow any flexibility restricted the modes of recruitment to the plan in my application and I believed opportunities for effective recruitments were missed later on during recruitment. The amount of time that elapsed while I was waiting for the committee's approval raised questions regarding the contribution of the approval process to research efforts other than maintaining the perceived ethical integrity of the process. If I had not been flexible in my application, the process of going through an amendment would have been a more daunting experience altogether. However, having realised how restrictive their review was, for example with the use of clinical terminology like obesity, I adopted a position of compromise. This position

enabled me to clarify the aspects of the application that the committee would not shift their position on, and at the same time ensured the feasibility of the study.

Although it was not a very straight forward process as there were many surprises which developed as I waited for the committee's response, I would still like to acknowledge the committee as they gave very encouraging feedback about my application along with granting me the approval which kick-started my fieldwork for data gathering. The committee also asked if I could give them the permission to publish my proposed study on their website, which I agreed to. Despite the fact that the NHS Research Ethics process seemed challenging, it means that conducting research with humans should be undertaken in a manner that is appropriate and ethical. The committee's emphasis on the ethical impact of the study from the beginning of the application process to the review committee outcome, was all a learning experience for me as a social scientist. The committee, however, can benefit from having members with a sociological perspective and background on the IRAS application review panel as a good mix of both clinicians and social scientists will give a balanced opinion on the review of researchers' application. It will also address the lack of breadth in the capacity of the committee to engage with the social scientist research model and approach fully. Involving experts with diverse interest will enhance the committee's ability to exercise, more extensively, its role as a gatekeeper as well as effectively engage with researchers from all backgrounds. The overall result is that the panel will be able to facilitate and offer welcome feedback which will enhance research proposals intended for qualitative study within a social context (Feldman, Bell, and Berger, 2003; Berg, 2004).

This will address the criticism by Cheek (2008) who asserted that ethics committees might wrongly reject qualitative studies because they considered them to be unscientific with findings that are not generalisable. Although the

ethics and research governance process appears to be arduous, it exists for incredibly sound reasons, to ensure that research activities meet approved levels of ethical standards agreed for research involving human participants who may also be vulnerable. The rigorous vetting of applications also helps to identify unethical studies and guard against the re-occurrence of highly unethical research, that had been carried out in the past, and which caused harm unnecessarily to research participants (The British Psychological Society, 2010).

Local Research and Development (R and D)

After gaining provisional access to conduct my research within NHS sites from NHS REC (Appendix 3), the next step was to navigate local Research and Development (R and D). The local R and D asked to see the information sheets for participants and all the documents used to gain access through REC was submitted to the R and D. The R and D also requested additional documentation before granting full access. Their requirements included the information sheets for all the participants (see appendices 4, 5, 6, 7 and 8), a criminal check and medical report. This clearance, was necessary to provide assurance that I can have access to women without posing any danger to them and their unborn. The local Research and Development lead, who explained that its purpose was to protect pregnant women who are perceived to be vulnerable asked for a Disclosure and Barring Service (DBS) certificate. I submitted the additional documentation, including a DBS and received an honorary contract, also known as a research passport to fulfil the contractual requirements and to aid my research activities within the NHS Trust sites.

By the time these were verified, a meeting was arranged to meet the Head of Midwifery Services, who then gave the go ahead for me to meet with midwives. The same question of whether or not to use the term 'obesity'

arose again. This time, the head of midwifery and midwives took a contrary view on the use of the term obesity. So I went through the process I navigated during my negotiation period with NHS REC as part of IRAS process. I explained that NHS REC prohibited any alteration, outside typographical corrections, of the information as part of the condition for giving approval.

Recruitment

Participants to be recruited for the study included pregnant women with high BMI, midwives who provide care for them and obstetrics consultants from an NHS Trust in the North of England. The Trust was selected because it covered a multicultural population and is responsible for providing antenatal care to over 6,100 women each year. To recruit participants for the study, I contacted the head of midwifery services of the Trust, who then informed the community midwives and obstetricians in the Trust of my intended study. She introduced my study to them via email by sending the letter I had written inviting them to participate in my study as well as the information sheets and flyers about the study. They were advised to contact me using details on the information sheets to discuss their participation, if they were interested in taking part. Midwives and obstetricians who were interested contacted me and I followed-up with emails and phone calls to discuss their participation. The first set of participants recruited for the study were the midwives because they are the first healthcare professionals who pregnant women come into contact with.

It was several weeks before I got responses from the midwives and obstetricians. When the community midwives contacted me I advised them on how to go about recruiting overweight pregnant women for the study. I chose to recruit community midwives because they have most contact with women during pregnancy. Community midwives have contact with pregnant women from the time they first access antenatal care during the early stage

of their pregnancy to childbirth. To access pregnant women with high BMI, I had to go through their midwives who were strategically placed to identify pregnant women who met the inclusion criteria for the study.

The actual recruitment did not proceed as had been planned and anticipated. After a week and no response had been received to my emails, it became clear that I was not going to get the quick response I expected after the long wait for NHS REC approval. That was when I wrote in my journal:

'what will I do to get these midwives to be in my study, then pregnant women, and consultants. It is May, I got my approval since April – what will I do.' (May, 2).

By the end of the second week, I had met with the head of midwifery services, and she was receptive to the idea of an initial meeting with community midwifery teams, for me to introduce myself and discuss my study with them. She gave me the contact details of the leaders of three of the five teams. I was then able to meet the midwifery team leaders and clarify my research interests and the study in general.

The objective was to explain to them that the assistance I needed from them would not significantly add to their job. Convincing them that their involvement would not be an additional burden was important because the few midwives I had spoken to on the phone had not agreed to participate due to their busy schedules. I reflected back on the meeting with NHS REC and recalled that the committee asserted that getting midwives to participate in the study would be difficult. I also recalled the reason they gave for their assertion and wrote in the research journal:

'Why does it look like these midwives are avoiding me, the more I try to approach them the more difficult it gets and the more difficult

it appears to be? Could it be because I'm not a midwife, (an insider?).' (May 20).

The appointment with the second community team of midwives was a successful one, although the midwives could not take part in the research. They were receptive and interested, but as specialist midwives who provided antenatal care for women with complex needs, both the study and the group of participants that needed recruiting were outside their domain. Though some of the pregnant women they care for had high BMI, they also had additional health issues such as poor mental health, dealing with domestic violence and/or some other medical conditions, for example, diabetes and hypertension. These other health issues and medical conditions meant that these women did not meet the requirements of the study. I, therefore, did not include midwives from this team in the research. I had met with three teams of community midwives in one town and had one more meeting arranged for another that held some positive prospects. I attended the meeting as arranged but not one of the six midwives I expected to meet turned up. I became really worried about how to progress regarding when to begin interviewing. Here is an excerpt from my research journal:

'I remember very well that I received an appointment for this meeting and I have been stood up. Why have they done this? Is it because I am not a midwife? Why else would I be asked to come to a meeting and find no one, not even one midwife turned up? I've double checked my email; I was supposed to meet with them. It got me worrying.' (June 10).

This occurrence had been a surprise, and I assumed straight away that it was because I am not a midwife. My thoughts went back again to the observation of the NHS REC panel.

Amendment to initial design

The barriers to recruiting enough participants persisted, and forced the decision to amend the initial research design (Robson, 2011) to enable me to recruit women directly from community centres using a flyer (see Appendix 9). This amendment was sought through the SREP because it was not a major amendment. A new flyer was designed to increase participation. I believed that the display of posters around community centres, bus stations and local churches in the towns proposed for the study would increase participation. Another important reason for the amendment was to increase participation from ethnic minorities. The need to focus on increasing participation by members of ethnic minority communities was highlighted by the observation that at the time, I had only one participant who described herself as black British out of six participants. Also, the flyers which would be the product of the amendment approved by SREP (see appendix 10) was not used in the NHS site or premises; it was not necessary to re-apply for ethics approval through NHS REC. The ability to adjust my research design has been described as one of the advantages of qualitative research, as this flexibility enables a qualitative researcher to be iterative because researchers adjust original designs according to what is learned (King and Horrocks, 2010).

Increasing participation (outside the NHS sites)

In addition to the initial information sheets, flyers and posters were used to increase participation. The flyers were posted at local bus stations, community centres, and local churches. After a week of posting, I decided to visit the local Pentecostal churches that have a high ethnic minority membership. I made calls before I visited to speak with the church head and asked for permission to post the flyer on the church notice boards. Two out of four of the Pentecostal churches visited refused, one of the church heads said if he allowed it, it would encourage more research and adverts to be put

on their notice boards. The second refusal was based on my not being a member of the church. This church pastor, however, said that if I saw a pregnant woman that I wanted to pass the flyer to, I was encouraged to do so. Here is a comment from one of the church pastors that specified his and the church's position:

"...we do not allow things like this in this church at all. If we do, we will be overwhelmed by the number that will be coming in to ask to use our church for such activity; I am sorry about that. However, in the event, you find a pregnant woman, and you want to pass your flyer to them, I cannot stop you, just go ahead but do this after church service..." (A spokesperson, church 2, research diary).

According to Earl and Penney (2001) there is the need to recognise diversity because within every social group and life experience; shifting populations create diversity, and this is rising. Having been turned down by church number 2, I decided to travel to church number 3 because the majority of the worshipers are of African decent. They originated from the West Coast of Africa as do I. I greeted the pastor and introduced myself, and he recognised my voice from a previous conversation on the phone. He asked if I was staying, I quickly gave a 'yes' response because I was welcomed and felt there might be a successful outcome from this research site. After the church service, the pastor asked me to meet up with the women in a separate room as there were various after worship meetings of different groups in the main church hall. I liked the fact that I met both pregnant women and women who were not. After introducing myself, I showed my identity card and relayed the reason for my visit. There were questions from a few of the pregnant women, and those not pregnant even had something to say about their experiences of research. For example, the first woman from this site to contribute, asked:

"...why are you doing the research, and will the benefit reach us, this is going to be my last pregnancy anyway. I don't trust research ooh because you never get to hear from the people when they're done ..." (Research diary).

This initial scepticism was picked on by a second woman who asserted that:

"...I am not sure that I will take part in the study, especially with the fact that voice will be recorded, because I'm not sure where my voice would be taken. I'm worried that after you get what you want from us, that we will not see you ever again, and if you did something that you should not have done with our word or voice, it would be too late for us to do anything about it" (Research diary)

And a third woman in red also said:

"...I have taken part in research before, and all they did was to tick boxes, and our voices were not recorded, so I am wondering why yours is different. We just answered yes or no in some instance", the woman insisted (Research diary).

Given comments like these, I felt there was the need to begin a relationship with this group of people by gaining their trust, and I knew this would require time and effort (Earl and Penney, 2001; Zubair et al., 2010).

Issue of trust

After listening to their different comments and the fear that had arisen about what would become of their data, I explained what qualitative research is, and how it is different from the research they said they had taken part in, in the past. Interestingly, I did not feel the women would be doubtful about the objectives of my research after I had explained it to them. I took the fact

that I share the same ethnicity with these women for granted and felt it would be one of the easiest sites for me to recruit women from to participate in my study but I was wrong. Despite the fact that we share the same ethnic identity, they were not sure whether they could trust me with any information, for example, they were very quick at asking why I was undertaking the study, what it was for, and my profession. Their interests were focused on my profession; they wanted to know whether I was a social worker since I had confirmed to them that I was not a midwife or a nurse. Therefore, I guessed I was treated with the same suspicion and distrust that would have been meted on an 'outsider.' On reflection, I realised that though I shared the same ethnic background with them, I was not a member of their group as defined by their shared perception, beliefs, and experiences. As a result, for all intent and purpose, I was truly an outsider who needed to gain their trust to be accepted in.

Mention had been made in the past regarding why people from ethnic minority backgrounds are less represented in research studies (George et Duran and Norris, 2014). One of the major barriers to participation from ethnic minorities in research is the lack of knowledge on the part of researchers about the complex factors of cultural difference between ethnic minorities and their inability to gauge how much distrust this can create. The lack of awareness of the impact of cultural differences was also evident in the initial assumption that I will be welcomed by the group because of shared ethnic origin and that this will engender the willingness of the group to want to participate in my study.

Furthermore, because of the perception of minorities about research, researchers find it difficult to recruit from ethnic minority groups. For example, Africans and Africans in Diaspora hold the perception that their communities have been used to collect data in the past without any benefit from the outcome (Wenger and Plowden, 2000). Rooney et al. (2011) added

from their study in the UK with South Asian descent that forming a trusting relationship was described as a key aspect of the successful recruitment of ethnic minority groups into research. To this end, I explained how the findings from the study could be used to enhance the care delivered to pregnant women in their respective communities.

In hindsight, I did not fully identify and address the cultural hindrances to the willingness of ethnic minority groups to participate in research studies. For example, the aversion amongst people of ethnic minority backgrounds to confide in strangers irrespective of their geographical proximity to them. The lack of effective engagement with ethnic minorities resulted from inability, at the time, to separate self from the research activity and the assumption that I am a member of the clan. The lack of engagement was further exacerbated by the cultural barriers that have been implicated as a contributory factor to the ineffective communication strategies in health research that is linked to challenges in recruitment and retention (George et al., 2014). To avoid this, Laverentz et al. (1999) pointed out that researchers should build trust through positive attitudes and actions of a researcher, for example by the willingness to take the time to gain trust and respect. To gain the trust of the women, I attended worship service with them at their church for three consecutive Sundays, and as advocated by Laverentz et al. (1999) it was a key aspect of me building trust and a feeling of mutuality between the women and myself. George et al. (2014) added that such efforts can increase the likelihood of participation. So despite not recruiting any participant during my first two visits, I revisited the third time, and one of the women interestingly said:

"...you are still coming hmm you are not tired of our saying no, hun? That shows much seriousness in this business of yours, I'll see you after worship if you are staying until the end of the services, are you?" she asked, and I responded 'yes!'

On that day too I met another woman who fit, my inclusion criteria who I had not met before and I had a conversation with her regarding my study given that I had not met her before and she had witnessed the positive response of a member of her church. She also agreed to take part in my study. This effort and time investment has been applauded by George et al. (2014). They emphasise that it is important to spend time and engage with people in their community to build and enhance trust. Although I had positive responses from some women from this church, there was, however, an element of distrust as the women who called to discuss their participation asked me not to let the other women in the study know about their participation. I set their mind at rest and assured them that I would not discuss their participation with anyone else, adding that if they hear otherwise, they should email or call my supervisor whose contact details were on the information sheet. Reassuring these women was to secure the trust that was beginning to develop between them and me and to reaffirm my commitment to them about keeping to my word on how the research would be carried out. This was necessary to address their concerns about the failure of researchers to keep up to their word after participants were persuaded to partake in research (Corbie-Smith et al., 1999). I also reassured them that the data collected from them would be relayed back to them, for them to ascertain if their experience and account have been represented correctly. In total, I recruited five women who identified themselves as Africans and suddenly realised, that I could not categorically say that my research participants represented a good mix of diversity. There were no women of South Asian decent amongst the participants in my study. It was at this juncture that I decided to be more proactive to get women of other ethnic backgrounds other than African descents to participate in my study.

So, I tried to recruit women of South Asian descent; that is individuals whose ancestral origin lies in the India subcontinent of Pakistan, India, and

Bangladesh irrespective of whether they were born in or migrated to the UK. I made this decision because according to the Office for National Statistics (2010) the towns covered by this study have a large population of people from this ethnic minority descent. I did this by visiting antenatal clinics, on clinic days, as advised by clinic staff. I felt that if I went to antenatal clinics to speak to women myself, women would see that I identify with them; that I had undertaken the pregnancy journey before and had an understanding of their journeys. I approached a number of women from the South Asian ethnic minority group with a description of the physical features that fit my inclusion criteria and who came to the antenatal clinic. I felt that if I recruited women from South Asian descent, it would give an insight into their view about antenatal care for women with high BMI (Twamley et al., 2009) in the UK.

Every effort I made to include women from this background was in vain. Upon reflection, I felt I did as much as I could. I was culturally sensitive in terms of dressing. The consideration to be culturally sensitive in terms of appearance in the presence of the South Asian population is one that is both recommended and applauded by Zubair et al., (2009) but it was not enough to persuade the potential participants of South Asian descent that I spoke to. The lack of willingness or aversion to participating in research studies is consistent with the submission of investigators of social and human sciences. Their experience of the under-representation of the migrant population in social and human research is well documented in qualitative research (Barata, Gucciardi, Ahmad and Steward, 2006 and Sheldon et al., 2007). Barata et al., (2006) and Sheldon, Graham, Pothcary and Rasul, (2007) pointed to the difficulties in securing research participation with ethnic minority groups and there are obvious reasons for this, such as language barriers and literacy issues. Language barriers were not an issue in the current study because the women I interacted with in the antenatal clinics communicated very well in the English language.

In most cases, the women were with relatives who most of the time, were introduced as mothers-in-law, aunties, sisters or sisters-in-law. The relatives were very quick to question the purpose of my research and wanted to know more after a glance at the information sheets I had handed out. They displayed strong feelings of scepticism and suspicion of what participating could lead to. This is consistent with reports from previous research studies where suspicion and fear were raised as barriers in studies concerning HIV and mental health issues amongst black women. Mills et al., (2006); Suite et al., (2007) and Liamputtong (2010) contend that the unwillingness of ethnic minority groups and their lack of involvement in research is due to the misrepresentation of their input from previous studies. Im, Page, Lin, Tsai and Cheng, (2004) also claimed that the difficulty is more pronounced when the researcher does not speak the same language or is not of the same ethnicity. This assertion was not surprising as the relatives of the pregnant women that I approached, asked several questions such as "are you a social worker"? "Are you a health visitor"? To which I always responded 'no.' Although the women left the clinics with my information sheet, they never got back to me as they had promised. I realised that trust is a vital element in the qualitative research process because of the manner in which pregnant women of South Asian and African backgrounds scrutinised the research design and aim. This brought to the fore the need to consider the means for addressing doubts or lack of trust in the research process and/or the researcher and to identify actions for overcoming the lack of trust. These actions were cautiously and thoughtfully implemented in this study to successfully conduct this cross-cultural study.

According to Zubair et al. (2010) researchers who need to gain the participation of ethnic minority groups in research studies must recognise the importance of building trust and cultural rapport. I felt that all the women of South Asian background who I had encountered during visits to the antenatal clinic did not feel that they could trust me.

Insider/outsider continuum – being an outsider

In the research ethics panel review it was mentioned that because I am not a midwife, it would be difficult for me to get midwives to participate in my study. To me, that raised questions about the neutrality of the researcher and confirms the views expressed in extant literature which ascribed importance or premium to being an insider and emphasised the potential for challenges for an outsider. The question about not being a midwife asked by the ethics review panel came to the fore in my reflection on the position of the researcher in truth-seeking. Merton (1972) also did and demonstrated in the assertion that researchers should no longer ask whether an insider or outsider status affects the access to the social truth but rather, they should begin to consider their distinctive and interactive roles in the process of truth-seeking.

Concurring with the above assertion, Wray and Bartholomew (2010) acknowledged that the researcher is neither an insider nor an outsider, but situates self in both positions at the same time at different points throughout the study. As a result, I am a both an insider and an outsider. As a non-midwife, I am an outsider, but because I am a woman and a mother, this situated me as an insider. This 'insiderness,' goes beyond seeking access to my research participants, as I will explain in this section later.

Labaree (2002) stated that it is not always an insider/outsider dichotomy, but a continuum within which researchers situate themselves. Though I felt that the challenge I was facing in recruiting both midwives and women was a result of my being an outsider, I realised it was not always the case as I later discovered during my interaction with midwives. The midwives who I discussed my study with, all agreed that not having a midwifery background was a positive thing as it would bring fresh perspectives to the review and examination of the phenomenon. Concurring with this notion is Rabe (2003) who stated that one major advantage of being an outsider is quite evidently

that you look at things with 'fresh eyes' and thus, reveal and emphasise things that insiders take for granted or do not notice. More so being an outsider may also bring the possibility of novel insights and understanding of the issues that impact how women feel about antenatal care delivery.

Insider/outsider continuum – being an insider

During the early stages of the recruitment process for research participants', I considered myself as an insider because of my position as a woman, a mother, and a researcher. I believed that pregnant women recruited for the study saw me as someone who empathises with them because I am a woman and a mother. I also believed that this was enough to make my insider status visible and that this visibility of my status as a woman and a mother would make access to information relatively easy. However, as I spent time with each woman during data collection, my 'insiderness' became more uncertain, which confirms the position adopted by Rabe (2003) when he asserted that 'insider' and 'outsider' status of a social researcher is fluid.

The fluidity of my 'insiderness' became apparent after my unsuccessful attempt to recruit from the church with predominantly Nigerian members. My status as a woman, a mother and even a Nigerian did not earn the acceptance accorded an insider or the willingness of members of the group to participate in the study. A similar observation and experience were reported by Wray and Bartholomew (2010) and supported by Labaree (2002) who emphasised that having an insider status does not automatically give advantages to gaining access contrary to the belief that 'insiderness' provide researchers with greater access to research participants. Here is what I noted in my journal:

I went to this church today with lots of enthusiasm, only to be told, by the potential participants in the church, that they were not going to be part of my study. I had assumed that my shared identity with

them would secure their consent. However, one of the women later came to me to discuss her participation and said that she did not want the others to know.

Being perceived as an insider can create prejudice in participants as they may draw on what they perceive as shared attributes in shaping and framing their perception and view of the researcher. For instance, pregnant women who participated in my study believed that I had received antenatal care from the NHS as I had informed them that I have two sons. This contributed to my decision to introduce myself to the pregnant participants as a mother who did not receive antenatal care from this country as my children were born outside the UK. My identity as a woman and a mother would have influenced my approach and the interpretations of the data, however, I engaged in continuous reflexivity to ensure the credibility of the process and safeguard the trustworthiness of the outcome (Carcary, 2009). The impact of shared experience between a researcher and participants is a key point that has been discussed by Skeggs, (1997) and Le Gallais, (2008). They noted that actual or perceived similarities and differences may influence how the researcher/participant relationship develops. I documented evidence of my development, experiences, feelings and relationship with participants throughout the research. I constantly reflected on how the research was unfolding and the role of my practice in this through the use of a research journal.

Field notes/research journal

The rationale for using research notes is that they are a useful aid for keeping an objective record of observations made in a particular setting. They afford the researcher a means of keeping a detailed record of research activities and discourses in the course of conducting qualitative interviews (Finlay, 2002). A research note was entered in the research diary

immediately, the necessity to take notes arose during the interview. At other times where circumstance did not advise actual note-taking, the entry was made from memory a few minutes or hours after the event or discussion from memory. This mental note-taking is a form of field notes, which Liamputtong (2007) suggested should be used when the setting is not appropriate to taking actual notes. Jotted notes were taken during discussions or after interviews, which consists of salient but key points that were developed later. It was used to compare data that had been transcribed and also to make a clarification on responses from participants. I particularly found my field notes useful because it allowed me to reflect and to recapture responses made by participants both during and after interviews. There were times I felt overwhelmed by the stories the women in my study relayed to me especially after the interview and some of these discussions stayed with me for a long time. Situations like this have been referred to by Liamputtong (2007) as researcher's trauma and Liamputtong (2007) suggests that it occurs when researchers explore sensitive topics. Though my topic is sensitive, it does not involve the potential for trauma, and therefore, I did not experience a feeling of researcher's trauma, but I did admire the women for their responses when asked how they coped with feeling unhappy about their antenatal care. According to Robertson (2000) a topic is sensitive when the research includes the private aspects of a person's life and when it involves deep, meaningful conversations about their life's experiences which they may not have talked about before. One question women asked, again and again, is, if I would inform the healthcare policy makers about how they felt? I confirmed my intention to put together a summary for participants and policymakers at the end of the study.

As much as I tried to make my field notes in chronological order to reflect the sequence of events, I found it challenging and I did not note every single occurrence during my fieldwork. After I realised the challenges of noting a

chronological occurrence of my fieldwork, I then drew on the suggestions of Wolfinger (2002) about two principal methods to field notes. The first is the 'salience hierarchy' where issues perceived to be important to the research focus are noted and second is 'comprehensive note taking,' used for logical and more comprehensive note taking about every occurrence in the field. I used the first method as it was not practical to note every occurrence during interaction with participants, which is why there was the use of a "significance filter" as suggested by Tjora (2006, p.433). Tjora (2006) agrees that the researcher must make use of their unspoken knowledge with regards to what they focus on when making notes and acknowledge that the subjectivity that is involved in this is a vital aspect of qualitative research, especially a study such as this, which utilises the social constructionist lens. I realised the danger of wielding subjectivity arbitrarily as it would allow for a multiplicity of views to be drawn from the data I generated. To identify, capture and develop the most appropriate and relevant view, the study used reflexivity throughout the research. Corbin and Strauss (2008) and Marshall, Fraser and Baker (2010) asserted that a reflexive approach increases the opportunity identifying an appropriate and relevant view.

Ethical considerations

Informed consent

Every participant who took part in this study volunteered to do so. The participants gave verbal consent before agreeing on a date for the interview. Similarly, participants signed a consent form which clearly pointed out the level of consent given before interviews commenced. Participants only signed the consent (see appendix 11, 12 and 13) form after the researcher had provided complete, accurate, transparent and honest answers to any questions a potential participant might have, in a sensitive manner. This approach is recommended by Beauchamp and Childress (2001). Women

were advised about their right to withdraw from the study at any time and assured that it would not in any way affect the care they received from the antenatal services. Information regarding the rights of the participants to withdraw from the study at any time was also supplied on the information sheet given to women. A written consent form was also provided for every participant to sign indicating that they were participating in the study from an informed position. The researcher informed potential participants that should they appear to be upset during interviews, that they have the option to terminate the interview or stop the tape recorder at any time. In addition to assuring participants of their ability to stop the interview at any time for whatever concern, they were also provided contacts of counselling services should they need it, for example if they became distressed as a result of the interview at any time. These were measures taken to protect participants from undue harm. However, none of the participants experienced or reported any feeling or form of distress as a result of the study interview, and therefore the contact details provided to participant were not used.

Anonymity and confidentiality

The use of pseudonyms ensured the anonymity of the research participants. Some of the participants chose their pseudonyms to protect their privacy and the study used their chosen pseudonyms to respect the privacy of participants. Audio recorded materials and transcripts of interviews are in a locked cabinet. Participants' names are kept separate from pseudonyms in a different location; this is for identification purposes only in case a participant decides to withdraw from the study. No request for withdrawal has been received from a participant.

Respect for participants

Participants recruited for the study are pregnant women with high BMI. They are in the range of the high-risk classification because their high BMI

exposes their pregnancy and pregnancy outcomes to higher risk. They can speak English and live in the local area. The emphasis on the local area is because the local NHS Trust research and development passport obtained only grant access for the research activities to be carried out on the sites within the areas that their maternity services cover. A total of 12 women were recruited and took part in the research study. These twelve participants were made up of seven white British, one black British of the African Caribbean decent and another four who identified themselves as Africans. One of the African participants was a student at the time of the interview and the other three migrated to the UK as adults. Five of the women were prospective first-time mothers while the others had previous experience of pregnancy and childbirth. The study was designed to record pregnant women initial booking with their midwives. However, only one pregnant woman gave consent to record her consultation meeting.

The data from the consultation booking of Renee' (a pregnant participant) with Sylvia (the midwife to Renee') produced very important insight of what happened in the consultation meeting, that interviews of the participants after their consultation could not. So, pregnant women were asked in subsequent interviews to describe the pattern or form of their consultation with their midwives. Their responses confirmed the recording from the consultation between Renee' and Sylvia.

Prior to each interview, the researcher briefly talked about the purpose of the study to establish and build rapport with women and to create real interest in the study. Interviews lasted between forty-five minutes to sixty minutes and participants' desire regarding the setting, timing and the direction, and content of the interview was always respected. This is consistent with emphasis, of Dickson-Swift, James, Kippen and Liamputtong (2007) on the importance of rapport building. They recommended it as a helpful vehicle for building trust, especially when conducting research with a

vulnerable population, such as pregnant women with high BMI. Building rapport with these women was important as, it minimised the incidence of a 'smash and grab' (Baird and Mitchell, 2013. p.23) interview; that is where the researcher and participants just go through the motions of doing the interview, with the participant having or showing no interest in the study (Liamputtong, 2007; Irwin and Johnson, 2005). Before the commencement of interviews, the researcher met with a participants after several phone calls and text messages to discuss and confirm an appropriate time and place for the interview. Although the researcher included an email address on the information sheet given to women, none of the pregnant women sent emails. Discussions about the pregnant women's interviews was mainly through telephone conversation and text messages, while midwives called to discuss their participation and the obstetricians were spoken to verbally to arrange interviews. Also, the study was appropriately sensitive and deployed excellent communication skills, including the display of attributes such as being empathetic, objective and complementary, and making sure the participants/researcher relationship was one of respect, compassion, openness, trust and gentleness (Raheim et al., 2016).

Using these strategies afforded the opportunity to identify with the participants and acknowledge to them that their views and perception would be valued and highly rated. It also opened up the opportunity to own up to the "ignorance of one's privilege" (Devault and Cross, 2007, p. 183) position as a researcher. Demonstrating this position of ignorance regarding the content and form of the data participant will provide and the privileged position of the researcher to be able to capture and use it to create or contribute to knowledge, encouraged participants to open up. It engenders listening to what women were sharing, listening for silences and pauses in statements as some had the potential to hold meanings outside the statement made.

Methods of data collection

The research questions inform the decision to collect data by any method, which inextricably linked the theoretical perspective of the researcher or a researcher's way of viewing the world. Very often, researchers who focus on the Health Service tend to address a specific problem or issue rather than theoretical considerations, and in most cases, this determines the method or methods employed to conduct the research (Mays and Pope, 2000). The methods of data collection that fit the theoretical stance and which the review for the study indicated will provide the most viable means for answering the research questions were interviews and field notes.

Qualitative studies use interviews extensively in either a semi-structured or in-depth unstructured layout. One of the benefits of the semi-structured interview is its flexible formation of open questions. It allows the researcher the flexibility and freedom to diverge from the initial questions so as to be able to explore ideas that arise through the course of the interview and so, provide an adaptable method of getting information (Robson, 2011).

Another justification for using interviews was to elicit the research participants' meanings and interpretations of experiences as in events, process and actions (Ritchie and Lewis, 2003). However, its main disadvantage is that the success of the interview is largely reliant on the ability of the interviewer to prompt and follow-up any points raised by the research participants and the participant to tell the story of his or her experience fully and truthfully. It is, therefore, important for researchers to hone their interviewing skills through training and experience. To get suitable and quality data from interviewees, the questions used in this study will be open-ended, neutral, non-leading, sensitive and clear (Mason, 2002).

Recruiting participants

Midwives were the first participants recruited for the study after an email with details of the research was sent to community midwives and

obstetricians in the NHS Trust by the head of midwifery services. The midwives and one obstetrician that were interested in taking part in the study contacted me via email to indicate their interest. I had meetings with the midwives to discuss their potential involvement in the study. The discussion included the inclusion criteria (see appendix 14) that qualified overweight, pregnant women for the study and how they would facilitate the recruitment. Midwives identified and approached pregnant women who fit the inclusion criteria and handed them the information pack for them to read and decide whether they are interested in the study and willing to be participants. Women with interest in the study who were also open to being participants contacted me to discuss the study and what participation would involve. In addition to the obstetrician who indicated interest in the study by responding to the head of midwifery services' email, another two were recruited through phone calls which were followed by a discussion of the study.

Interviews

The qualitative interviews conducted with women were carried out at various stages of their pregnancy; some at around sixteen weeks, some around twenty weeks, and others at about thirty weeks. Interviews took place at locations and times chosen by women. Some took place in participants' homes, restaurants, in public houses and one on campus. This study recognised that conducting interviews in a conducive setting that was chosen by each of the participants has the potential to be empowering for women as they were more likely to feel comfortable, free and relaxed in a setting they had chosen. Most women opted for an interview in their homes. Holding interviews in participants' home is supported by King and Horrocks (2010) and is also considered to be a place associated with feelings of comfort, ease, calm and security. Smart (2007) also concurs with King and Horrocks (2010) and asserted that participants' homes could create the experience of

being in the world; it is not just space but a temporal composition, where participants can also express their sense of self and identity.

The researcher verbally informed the participants before the commencement of the interview that the interviews might take longer than the time suggested in the leaflets. The approximate time the interview lasted for was about forty-five to sixty minutes. Topic guided questions (see appendix 15, 16, 17 and 18) were used to elicit responses from participants as follows:

- Midwives: To share their experiences of providing pregnant women with high BMI antenatal care,
- Pregnant women: To discuss their experiences of the antenatal care they received and give their assessment,
- Consultants whom midwives refer pregnant women with high BMI to: For them to provide insights as to how high BMI might impact pregnancy and how this shapes the recommendations they make.

In keeping with the principles of an interpretive constructionist approach, the review of the literature identified key potential concepts and ideas. Brannick and Coghlan (2006) points out that this approach is useful to initiate the inquiry process and to develop interview questions that would enable the researcher, to explore the breadth and nature of participants' experiences. Identifying potential concepts and ideas are particularly important for a novice researcher who may inadvertently direct participants' responses (Brannick & Coghlan, 2006). These concepts were significant for the study, as it helped with initial data collection by forming the basis of the interview guide. Questions were formulated using insight from existing literature reviewed and through informal discussions with overweight pregnant women and midwives as well as using responses from participants to ask questions.

Though the focus was to bring out participants' experiences, the topic guided questions prompted me to identify areas to explore during the interviews.

This helped me to consider the line of questioning and how to phrase questions, which enhanced my self-confidence and ability. I did not rely on the topic guided questions in their entirety or use them in a descriptive way, but I used participants' responses to invoke follow-up questions as the responses were unique to individual participants (Charmaz 2006; Silverman 2006). As interviews progressed during data collection, questions asked became more focused and allowed the exploration of the theoretical framework that emerged.

Initial themes that emerged from the data enabled me to further explore certain area(s) with other women to ascertain whether they had the same experiences or identify where their midwives or consultants highlighted possible risks as a result of their weight. This further enquiry in qualitative research does not only serve the desire to describe a phenomenon, but it also helps to bring more meaningful explanations to it (Mason, 2002). See table 2 (page 151-153) for example of initial themes.

During the course of my study, I maintained a reflective journal which helped to map a collection of ideas that emerged from the conversation with the research participants. This was usually, carried out after the interview with participants and involved noting the line of key themes to pursue in the subsequent interviews with other participants. This action did not only allow me to develop and pursue key themes, and to explore them further in subsequent interviews but also provided the opportunity to bring greater clarification to the emerging themes from data. It also facilitated and supported issues that formed the basis of discussion during supervision meetings, which led to a better understanding of the evolving themes from data.

This insight also came with an awareness of the impact of insider status, and given that qualitative research is subjective in nature, I was always aware of

the potential for my own bias and shared experience to influence the understanding emanating from the study as advised by Dwyer and Buckle (2009). They stated that it is a recognised perspective that has a potential to be problematic to some qualitative researchers if a researcher occupies a position of insider and outsider rather than an insider or an outsider, and they suggested a regular self-reflective exercise to limit any bias. Watson (1999) asserted that it was not clear whether the analysis of text arising from her interviews was her interpretation of the actual phenomenon or if she was projecting her own needs on her research participants. Recognising this potential bias, I became cautious, and consciously represented the experiences and views of my research participants through critical reflection (Dwyer and Buckle, 2009). For example, during interviews, women assumed that I had utilised the antenatal care system and made statements that demanded a response from me. So I used positive body language such as nodding to encourage them to continue discussing their experiences. At other times, women asked questions hoping for a response which indicates my agreement with their opinion. Being perceived as an insider at this time in question, allowed me to adopt a researcher's (outsider) position which was important, as participants were not aware of the impediment to the research process of me adopting an insider position by providing them with expected responses.

The process of a qualitative research interview is an active one between the interviewer and research participants which result in identifying themes, that leads to interpretation of the themes and construction of meaning between both parties (Holstein and Gubrium, 2004). Choosing a semi-structured interview style for my study, helped significantly in eliciting women's experiences and what it meant to them through their own interpretations. The network of interpretation and the power dynamic in the interview setting provoked specific thoughts around pregnant women with high BMI and their experiences of antenatal care. In terms of the power dynamic in qualitative

research, Fairclough (1989) defined power as controlling and constraining other people's view in order to achieve one's goal. According to Hoffman (2007) there is power dynamic within the interview setting, and although the processes of qualitative research interviews are considered to be active, power shifts depending on the situation. For example, there were questions the obstetricians did not give answers to that I had to reframe to elicit a response that would be useful for my research from them.

The interview agenda was set by the researcher who initially holds power over the respondent since the researcher initiates the questions and is therefore seen as one with authority (Hoffmann 2007; Nunkoosing, 2005). However, power shifts to the interviewee when the interviewer needs to hear their stories, as in my study. As a researcher, I needed my participants to tell me their stories in order to answer my research questions. This is because qualitative research participants could choose the aspect of their life that they want to discuss or share information about, and this could be part or the full story. Some participants may want to tell the part of their experience that is most interesting to explore. However, my position in in-depth interviews is that the stories research participants choose to tell are important for their contribution to my understanding of their experiences and the factors that have shaped those experiences (Nunkoosing, 2005).

Reflecting upon my first interviews, I realised that the questions asked during the initial interviews needed to be reviewed (see appendix 17). It also turned out that I was nervous at this stage too, and did not have the courage to probe participants as much as I should have. But as I continued scheduling interview sessions with more participants, I became skilful and more courageous and probed responses for clarification. As data were transcribed, it was used to make further enquiries in subsequent interviews; this is referred to as the iterative process in qualitative research (Srivastava and Hopwood, 2009). Being nervous and sometimes not being adept at the

start of data collection, is a usual occurrence and have been identified in the novice researcher by Roulston et al. (2003). This is a major reason why it is important to pilot interview questions in order to ensure that they are consistent, clear and appropriate to the participant. To avail myself of the benefits of piloting interview questions before using them in the actual interview, I administered my initial guided questions with a group of other research students and used the experience and feedback to enhance the final version which I used in my interview with the participants in my research. Building on this knowledge, I consciously asked more open questions in future interviews; probing as well as using non-verbal cues to encourage detailed responses (King and Horrocks, 2010; Hennink et al., 2011).

Analytical Approach

Table 1: outline of the characteristics of the pregnant participants interviewed.

Pseudonyms	Age	Parity (no of children)	BMI	Ethnicity	Religion	Occupation
Rita	40	3	40	African	Christian	Student
Renee'	37	0	35	Unknown	Christian	Teacher
Piper	42	3	44	White British	Not known	Civil servant
Emma	39	2	44	White British	Not Known	Teacher
Charly	38	2	32	White British	Not religious	Teacher

Alison	Did not say	0	40	White British	Not religious	Beautician
Kelly	Did not say	0	44	White British	Not religious	Nursery nurse
Agnes	26	0	47	Black British	Not religious	Civil servant
Khadijah	30	3	37	African	Muslim	Student
Pat	30	3	40	African	Christian	Homemaker
Philomena	36	0	40	African	Christian	Homemaker
Nikky	38	1	35	White British	Not religious	Dietician

This study gathered data from several participants with different demographic attributes (see Table 1) in a discrete form by conducting interviews with pregnant women who were at different stages of pregnancy and different points in time. The diversity in the demographic attributes and progress in the pregnancy of participants created the challenge that data collected may present different and unrelated perspectives or themes. A thematic analysis of the data was carried out to make sense of the seemingly unrelated themes that interview data from a different participant, who had experiences and perceptions that varying personal and social values created. According to Attride-Stirling (2001) and Braun and Clarke (2006) thematic analysis also allows the researcher to employ several or multiple theories and concepts as part of the process of data analysis and interpretation and can accommodate the analysis of large data sets. It also opens up the opportunity to generate categories and/or use participants' data to support the interpretation of the themes identified from data

analysis. By supporting assertions with data from grounded theory, it engenders the construction of theories that are grounded in the data provided by participants. Thematic analysis is an aspect of and complements qualitative and in-depth, interpretative approaches (Attride-Stirling, 2001; Braun and Clarke, 2006; 2013). Six phases make up the framework of thematic analysis (Braun and Clarke, 2006). The phases enable qualitative researchers to identify themes and patterns (Braun and Clarke, 2006, 2013) in interview data by affording researchers the opportunity to repeatedly listen to recorded interviews, and to re-read transcribed data and become familiar with the data (Bryman, 2012). The six phases in the guides to deploying thematic analysis are as listed below:

Becoming familiar with the data

Generating initial codes

Searching for themes

Reviewing themes

Defining and naming themes

Reporting or writing the analysis

As a result of the compatibility of thematic analysis with the use of multiple theories or concepts, which offers greater flexibility to researchers, the analytical process also used concepts from Michel Foucault which focused on the social construction of reality (Foucault, 1972; 1973, 1980; Berger and Luckman, 1966). This approach was adopted to examine the social process that participants engaged in, and their interpretation of it. I felt that a constructivist approach was most appropriate for this study as it is congruent with the ontological and epistemological position adopted (as discussed earlier) and is supported by thematic analysis.

The analysis was carried out manually, as advised by Kidd and Parshall (2000). They asserted that standardisation of some analytical tasks might misrepresent an underlying background and meaning of remarks. Another

reason for using manual analysis is that the use of software may unintentionally take the researcher away from a reflective engagement with the data. To avoid such situations, I chose to do my analysis manually using guidelines provided by Braun and Clarke (2006). A key advantage of the six phase process is that it ensures that the researcher engages directly and in greater depth with key activities; from becoming familiar with data to writing the research report of the actual study. It thus provides invaluable support and assists the researcher, as it helps to draw interpretations that are consistent with the data generated (Hatch, 2002; Creswell, 2003). One of the ways that researchers use to become familiar with the data and which facilitates interpretation is for them to listen to tapes and read data over and over again. Also, through the identification of novel features across the entire data set, initial data codes evolved. Coding followed the reading and identifying of data with latent and overt meaning. The codes identified relate to the aims and objectives of the study (see examples of codes/themes/sub-themes in Table 2). Researchers are advised to code for context and contradictory features, and simultaneously, try to establish patterns from codes. Thirdly, the analytical level becomes broader as the codes become themes and sub-themes as demonstrated in Table 2.

Table 2: Example of codes/themes/sub-themes.

Pregnant Woman	Coding	Themes	Sub-themes	Number
Renee'	I did not think my weight would be an issue when I become pregnant ...I	Knowledge seeking	Knowledge	7

	<p>have discussed it with my friends and my mum and ... I have also read about it ...</p>			
Agnes	<p>I knew my weight would be flagged. I went to raise it with my GP ...obviously, I'm a bigger girl ...</p>	Aware of weight issues	Knowledge	8
Kelly	<p>... harder for him (baby) yeah and whether or not that excess weight it is gonna be you know damaging for me as well during labour, so and obviously what the risk are ...</p>	Knowledge about risk	Risk	10

Piper	She (midwife) said that I scored high, and I'd to see several different people and have ...shared care ...due to my weight ...	Knowledge about risk	Risk perception	9
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After the search for, and the identification of themes as they emerged, the researcher then began the fourth phase of the guide which states that themes should be reviewed to ascertain which to use. According to (Attride-Sterling, 2001) some of them will be 'candidate themes,' as they are referred to at this stage, because they may not have sufficient data to support them to qualify as actual themes. The identification of 'candidate themes' is followed by the merging, separation or complete removal of some of the candidate themes. Reviewing themes helps to reduce the data further if the researcher wishes to, as well as allows strong distinctions between themes.

The fifth step is defining and naming themes. The fifth step is the stage where the researcher describes the themes in a way that captures the essence of the theme in question. For example, after reviewing themes for this study, themes were defined as main themes as shown below.

Table 3: Defined themes.

Chapter 5	
Main themes	Sub-themes
Risk	<p>Women’s understanding of risk and risk perception.</p> <p>Power influence on midwives perception of risk.</p> <p>‘BMI’: power of science construction of maternal health</p> <p>Obstetricians’ authoritative knowledge on pregnancy and childbirth risks.</p> <p>The use of medical and technological terminologies in risk framing.</p>
Chapter 6	

<p>Communication</p>	<p>Midwives' risk communication with women; more than just talking.</p> <p>Medical surveillance and its negative effects on pregnant women.</p> <p>Language use to enhance understanding whilst building a trusting relationship.</p>
<p>Ways of knowing</p>	<p>Women's knowledge about the construction of 'normal '</p> <p>Midwives knowledge use: providing information whilst maintaining relationship with women.</p> <p>Obstetrics power in the justification of medical intervention in pregnancy and childbirth</p>
<p>Chapter 7</p>	
<p>Risk Concurrence and Resistance</p>	<p>Antenatal care for overweight pregnant women the 'the Hobson's choice'</p> <p>Demonstrating self knowledge and striving to create healthy pregnancy and childbirth identities</p>
	<p>Women's integration of knowledge: religion and science</p> <p>Obstetrics and midwifery: competing or complementary knowledge.</p>

Lastly, the production of the report from the data gathered for the study was carried out in an analytical narrative (Braun and Clarke 2006; 2013). The analytical narrative is consistent with the overall plan of the study as it allows the researcher to write up a thesis rather than summarise the responses to the interviews conducted.

Reflexivity

The process of reflexivity is at the heart of all qualitative research as it improves quality by providing an honest and informative account of the researcher's journey (Gerrish and Lacey, 2010; Denzin and Lincoln, 2003). According to Etherington (2004) reflexivity is the conscious ability to recognise how one's subjective experiences shape the process of research and guide interpretation. The implication is that the effective exercise of reflexivity allows the researcher to be mindful of how his or her subjective experience may be shaping how data has been collected and analysed. By being aware of the subjective impact of self-experience, the researcher can consciously manage or reduce the subjectivity allowed in the interpretation of data. Reflexivity will allow the researcher to occupy a location that is not within the body of the text (Denzin and Lincoln, 2000) so that data can be analysed as intended by participants. As a result, reflexivity plays an important role and ensures that the proximity of the researcher to the participants or researcher/participant interaction in creating interview data, (Brannick & Coghlan, 2006) does not suppress the participants' voice in the analysis and interpretation of data.

In making this position as explicit as possible, the researcher enhances the reader's ability to make sense of the research and this increases trustworthiness and validity of the outcome by ensuring transparency in every account (Kingdon, 2005; Morrow, 2006). This position received the support of a study which asserted that the multiple meanings of reflexivity

depended on theoretical or methodological positioning, a comparison of social critique with introspection and argues for greater reflexive analysis whichever path is adopted (Finlay, 2003). Reflexivity within research brings an awareness of self, and self-consciousness, into the process of designing, interpreting and writing up a research thesis (Mason, 2002; Yardley, 2008). As a result of this, it is important to reflexively consider the experiences and thoughts that have shaped the researcher's position in the research.

As an acknowledgement of the importance of reflexivity, I was mindful of how my personal experiences may have been influential in my research methodology and paid thorough attention to this in the analysis of data. By doing this, I could see how, for example, I had unintentionally closed off certain areas of interpretive potential and instead opened up others that are related to the themes that interest me most. For example, themes like '...my partner was very upset when he saw my notes and became worried about what could happen', are followed up with, what did your partner say when he saw your notes? The adopted approach that shaped the analysis was balanced out and made more objective, open-ended and outward looking by the conscious and deliberate exercise of the principles of reflexivity. Through conscious and active reflection on the objective of the study, I was able to situate myself outside my personal experience and stories, (see page 15) which challenged my beliefs and perception vis-à-vis the obesity debate in the UK.

The purpose of the story of my experience is that there is a degree of similarity between my experiences and those of some of my participants, an important point raised by Plummer (2001) as he argues:

"How can one theorise or interpret ...if there is no familiarity with what it all means to the participants themselves" (Plummer, 2001. p.37).

My experience with my local college and undergraduate colleagues, the opportunity of talking to people about their encounters with healthcare providers and the impact of social construction of fatness in the media shaped my perspective. It is not only my experience within the community that triggered my interest in the research topic. The persistent emphasis on obesity as a topical issue of concern by the media, the government and the Department of Health (DoH), the NHS and Health England (see Allison et al., 2008; DoH, 2011; NHS England, 2014; RCOG, 2010) on regional and national news coverage played a significant role. As a result of my proximity to the obesity discourse and its acclaimed impact on individuals as well as its challenges to the NHS, my interest in understanding the perception and framing of fatness and how it affected individuals, grew stronger. My goal, then, was to achieve the threshold of performance in my undergraduate study necessary for obtaining the university scholarship and my aspiration was to explore the topic of 'fatness' especially how being perceived and treated differently because of body size or weight-affected women who are pregnant.

Another powerful aspect of my personal biography impacting, not to a great extent, on the subjectivity of my research is that I became pregnant myself, unexpectedly, towards the end of the data analysis phase. The timing of this event in my life, a case perhaps of life imitating research, gave me a vivid contemporary insight into the process of antenatal care. My experiences of antenatal care in the UK have most certainly added to my understanding of the experiences of the women I was interviewing. Although I was not a pregnant woman with high BMI, I had 'high-risk' care provision. My care pathway was defined as a midwifery-led one, but I was advised to go for tests in the same category of care as the 'high-risk' women that I had interviewed. Moreover, whenever the question was asked as to why a particular test has to be undertaken, I was either told it was because of my age, over 35 or my black ethnic background.

I learned first-hand the shock of wondering what could go wrong, I will say it is a helpless place to be and regarding my daily pregnancy experience, everything was completely altered as the tests that followed each consultation came with the discussion about risk. This first-hand experience enabled me to gain a sense of an awareness of the issues that I had explored in this empirical study. Also, the experience gave me an awareness that enabled me to relate to the women I had interviewed. I was able to relate very well to the feelings of frustration and helplessness a woman experiences when told that because of a particular non-medical issue, in my case age and having a different ethnic background, that she is at a higher risk of a poor outcome during pregnancy and childbirth.

Validity

The quality assessment of qualitative research is different from validity and reliability assessment of quantitative research and requires different assessment criteria (Barker, Pistrang and Elliot, 2002). There are a variety of guidelines that exist for assessing validity and quality of qualitative research. Nonetheless, Smith et al. (2009) particularly recommended the application of Yardley's (2000) guidelines of four principles that evaluate the quality and reliability of research. I also drew upon Smith's (2011) recommendations for evaluating the quality of qualitative research which included the consideration of sensitivity to context, rigour, and transparency and coherence.

Sensitivity to context

A description of the sample characteristics of the method of data collection and analysis, the adoption of effective consideration of and the use of reflexivity to manage and safeguard objectivity in data gathering ensured sensitivity to context. Similarly, the use of an in-depth analysis, as well as the use of verbatim extract to support every interpretation also

demonstrates sensitivity to data. These actions according to Smith et al., (2009) allow the participants' voice to be conveyed in the study and provide an opportunity for the readers to verify the researchers' interpretations and how it ensures the application of ethical principles.

Rigour

According to Yardley (2015) rigour refers to the entirety of the data collection and its analysis, the proof of the achievement of rigour is the existence of a sufficiency of participants and data to obtain evidence to pursue new lines of enquiry until there was no need to continue (Walker, 2012). Sufficiency of data, however, is not about size but the data quality and its ability to generate all the necessary information needed for a complete analysis (Yardley, 2015). Rigour was achieved through careful transcription of the data, immersing myself in the data, reading and re-reading of data during analysis. Careful consideration was taken to present a comprehensive account that is representative of the accounts of the research participants. As a result, the themes that emerged from data analysis are coherent, consistent and distinctive (Braun and Clarke, 2006). There is also a clear audit trail that any qualitative researcher can follow if the study was to be replicated. Interviews were conducted with twelve pregnant women, six midwives, and three obstetricians. The decision to stop carrying out further interviews was made when the data generated from the interviews of women, did not identify new ideas or themes. Walker (2012) also asserted that rigour in qualitative research also includes the wholeness of the interpretation, I deliberately addressed the complexity of preserving both the assertion and the context of assertions made by women. This was achieved by using verbatim quotes as extracted from transcribed data in their entirety as well as in interpretation.

Transparency and coherence

Transparency and coherence relate to the level of clarity and the logical power or persuasiveness of description and argument in qualitative research (Yardley, 2008; Moravcsik, 2014). It encompasses the researcher's functions of telling his/her story, not in a descriptive sense but rather to construct an account of reality (Denzin and Lincoln, 2011; Freeman, 2015). The study demonstrated transparency in the empirical data collected for analysis and interpretation. Also, this thesis includes a detailed account of the various aspects of data collection and coding processes used in the study and the link between data collection and interpretation. There is also evidence of excerpts from transcribed data which has been made available throughout the analysis chapters (Moravcsik, 2014). More so, there is a demonstration of the interplay of construction of meaning from the construct of participants, and these were presented as part of data analysis through the use of extracts to support themes as constructed by different participants. The reality created in the research is recognisable, and the expectation is that this will make meaning to readers. For example, there are excerpts of midwives relaying the discussion of risk with women in the thesis. The expectation that readers will be able to make meaning of the reality created follows from the fact that the data collected for analysis are representation of the participants responses. The use of excerpts from the data set implies that conclusions drawn using data from the sample will mirror the view and position of the relevant population. Another important aspect of transparency is the fact that as a qualitative researcher, my experience of the world is influenced by assumptions, intentions, and actions as explained in the section on 'reflexivity.'

Coherence refers to the 'fit' in the choice of research methodologies utilised for a qualitative research study. Within the overall qualitative methodology, the study used a range of methods to generate research questions, define the philosophical underpinning adopted for the study and the methods of

investigation employed. Throughout the planning and execution of the research and during the writing up of this thesis, the study recognised the need for coherence in the research questions. Similar need for coherence was considered in the choice of the methods utilised to safeguard the 'fit' as the participants and data collected all offer a consistent and whole description as presented in this thesis.

Conclusion

This chapter set out the plan for conducting the field research necessary for gaining an imperative context to and acquiring a thorough understanding of the perception and emotion that overweight, pregnant women cope with and feel during their journey through maternity services. The chapter discussed how at the onset of planning for the field work it became clear that a choice of research approach and paradigm had to be made. The discussion in the chapter explored how the plan embodied in the research methodology was navigated and negotiated. For example, the choice not to use a particular qualitative method but to use guidance provided by various qualitative researchers was discussed.

Similarly, the chapter also examined various concepts from determining the philosophical position that should guide the identification, accumulation and analysis of evidence from the study, to ethical consideration that will safeguard the safety of all participants and their inputs. A key consideration of the chapter was how to secure and maintain the feasibility of the study. As a result, the chapter considered various issues that could potentially impact the efficiency and effectiveness of the research process. The result is that the study plan was both robust and flexible. Potential bottle necks, such as gaining access to participants, defining sample size and sampling techniques and deciding whether to adopt a particular position on the 'insider/outsider' spectrum were among several key issues considered.

Chapter 5

Risk framing and risk communication

Introduction

This chapter presents an over-arching theme of 'risk' framing and communication to women, the influence it has on pregnant women and its potential to shape how professionals deliver and experience the delivery of care to pregnant women with high BMI. It discusses BMI as a risk factor, women's perception of risk, midwives' perception of risk, obstetricians' perception of risk, and the general risk framing in healthcare settings and the readiness to see pathology.

The literature review conducted for the study suggests that certain factors affect how pregnant women generally, and especially those with high BMI, experience antenatal care (Nyman et al., 2010, Fuber and McGowan, 2011; Furness et al. 2011; Schmied et al., 2011; Mills et al., 2013; Heslehurst et al., 2013). The factors include health education, midwives support for pregnant women, actual rather than perceived empowerment of women, their ability to freely exercise choice, society's view and framing of the concept of good mothering and professionalism as demonstrated by healthcare providers. These factors also shape how they feel about their experience. Though the two literature review chapters, chapters 2 and 3, have two distinct responses to the aims of the study, there is a common thread of risk that runs through the experiences of the women in the study and the kind of antenatal care they received.

According to NICE (2008, 2010), pregnant women with a BMI 30kg/m² or above should be cared for not just by a midwife and a GP, but with

contributions from other healthcare professionals. Under the arrangement, midwives and other healthcare professionals jointly deliver antenatal care via the route of the shared antenatal pathway. The other healthcare professionals are mainly obstetricians and sonographers. NICE (2010) offers guidance regarding when pregnant women should receive care outside the traditional midwifery led pathway. It also gives a specific recommendation that women with a BMI of 30kg/m² or above should be cared for by both midwives and obstetricians, so as to mitigate the high risks in this category of pregnant women, which is a direct communication of the Institute's belief that high BMI directly translates to high risk. It is important to note that the Institute did not recommend additional assessments before categorising these women as being in need of antenatal care that is to be provided by midwives and obstetricians. The fact that NICE (2010) did not consider additional assessments demonstrates that NICE (2010) belief that a BMI higher than its predetermined threshold, is a sufficient marker of the existence of higher risk. It is this perception and framing of weight when it is over an arbitrarily set threshold, that key stakeholders in individual, communal and national health and wellbeing have accepted as the truth. It, therefore, guides the discussion of weight and risk with pregnant women with high BMI. The objective of healthcare professionals, in their initial meeting with pregnant women is therefore not driven by the desire to identify what the individual, pregnant woman's need is, but to determine whether they can be put in a blanket category as advised by NICE (2010). As a result, information from the consultation is put through to women by letting them know that they are in the high-risk antenatal pathway of care. Midwives inform pregnant women of risks associated with pregnancy and high BMI during what they expect to be a routine antenatal booking and visit to their midwife. Also, they are referred to see a consultant, not because they have any other medical condition or sign of exposure to any medical condition outside their BMI. Though there is no evidence of a causative link between high BMI and any known medical condition in pregnant women

their midwives refer them to consultants who used their first encounter as an opportunity to emphasise the risk of high BMI to their pregnancy. The emphasis of risk before helping women to understand the concept and how it relates to health generally and pregnancy, in particular, is not being sensitive. It is therefore not consistent with the guideline of NICE (2010) which specifically advised sensitivity in risk discourse with pregnant women. The encounter is also not used to discuss how high BMI would pose risks to the women and/or their pregnancy as recommended by NICE (2010) but is used to roll out a list of conditions associated with pregnancy in women with high BMI. The findings from this study showed that some women view this risk-focused antenatal care as a vehicle for imposing the alternative medicalised antenatal care on them or to deny them access to traditional antenatal care. Women argue that there is a disciplinary undertone to the justification of imposition medicalisation on them by reference to their body and lifestyle. The perceptions of the participants in this study regarding risk in antenatal care are different to those of healthcare professionals. This study found that women, on the ground, do not have any medical conditions and therefore, view themselves as healthy. The findings of this study also suggest that the risks associated with weight and pregnancy are viewed differently by pregnant women and the healthcare professionals who deliver their care.

Women's understanding of risk and risk perception

Data collected for analysis in this empirical study indicated that, before women's visit to the antenatal clinic, they were already aware of their weight and the possibility (not probability) of their weight impacting on their pregnancy in ways they would rather avoid. Some midwives reported in interview sessions that women already knew that their weight would be mentioned during their booking appointment. Midwives made this assertion because it was not uncommon for pregnant women to mention it straight away to their midwives at the initial booking appointment and also joke

about it. This is confirmed by Gemma a midwife who reported that some of the women she provided antenatal care for, acknowledged their weight and joked about it when it was discussed:

"...they have a bit of a joke about it when we discuss their weight and laugh about it, you know when we first see them they do, they do honestly..."

While women's prior awareness of what to expect from midwives may have been the reason, the women Gemma referred to was able to joke about the discussion around BMI and risk, it could also be perceived to be because she did not make an issue out of it. This finding is similar to that of Nyman et al. (2010) where women saw healthcare professionals smiling and laughing with them as they provided care for them. Five of the twelve pregnant women interviewed were prospective first-time mothers. Data from these five research participants showed that before they became pregnant, they had previous meetings with healthcare professionals who linked their ill-health to their weight. These prior encounters with healthcare professionals and the propagation of the biomedical view that being overweight increases exposure to health risk often caused a shift in the women's position regarding how they view risk in pregnancy after being categorised as high-risk due to their BMI. The shift in or the actual willingness to be compliant with the biomedical perspective of 'overweight,' and its framing as an indication of higher risk, resulted in part, from women's reaction when they first realised that they had become pregnant. They went in search of information so as to equip themselves with the knowledge of the kind of antenatal care provided by the NHS for overweight, pregnant women.

These mothers-to-be indicated that they had sought information from the Internet and read blogs of other women with high BMI to learn of their experiences of antenatal care provision. They did so to gain insight into what

makes up antenatal care for overweight, pregnant women. Women relayed their past experiences within the healthcare system and stressed that the care system had linked every health concern they had earlier with their weight. They claimed that the reason they went to look for information was the premium they attached to their pregnancy and their awareness that they would be with the healthcare system for a much longer period compared to their previous experiences with other visits to their GPs or hospitals which were for short periods of time. For example, Kelly said:

"...I felt a bit daunted about going because I knew straight away that my weight would be brought up, I knew it myself from previous experiences..." (Kelly).

From the beginning of her pregnancy, Kelly anticipated that her weight would be an issue when she went for antenatal care. She recounted her past experiences of risk discussion with health professionals and how it was linked to her weight. Kelly felt that healthcare professionals use every opportunity to emphasise her weight as a source of concern repeatedly and claimed it was creating anxiety for her. When asked why she thought this would be the case, her response was:

"... Well it's just because of the way ...weight in the media and things, you are kind of made to feel as if you're not normal, and then when I've been to the doctor's previously about other issues, say perhaps when I've had problems with my knee, well the first thing they say is "well, you need to lose weight for the issue ...you need to lose weight for this" and that's kind of where the advice stops ..." (Kelly).

Pregnant participants appeared to be aware of how risk framing affected their initial assessment. They were also mindful, from their past experiences

with their GPs and other encounters within the healthcare system, that this assessment would influence the antenatal care they receive and how they will experience antenatal care within the NHS. Pat and Agnes claimed they expected some form of prejudicial care at some point of their care because of their weight. Their expectation is consistent with the report of women who expressed a feeling of anxiety that there would be prejudice in their care (Puhl and Heuer, 2009). They described this as being treated differently to any other pregnant woman or being cared for as women with high BMI. In some cases, women also expressed a feeling of aversion towards their fear of how healthcare professionals would focus on their BMI and claimed that; given a choice; they did not want to seek or receive antenatal care from healthcare professionals in the NHS.

The fear of being judged by their healthcare providers emerged as a key factor that pregnant women with high BMI would consider while making the decision to access healthcare. Kelly confirmed the fear of being judged in the following assertion:

"...if I ever had a problem, weight is been an issue, or you know ...I always feel quite nervous in medical settings because I feel like I'm being judged sort of, if that makes sense ..." (Kelly).

The anxiety expressed by overweight women regarding the perception and framing of their weight and how that framing had impacted their experience of NHS care when they visited their GP for other health needs in the past, is reaffirmed by a narration from similar past experiences of Alison:

"...I have had it you know most of my life "you are a high risk, you are a big girl, you're a high risk, you're a big girl ...it's kind of become drill into you ..." (Alison).

The apprehension expressed by Kelly and Alison towards how their weight has been the dominant issue of focus in their previous encounters with their GPs created a feeling of being seen through the obesity lens in these women. Alison believed that because everything is linked back to weight, and the perception, beliefs and framing of high BMI, it became drilled into her that high BMI will be picked up as a source of risk to her pregnancy. This caused women with high BMI who repeatedly heard or read about high BMI being a marker of increased risk, or a source of poor health outcome, to begin to see themselves in the same light that they hear biomedical commentators present them in the media or the way members of the society view their overweight or high BMI. The culmination of these past experiences and the knowledge that they will be weighed at their first visit with the midwife, for the purpose of determining their antenatal care pathway, was enough for women to dread their initial visit to the antenatal clinic.

Classifying some pregnant women who seek antenatal care as 'high-risk' based on the sole reason of high BMI and providing them with a different antenatal care package, substantiated the argument presented by Beck (1992) and Beck-Gernsheim (2000) about our modern society being a risky one. Beck (1992) stated that the modern society has become increasingly concerned with identifying, calculating, and managing risk with the intention of reducing or eliminating the potential for a negative outcome that is associated with everyday life. While the reduction of risk is desirable and probably a feasible goal, to pursue a risk elimination agenda within the human society is both utopian and likely to encourage behaviours that include treating people as objects by those seeking to eliminate risk (Beck, 1992).

The social and moral responsibility on everyone to manage their risky bodies is projected on pregnant women with high BMI within this context of risk

mitigation or elimination (Lupton, 1999). The construct of responsibility, according to pregnant women puts additional pressure on them during pregnancy and often limits their ability to tap into the positive emotion and feeling that women of 'normal body weight' enjoy during pregnancy. It would seem that women's responses to risk classification, which is influenced by their experiences, are a construct of what exists in the society in general and in the healthcare setting in particular. For example, Emma's knowledge and awareness of how and why people are categorised are shaped by her experience as a teacher and other interactions in work and other social environments:

"...I see it as, as a teacher you're aware that you put people into boxes, and you've quite often even before you've met the people you compartmentalise and put people into boxes and categorise them and feel that quite often that's what happens. I feel ... even before you've ...having your booking appointment you're put into that place, and you're considered high risk and think pregnancy is really scary anyway (laughed) even when it's your third ... this word "high risk" or the phrase "high risk" is really, it's quite frightening ..." (Emma).

'BMI': Science, knowledge and its construction of maternal health

When asked if they understood the meaning of body mass index (BMI), because it is the tool used to assign them into the different classifications of care provided for them, the women in this study were not very clear about what the term, BMI, meant. They did however, have their interpretations of it. This finding concurs with the finding from a study conducted by Khazaezadeh et al. (2011) where the majority of the pregnant women

reported that they did not understand BMI classification. The pregnant women in this study did not identify with biomedical representations of maternal obesity and reported being in good health. For example, Alison says:

"...It doesn't mean much, to be honest ...I just think I am who I am, I do not have any health concerns, I still think perhaps I could be fitter ..." (Alison).

Another participant also expressed her understanding of BMI as follows:

"...I think it is kind of measuring how much weight you are carrying I think I don't know, I don't know, something to do with excess weight or fat or whatever ..." (Agnes).

Throughout the interview for this study, women expressed the same perception and framing of BMI. This lack of understanding or misunderstanding of the medical perception of high BMI and its potential risk impact on pregnancy for pregnant women did not seem to be properly addressed by healthcare professionals during their contact with women. Rather than explain the rationale for using the BMI measure as a marker of risk for categorising women into the two types of antenatal care services provided to women, healthcare professionals skipped this important window of opportunity and moved straight to focusing on perceived risks. It is therefore not surprising that the findings of this study also indicated that pregnant women still demonstrated a lack of interest in the medical assessment of pregnancy to risk exposure from high BMI.

According to women in this study, they interpreted the framing and manner in which risk was communicated to them, to mean that their antenatal care would be different from what they expected. Women felt that the whole exercise of weighing them at their initial visit or ascertaining their pre-

pregnancy weight was another means that the government uses to fulfill its purpose of putting people into categories that are already created in government health policies (McNaughton, 2011). This is in part the point Emma made above (page 170), on being categorised even before the meeting with a midwife. She emphasised as part of that submission that the readiness of healthcare professionals to ascribe risk to pregnancy with just information about a woman's BMI, makes the pregnancy journey and experience a scary one for women with high BMI.

Also, data collected for this study showed that the pregnant women were aware of how the NHS antenatal care units work and the policies that guide the working of antenatal care units. For example, Philomena commented that:

"...I know, this because a friend whose BMI is 40 told me this and I have been reading blogs of women with high BMI too, they say these things too ..."

Agnes also added that:

"...because they recommend that you do try and lose weight and get fit and healthy before you conceive d'you know what I mean? So I guess in my head I kinda thought oh well, you know, I guess it's gonna get flagged up it's gonna get discussed..."

Most of the women interviewed also mentioned reading around risks that media ascribed to being pregnant with high BMI. Pregnant women obtained information from blogs and other contents on social media, regarding the antenatal care that is available for women with high BMI. Women then used the knowledge they had gained from these sources to prepare themselves, and considered what their reaction would be should they face the same

experience or experiences they had read about (Lagan et al., 2010). A previous empirical study by Root and Browne (2001) demonstrated this advanced preparation for the reported experiences of other overweight women. It also found that many pregnant women had a good awareness of and were actively anxious about the possible risks they and their unborn babies faced. Kelly reiterated this in her comment:

"...I mean it was still in ... it was still something I was conscious of before I'd seen anybody in the medical profession only because of media and what you see and just the way you know, I say the world is, but the country is the way it's thrown on you that you know you're obese..."

The purpose of women seeking out information, awareness or knowledge about how their high BMI will be perceived and framed by healthcare professionals, and how it will impact the antenatal care delivered to them, is to be ready for their antenatal care. However, it did not prepare them for or insulate them against the anxiety that comes with the risk discourse from healthcare professionals. According to Kelly, it probably made her more sensitive and increased the anxiety she experienced:

"...you're gonna have problems you'll have these health problems it's I think it was already in my mindset to worry a little bit, I think if I hadn't had any of those prejudices and wasn't aware of them I wouldn't be worrying half as much I don't think I think from very early on I was having ... oh has baby got enough room to grow, oh am I good enough to get through this kind of thing..." (Kelly)

This view, that prior searches for knowledge and awareness about the risk of high BMI to pregnancy does not prepare women for the impact of risk discussions with healthcare professionals, is re-enforced by Emma. She

emphasised the uncomfortable feeling that comes from being categorised as having higher than normal risk as a result of weight despite having read about the topic. In her words:

"... from the BMI point of view, it does make you feel uncomfortable and I think as I've said before, if it's down to do with whether you're in a position to go and read around it and find out things for yourself, and when you do the research you realised that actually, I don't think there are any greater risks, it's this shoulder dystocia that keeps coming ..." (Emma).

Emma was not comfortable with the discussion she had with her consultant obstetrician because there was a continuous emphasis on the risks associated with being pregnant with a high BMI. Emma's feelings echoed what she had read about the experience of other women and evoked a feeling of fear, anxiety and discomfort. She reaffirmed that though she had read and researched about being overweight in pregnancy and realised it was not something to worry about she was still worried due to the content and the implications of the BMI and risk discussion with healthcare professionals. This feeling resulted from the framing of risk as an inherent attribute of high BMI and by deduction a threat to pregnant women with high BMI and their unborn child which required a series of tests and scanning to manage.

The potential for the link between body size and health to be used as a justification for increasing surveillance by contemporary medicine (McNaughton, 2011) has received comments from various authors. According to Armstrong (1995), contemporary or modern medicine shifts the medical gaze from the individual to the whole population and makes people pay increasing attention to their bodies and behaviours. In Foucauldian (1973) terms, presenting obesity as a health threat is a way of exercising

power, control and surveillance. The state also uses the necessity for and the benefit of ensuring, not just the health of individuals, but the health of whole communities and the wellbeing of the national population to justify its decisions to intervene (Evans et al., 2008). Some feminist commentators including Jutel, (2005) and Murray, (2008) have argued that framing high BMI in individuals as 'risky' is an exercise whose outcome is only intended to strengthen the position of the state, which strongly aligns with the biomedical model on how fatness is perceived and framed. The view popularised by the media is the shared view of fatness that stakeholder's groups with an interest in national wellbeing, have legitimised. This view allows 'expert' biomedical scientists, healthcare regulators and the government to create a consensus and to propose that there should be multiple ways of looking at obesity as a health (Murray, 2008; Bacon and Aphramor, 2011) rather than a social issue. By emphasising the presence of risk in pregnancy, the pregnant woman is put in a position where she is required to make a decision that is in her interest and the interest of her unborn child (Johnson, 2014). However, there has always been a cultural and social responsibility for a pregnant woman to ensure that her decisions and actions during pregnancy deliver a primal benefit to her unborn child, ahead of herself (Bell et al., 2009; McNaughton, 2011; and Salmon, 2011). So, this responsibility when emphasised in the course of risk discussions by healthcare professionals places an undue burden on overweight, pregnant women (Heyman, 2010a) and an expectation to comply (Oteng-Ntim, 2012). The response that a pregnant woman, therefore, makes in the belief that it is the only option that will safeguard and benefit her unborn, is then portrayed as the woman freely making an informed choice. Pregnant women reported that their discussion with obstetricians produced evidence of a popular cultural context that requires pregnant women to single out themselves to bear full responsibility for the health and development of their unborn baby (Bell et al., 2009; McNaughton, 2011).

However, women reported that midwives were the least keen amongst healthcare professionals to overemphasise risks. Although midwives mentioned various risks, they did not engage in risk discussion. This is consistent with the findings by Keely et al. (2011) where women reported that midwives did not discuss risk with them. Some midwives claimed that some women did not wait to be informed of their assigned antenatal care pathway but instead they told the midwife of their awareness of how the system works. Also, some midwives asserted that women already knew that their weight would be mentioned during their booking and mentioned it straight away to their midwives, even joking about it. As Gemma commented here:

"...we have a bit of a joke about it when we discuss their weight and laugh about it, you know when we first see them they do, they do honestly..."

Midwives and power/knowledge: perceptions and constructions of risk

A variety of factors shape midwives' perception of risk. The main factor is the fundamental principles underpinning midwifery training. Other factors include the biomedical views beamed their way regularly by the media and the proximity to other colleagues, such as obstetricians, who view pregnancy and childbirth as medical events with the inherent risks that require medical intervention to manage (Oakley, 1984; Earle, 2005; Beech, 2011; Lupton, 2012a). The result of these conflicting views is that midwives; as a unique group of professionals within the healthcare profession; subscribe to the different way of viewing pregnancy, overweight in pregnancy and the risk of high BMI in pregnancy. Despite these differences in how different midwives view risk and by implication a visible lack of agreement within the midwifery

profession, that overweight should be used to refuse women traditional antenatal care, the midwives interviewed for this study readily weigh women and take their height measurement during their first meeting with pregnant women. These measurements are used solely for profiling the woman's exposure to risk by calculating her BMI. The calculated risk exposure is then used to determine the antenatal care pathway that a woman will be assigned. According to NICE (2008) where a woman's BMI is greater than 30kg/m² midwives should make the pregnant woman aware of the risk of high BMI to pregnancy and in cases where it is 35kg/m² or over the pregnant woman should be assigned to a shared care antenatal pathway. This involves consultation with an obstetrician because a pregnant woman with a BMI of over 30kg/m² is deemed to be exposed to 'high risk' and when the threshold of 35kg/m² is reached, the risk is deemed to deserve the attention of an obstetrician as confirmed by Sylvia's statement that:

"...the reason we do your height and weight and work out your body mass index during pregnancy is that there are certain things that could affect your pregnancy ...".

When obstetricians use phrases like 'certain things that could affect', it confirms the fear women had before their initial consultation with their midwives, as portrayed by Pat and Philomena in their assertion that they expected healthcare professionals to make an issue of their weight:

"...She gave reasons why I was in high-risk care and so many things that I would do and not do scans, tests, and what have you?..I said nothing really, just yes and yes hahaha! Because it was like a list, she was reading to me..." (Pat)

Reaffirming Pat's view, Philomena stated as follows:

"...She gave me reasons my height and weight was taken and why I have to be monitored closely and all the list of test I have to do and so on, I was just at the receiving end.. .there was no room to say much really, because you are being told so many things, and all I did was just saying yes and ok..." (Philomena)

The statement by Sylvia (see below), which represents the first series of discussion between the midwife and the pregnant woman reveal a deliberate effort on the part of the midwife to be sensitive. The midwife broached the issue of risk in a very subtle manner without actually describing it as a negative. She expected that by avoiding the use of 'you are at risk of' and instead using 'certain things could affect' pregnancy in overweight women without being specific that these things are or may be negative, is sensitive. However, as already asserted above, the risk of high BMI is perceived differently from one midwife to another and between midwifery as a profession and obstetrics. So, while some midwives may not emphasise the position that there is a higher risk to pregnancy with higher BMI, as in the case of Becky, a midwife who asserted:

"...Err, like I said I don't class them as any different to other women, so I don't give out different advice to them..."

Other midwives, for example, Sylvia would discuss the risk in a manner they perceive as sensitive, as well as its possible impact on women following their weight measurement as demonstrated in her submission that:

"... The reason we do your height and weight and work out your body mass index during pregnancy is because there are certain things that could affect your pregnancy... this is because you're

more prone to developing increased blood pressure and more prone to developing gestational diabetes because you've got a higher body mass index..."

Some midwives may have adopted Becky's position because of their belief in the social model of care which de-emphasises the pathologisation of women's life's natural events and changes such as menstruation, pregnancy, childbirth and menopause (Oakley, 1980, 1984). But it has been suggested that midwives avoid the risk discussion because they are uncomfortable with discussion around overweight or high BMI (Furness et al., 2011; Mulherin et al., 2013; Foster and Hirst, 2014). Another possible reason alluded to for the avoidance of risk discussions is that, they do not want to create anxiety in women (Nyman et al., 2010; Fuber and McGowan, 2011). However, they explain to pregnant women that their weight and height measurements have been taken to allow the calculation of their BMI, which will be used to guide the decision/recommendation about the type of care that is best for them. While this explanation is correct, it is not complete or transparent.

It is correct because it will impact the decision of whether a woman is assigned to the traditional midwifery-led antenatal care pathway or the shared antenatal care pathway often described as a medicalised antenatal care. However, midwives do not inform women that the calculation of their BMI is also the calculation of the risk of overweight to their pregnancy. In other words, midwives do not inform women that they interpret high BMI to be similar to higher risk and that it is because of this interpretation that they are in shared care. Without providing this information, the explanation cannot be deemed to be complete and transparent as women do not have all the information and insight available to the midwives. As Keely et al. (2011) noted, women largely have a limited awareness of the risks associated with high BMI and pregnancy. Various reasons have been given for the decision or choice by some midwives not to emphasise BMI and the perceived risk of

increased BMI to pregnancy and pregnancy outcomes. One of the reasons is that some of the midwives are overweight and find it uncomfortable to present being overweight as bad (Pett, 2010; Forster and Hirst, 2014). Another reason that has been put forward for some midwives' evasion of the risk discussion is the desire to create and sustain a relationship built on sensitivity and empathy with the women. Midwives want to build this relationship to put them in a position to be able to offer help and support for pregnant women throughout their pregnancy and even beyond childbirth (Forster and Hirst, 2014).

However, other midwives readily initiate the discussion of BMI and risk of overweight in pregnant women. This communication with the pregnant woman during booking, which usually involves the midwife explaining the rationale behind the BMI measurement, shows that midwifery training or continuing professional development provides the necessary knowledge about the risks of raised BMI to midwives. This finding is corroborated by Nunes (2009) and helps to dispel fears that midwives lack of awareness may be compromising their willingness and ability to offer advice to women (Griffith, 2008; Cullum, 2009). During this discussion on the risk of raised BMI, midwives also acquaint women with the kind of antenatal care provision that is available to them but may also confirm the women's fears and anxiety of being subjected to more screening and monitoring. This fear of more screening exists in cases where women have already become acquainted with information from forums on the Internet about the kind of antenatal care provided for women with raised BMI. Women reported that there was a lack of opportunity to ask questions or they were too shocked to do so during these consultation visits, as most of the responses from women were 'ok.' They claimed that they received huge amounts of information during the consultation visit, but they could only listen and did not get the

opportunity to actively engage with the midwife as demonstrated in the discussion between Sylvia and Renee' below:

Sylvia: The reason we do your height and weight and work out your body mass index during pregnancy is because there are certain things that could affect your pregnancy.

Renee': Ok.

Sylvia (MW): This is because you're more prone to developing increased blood pressure and more prone to developing gestational diabetes because you've got a higher body mass index.

Renee': Ok.

Sylvia: So, we will obviously monitor your blood pressure quite carefully on each antenatal visit, we'll have your blood pressure checked.

Renee': Ok.

Sylvia: What we don't want to see is a raise of more than 20 milligrams of mercury on your diastolic which we did initially which was it's not written here on your note, it would be at your GP's surgery

Renee': Ok.

Sylvia: The other thing is you will automatically get the 20th week we'll offer you a glucose tolerance test (gtt).

The discussion continued in this pattern to its conclusion. It is thus at the very beginning of the antenatal care journey of a pregnant woman with above average BMI that the risk posed by high BMI to her pregnancy and childbirth is conveyed rather than explained to, or discussed with her. Pregnancy for this category of women is constructed as 'risky' solely on the evidence that a woman's BMI is equal to or higher than a predetermined threshold. The above conversation between the midwife and one of the

pregnant women proved that it is a health provision that involves screening and surveillance. This health provision according to French and Smith (2013), is one that creates documentary evidence to use as leverage by those in a position of responsibility with a duty to account should something go wrong. It is a safeguard that is available to healthcare professionals who occupy a position of relative power to pregnant women. It is evident from the report of Renee's consultation above that the pregnant woman is in a relatively weaker position. She is a recipient of information or explanation from the midwife but does not contribute to the discussion. The lack of engagement or contribution by Renee' challenged the perceived notion that risk discussion takes place between pregnant women and healthcare professionals during consultation meetings. The consultation between Sylvia and Renee' was used to give information to Renee' and no effective communication or discussion took place as her only response was 'ok' to all the reasons and explanation the midwife gave for carrying out a risk assessment of her pregnancy. The way Renee' responded to the midwife's discussion about the check for gestational diabetes in pregnant women with high BMI provides further evidence of the token involvement of pregnant women during their initial visit to a midwife. The midwife explained that a healthcare professional would advise additional investigation if the assessment found a risk that she could develop gestational diabetes, a medical condition she never had before she conceived:

Sylvia, Midwife: "...You starve from midnight the night before you go to the hospital first thing in the morning to have a fasting blood sugar taken, then they will give you a sweet syrup and to drink and you would be asked to wait for 2 hours while your body metabolises that and then, they will take another sample, and that's just to see if your body metabolism is normal and you haven't got any tendency to gestational diabetes..."

Renee': Right?

An examination of the foregoing quote reaffirms the view that women do not actively engage in discussion with their midwife about risk but passively nod or verbalise their agreement with any explanation and guidance their midwife provides. Several reasons may be used to explain this reaction. Some of the reasons are that women are shocked by the perceived reality of their risk assessment, or overwhelmed by the details and information coming from the assessment or by a lack of awareness of how the probable impact of overweight on pregnancy is perceived and communicated, or a combination of all of these reasons. The obvious unquestioning approach adopted by women during discussions regarding the way risks is ascribed with being pregnant with a high BMI and its explanation by midwives to pregnant women concurs with research findings by Stapleton et al. (2002). They observed that midwives speak for most of the consultations and that they rarely explore the information needs of individual women. In doing this, midwives draw on standardised information which may not address the individual needs of the pregnant woman they are having the discussion about risk with, and which has the potential to shape how they experience their entire antenatal care.

Another observation from the discussion with Pat corroborates the pattern observed in the discussion between Sylvia and Renee' and is evident of the claim that midwives do not say much about the pregnant woman's high BMI, but rather moves from one risk assessment to another. It has been observed that midwives focus on the medical conditions that are associated with pregnancy in overweight women but avoid the discussion of what is perceived and construed as the primary risk source of the condition. The lure for midwives to adopt such a position that avoids risks being discussed is a deliberate or inadvertent effort to avoid a situation that will present them as pathologising high BMI in pregnancy. They do this to avoid endorsing the position of an antenatal healthcare system that views other natural life

changes and events such as menstruation and menopause in women as medical conditions (Barker, 1998; Riska, 2003).

Another apparent inconsistency of the use of BMI in the assessment of risk in pregnancy is the fact that the BMI range used for women during pregnancy is the same as the categories designed for the general population. These categories or range do not particularly take into account any changes that may take place in a woman's body as a result of pregnancy and is in part why there is no agreed BMI classification for pregnant women (Heslehurst et al., 2007). There is also a lack of agreement on the ranges of what is below normal, normal or above normal at the onset of pregnancy or women's first visit to their midwives. This lack of agreement between various interest groups including epidemiological science also justifies the perception of midwives who do not subscribe to treating women with high BMI differently. These midwives, however, discuss high BMI and its associated risk as well as make recommendations and carry out certain tasks as a requirement of Trust policies, protocol, and procedures as described by Becky below:

"...Err, like I said I don't class them as any different to other women so I don't give out different advice to them ... only why due to policies, protocols and procedures I have to book them for glucose tolerance test (gtt)...if I don't ... do that I will get in trouble for that even though I don't agree with that cause – most of those majority of the time come back as negative ... you don't have to have a high BMI to have diabetes ..." (Becky, Midwife).

The view expressed by Becky may be indicative of other midwives who do not agree with how overweight or high BMI in pregnancy is perceived and portrayed. It may also suggest that the perception of the majority of

midwives, especially when viewed against the social model that shape midwives' training, is imposed on them by the requirement to comply with Trust policies, protocol, and procedures. They follow Trust policies and protocol to avoid finding themselves on the wrong side of where power resides within the Trust or the NHS.

Becky's response highlights that midwives' actions may not reflect their beliefs but is the result of the power imbalance that operates within the healthcare system (Shaw, 2013). She stressed that as far as it will not set her against the authorities of her Trust, she exercises discretion; below is what she said about using her discretion:

"...Yeah, we do ... a policy to follow is guidance ... the NICE guidance is guidelines ... so, therefore, you can get away with doing things that you still working within the remit of the guidelines but you ... I do try to support the women to the best of my ability ... I have been with women who do not agree with consulting interview, and I don't go with consultants, and I go with women during the appointment to support them that makes obstetricians, angry ..." (Becky, Midwife).

Becky's view also indicates that midwives may be acting to deliver a woman-centred care against much resistance from other healthcare professional groups such as obstetricians. Midwives do this to the extent that they can draw on support and protection from guidelines so long as the opportunity to exercise that discretion has not been specifically taken away by other professionals with more power and authority. When this happens, midwives experience a feeling of powerlessness; a feeling, which impliedly, pregnant women with high BMI go through during discussions of risk. As far as Becky is concerned, she is powerless in the sense that she cannot undo whatever an obstetrician has requested regarding risk highlights to her pregnant clients. There is a thread cutting through the responses from midwives which

indicates a passive compliance by them with the requirement to perceive and frame high BMI as synonymous with risk and to use this perception and beliefs when advising and providing care for pregnant women with high BMI. This passive compliance could be the result of a lack of an empowering environment for midwives within the antenatal units. Lafrance and Mailbot (2005) suggest that any relationship that does not include the intention of sharing knowledge and power and which does not encourage other parties in the relationship to willingly and freely contribute ideas and beliefs and to make informed decisions that are in line with their values, is not an empowering relationship. This is the relationship midwives in the study described as the prevailing relationship between obstetricians and themselves within the antenatal units as recorded in my field notes from Gemma and Sophie:

Gemma mentioned her experience with women, that when they (midwives) offer women support to go to the Birth Centre, in most cases these women return upset and disappointed because the obstetricians give them different advice, they told them to come down to the consultant -led unit.

Sophie reported that from her experience; some women want to go to the Birth Centre irrespective of their BMI, and they (midwives) give them the support to go to the Birth Centre as long as there is no other medical or health risk factor. But these women in most cases are asked not to go when they are referred to the consultants. Then the women's preference which we find acceptable is over ridden.

(Field notes)

The data provided by pregnant women during interview sessions also allude to the existence of a power imbalance between consultant and pregnant women that are referred by midwives to consultants. This view of obstetricians being the more dominant power was regularly expressed by midwives and pregnant women who participated in the study. Midwives recalled and reported instances of women that were referred to consultants expressing dissatisfaction about the way consultants focused on the risks associated with being pregnant with a high BMI. Obstetricians did not refute the belief that they exercised more power in the delivery of care to women in the shared antenatal care pathway, in a follow-up to this report from pregnant women with consultants as shown in the discussion of obstetricians' perception of risk.

Obstetricians' authoritative knowledge on pregnancy and childbirth risks

The participants in this study described their experience of consultation with, obstetric consultants as being stressful for them. They expressed that they felt stressed because the obstetricians overemphasised the risks associated with being pregnant with raised BMI. Some women felt that their consultants were insensitive in the way they discussed the risks associated with high BMI and pregnancy with them. Gynaecologists and obstetricians interviewed in this study attested to the ongoing medicalisation of pregnancy in women with high BMI. The medicalisation was attributed to the NICE (2010) and Royal College of Obstetrics and Gynaecologist (RCOG, 2010) recommendations. As stated by an obstetrician:

"... at the end of the day it's protocol isn't it, we have to follow protocol isn't it we can't go against protocol and guidelines and when it comes from NICE or RCOG or something, we have to do it ... the thing is from a medical point of view I think again, it's my

responsibility to tell whatever is appropriate is done base on the medical evidence that is available ...” (Obstetrician C).

Obstetricians feel they have to comply with adopted views of their regulatory institutions or bodies such as NICE, RCOG and any other vested with the authority to define and recommend standards or protocol. Compliance requires obstetricians to let women know of the risks associated with being pregnant with a high BMI, as expressed above by Obstetrician C. This process has been justified by the professional medical bodies as seen above and this has stipulated that the risks to above average weight women in antenatal care should be heightened. Obstetricians' medical knowledge and scientific answers, as expressed earlier by Becky, a midwife, are not questioned but perceived to be the best (Brubaker and Dillaway, 2009). These protocols and guidelines mentioned are the frameworks of medicalisation that subject women's antenatal care to the medical gaze and surveillance and has indeed been described by Zola (1972), Foucault (1972) and Conrad (1992) as a social control mechanism. This mechanism has seen much progress in their development, and can now be used to describe some everyday life events and changes using medical terminologies or medical vocabularies and so can legitimately define what constitutes illnesses. Pregnancy and childbirth which are both key to this study now fall under the sphere of the social control mechanism, where failure to meet predetermined expectations in pregnancy is interpreted by this assessment function of this mechanism as being fraught with a risk level requiring intervention from medical experts. Obstetricians have been assigned the responsibility to tell pregnant women about what is to be done about their care as this will ensure that intervention is effective and this role is a consequence of medicalisation argued Martin (1987) and Oakley (1984). They also argued that if all intervention is based on general or standard medical evidence from outcomes of sample studies, without exploring how

the individual circumstance might mitigate it, the outcomes will in all probability lead to situations where healthy conditions present themselves as unhealthy (Martin, 1987). The submission by Obstetrician C is also consistent with the position expressed by midwives who felt obligated to let the women understand the implications of being pregnant with a raised BMI. In effect, any effort to ensure that a critical and objective perception and framing of BMI measures will have to be initiated by medical regulatory and review bodies and backed by clear acknowledgment that the training and education of midwives, obstetricians and indeed all healthcare professionals is adequate for them as professionals to be able to assess the individual situations of service users and make an informed and effective professional diagnosis based on a set of principles rather than restrictive rules.

Such acknowledgement of the expertise of healthcare professionals will reverse the observed trend where obstetricians use scientific explanation of scientific knowledge to legitimise (Lyotard, 1984) the reason for using high BMI classifications, that leads to pathologisation of pregnancy. When asked if fatness impacts pregnancy negatively, Obstetrician B was not hesitant in responding:

"...Yes, medically it does and I've explained all that before, increased weight gain, of course, it will, if you are going to look at what you are looking at, as a BMI of 30, 35, or 40, is it because she is really tall, or is it because she is really short, ... you are going to look at where the obesity is, is it visceral obesity? You are going to look at her background, so I would unless I know that, I generally say yes, increase weight does impact pregnancy..." (Obstetrician B).

The submission of Obstetrician C is inherently contradictory. While insisting that the BMI measure does impact pregnancy negatively, the obstetrician drew attention to other aspects that needs consideration before concluding

on the impact of the BMI measure. These included the impact of height and other physical features on BMI, the ability of BMI to accurately identify the types and location of body fat contributing to a person's weight and their background amongst others. It is, therefore, surprising that the obstetrician asserted that s/he could comfortably declare that fatness affects pregnancy without being certain about the impact of the other factors s/he listed. As a result of such assertions, pregnant women with a high BMI are subjected to scrutiny, surveillance, and monitoring through various tests such as the glucose tolerance test (GTT) and a series of ultrasound scans to mitigate the risk perceived to women's pregnancies. Drawing on the Foucauldian (1973) concept of the medical gaze, Wheatley (2005) commented that it is the product of a wider form of clinical scrutiny and social control. Wheatley argued that normalising the gaze of medical science also serves as a means of power and a disciplinary tool that is used to control individuals by creating an avenue for them to be differentiated and judged (Foucault, 1972). The scrutiny, exercise of power and discipline that is the goal of the medical gaze is achieved through subtle differentiation and monitoring as can be inferred from the response below by Obstetrician B:

"...we try and reduce the risk of missing out the small possibly growth restricted baby, we arrange for a scan. However, I do like to see them back in the clinic usually depending on their body mass index, if they are not in the morbidly obese category then I'll say I'll see them right after the scan, the anatomy scan just after 20 weeks, so we could put the plan in place and that gives us an idea whether we should scan them more frequently depending upon their body habitus."

Obstetrician B relies on the authority of the clinical gaze in the representation of women's bodies as 'subjects' and 'objects' to be explored with medical knowledge (Wheatley, 2005). This same medical knowledge,

that was deduced from widely reported findings of epidemiological studies by the media, constructed fatness in the first instance as a health risk factor. Not all those who deliver antenatal care to pregnant women with high BMI share the view that high BMI constitutes a risk to pregnancy. Midwives hold the view that while high BMI may present an extra challenge to providing care, they do not have evidence from their experience that intrinsically link it to negative outcomes. As a result, Sylvia, Becky, and Michelle, who are all midwives interviewed for the study agreed that they would give the same advice to pregnant women with high BMI as other pregnant women. Their views and belief regarding high BMI and risk were discussed above under the heading 'Midwives Perception of Risk.' The view held by obstetricians that increased weight or high BMI implies increased risk is, therefore, contentious especially when made in an environment which does not look at all the facts and factors, such as a woman's background, that should inform an informed position. Despite not being sure of the role these factors will play, Obstetrician B holds strongly to the view that high BMI could be detrimental to a woman's pregnancy:

"...You are going to look at her background, so I would unless I know that I generally say yes, increase weight does impact pregnancy ..."

The reliance by obstetricians on medical knowledge to objectify women's bodies and ascribe risk to their pregnancy on account of their weight alone could be argued to be contrary to the recommendation of the Changing Childbirth report (DoH, 1993). Pregnant women, who are subjected to the scrutiny of the medical gaze in the form of a series of extra scans, feel that they are no longer able to contribute to the decisions made regarding their pregnancy and the care they receive. Women who are categorised as in need of focus risk care and are made to undergo a series of scans because of their weight, no longer feel in control of what is happening to them

contrary to the recommendations of the Changing Childbirth Report (DOH, 1993). This is because of the lack of capacity to influence or contribute to decisions about their care. To follow up women's reactions and feelings towards extra scans, obstetricians were asked the reason for referring women without known medical conditions for additional scans which women in the normal BMI do not have. In response to the question below is the statement given by obstetrician B:

"... I think we need to look above and beyond that, its a shame that's how they feel, we are not here to make them feel make them feel abnormal, I think with anything in medicine, not just pregnancy, you got to work together, you've got to get them on your side, it's a shame that's how they feel, you know, and I wish they didn't, that's the whole point of seeing them in the clinic because you've got to explain to them why we're putting measures in place, extra trips are not frequent, they are for scan, if there is a problem, then we call them again, if they are more prone to pre-eclampsia well that is pathology and its best to be seen than not to be seen. So the extra trips might be the extra scan, you know, would be the extra time to go see the anaesthetist, isn't that better err to have things put in place and to have a safer plan as ..."

Obstetrician B confirms that because women's weight is potentially viewed as a pathological condition, the extra visits to the hospital which are for scans and tests are necessary, and are a way of making sure that the woman and her unborn baby are safe. Even when in the past, these tests have proven most of the time to be negative, women are still subject to undergo them.

The use of medical and technological terminologies in risk framing

Pregnant women with high BMI expressed concerns about the way obstetricians overemphasised the risks of high BMI, unlike midwives. While at the end of their consultation with obstetricians they had a feeling of anxiety and fear, their discussion with their midwives about why their weight and height measurements were taken for categorising their BMI did not evoke the same level of anxiety and fear. Women reported that their midwives never stressed or overemphasised the health risks associated with their pregnancy as a result of their BMI, but acknowledged that midwives expressed concerns that it may make some procedures more challenging. It was against this background that women were shocked when faced with a different scenario during their appointments with the obstetric consultants they were referred to. When asked about claims by women that obstetricians overemphasise the risks associated with women's pregnancy on account of their weight, below is what obstetrician A said:

"... and if the BMI is over 40, then I just refer them to the consultant anaesthetist for discussion about birth, I mention some of the increased risks to do with BMI, but I don't go into it in great detail, because my feeling is they're already pregnant, so there're not many points scaring them rigid about all the extra risks that the BMI entails..." (Obstetrician A).

Obstetrician A takes the same view as most of the midwives, who believe that there is not much benefit in overemphasising the risk of high BMI to pregnancy with pregnant women with high BMI as any excessive focus on risk will only scare them. However, the obstetrician response does not fully support the intention of not wanting to scare the women. Any mention of some of the increased risks to do with BMI, albeit not going into the details,

is all it took for the women to be anxious and scared. It is therefore not surprising, that contrary to the intention and expectation of Obstetrician A, Kelly (a pregnant woman who participated in the study) reported that following her consultation meeting with an Obstetrician, she was scared as seen in her statement below:

"...just all the obstetrician mentioned was "you'll be at high risk of blood clots, so you'll have to wear stockings", you know, "they'll have to give you an injection" and erm that kind of put the fear of God into me a little bit, kind of ... when she mentioned you know deep vein thrombosis and clots I thought of erm but ..." (Kelly)

The women also reported feeling disappointed at the idea of consultants overemphasising risks with their pregnancies. Some women felt there was no need to scare them because it only makes them and their partners worry about the unknown; about what could happen to their unborn babies. Piper exemplified this view:

"...My partner would often ask are you sure you are making the right decision? Are you sure, I just want you and baby to be ok? That is all, they have said you should see these people for a reason, I'm worried that you are not going to do what they've advised that's all..." (Piper)

Further, on this point Pat said:

"...My husband is particularly worried because he's not looking at it from my angle, he said I'm not listening; he said he knows I've had children before, but I should listen to what the health team is saying"

and give birth at the consultant-led unit. I think it is the risk of this thrombosis, DVT, they sound scary that makes him worry... he's really worried about my decision, I'm sure he thinks I am putting my life and that of the baby in danger, but he's not put it to words...."

When presented with the concerns women expressed regarding how obstetricians overemphasised risk of high BMI to pregnancy, all the obstetricians justified why obstetric consultants have to be open to women about the risks. The reason they gave is that there is no other way than to let them be aware of the risks associated with their pregnancies. This finding is congruent with findings reported by Heslehurst et al. (2011), where antenatal healthcare practitioners felt that they were justified to let women know about increased risks associated with their pregnancies. Obstetricians in the Heslehurst et al. (2011) study justified mentioning increased risks to women to avoid blame and litigation in case something went wrong. The recent case of Montgomery VS Lanarkshire Health Board, (The Supreme Court, 2015) highlights the importance of healthcare professionals being fully transparent with pregnant women they provide care for. This is necessary if women are to make informed decisions about their options.

In the case, the claimant, Mrs Montgomery, is described as a woman of small stature who was also diabetic. Generally, diabetic pregnant women are at risk of having larger than normal sized babies. This in combination with her small stature created the risk of Mrs. Montgomery experiencing difficulty with delivery, but the obstetrician did not discuss this risk with her as it was deemed to represent a small risk of shoulder dystocia.

A panel of seven judges at the Supreme Court in London ruled that the only conclusion that we can reasonably reach is that, had she (the consultant)

advised Mrs Montgomery of the risk of shoulder dystocia and discussed with her dispassionately the potential consequences and the alternative of an elective caesarean section, Mrs Montgomery would probably have elected to be delivered of her baby by caesarean section (The Supreme Court, 2015). This judgement is a strong challenge to the rationale of midwives who have not fully embraced the need to fully discuss risk with pregnant women and support the position of obstetricians to discuss the risk of being overweight with women as recommended by NICE (2010). According to Sokol (2015 p.1), the law now requires a doctor to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments." It is however important to be mindful of the fact that Mrs Montgomery had a known medical condition, diabetes which is different to the pregnant women in this study as they do not have any medical issue.

Conclusion

This chapter considered how women and healthcare professionals perceive BMI as a risk factor in pregnancy. What high BMI means to the pregnant women who participated in this study was explored. Women were asked and allowed the opportunity to construe and frame what in their opinion and belief is the meaning and relevance of BMI. Women in their responses did not show any awareness of a link between high BMI and risk; or how high BMI is perceived to present higher risks to their pregnancy. In their account, they asserted that it is used by healthcare professionals to position them as being high-risk, pregnant women but did not understand the rationale behind using their weight to categorise them as high-risk. The responses of pregnant women in this study suggests that women view BMI as a measure that is used to assign them to the shared antenatal care pathway. Overall, women did not show particularly, that they understood the aim of calculating their BMI as the meanings and understanding they relayed did not show that BMI is a risk factor to them. Women asserted that they were aware that

their weight would be mentioned as they access antenatal care but not in the same way it was explained which did not enhance their limited knowledge of the implication and associated medical concerns held by healthcare professionals. The chapter also explored how explicitly, the concept of BMI as a risk factor during pregnancy has been presented in health policy regarding the care for pregnancy with high BMI. This review of how explicit policies present the concept of BMI and its link to risks in pregnancy observed that the explanation leaned towards more tests, screenings and medical surveillance.

In addition to pregnant women's perception of BMI and risk, the views, beliefs and framing of high BMI, and its risks to pregnancy and pregnancy outcome from the perspectives of healthcare professionals was also discussed. The chapter explored how the perception of high BMI and risks held by healthcare professionals might have influenced how they care for overweight pregnant women.

Chapter 6

Communication

Introduction

According to the Oxford Advanced Learners Dictionary, “communication is imparting or exchanging of information by speaking, writing, or using some other medium” (Oxford Dictionary online, 2016, unpaginated). Pregnant participants in this research made contact with three other antenatal care teams apart from their midwives, and this comprised; obstetricians, sonographers and phlebotomists. To understand communication in a clinical or healthcare setting, and to be able to identify key elements which will make such communication effective, it will be insightful to consider a definition of communication with a clinical perspective. So, an in-depth definition of communication in maternal services, the King’s Fund asserted that:

“...Effective communication is the key to all clinical care, particularly in the maternity services, where there may be multiple handovers of care. Communication is effective only if the relevant information is actually made available to, and understood by, those who need to act on it ...” (King’s Fund, 2008, unpaginated).

Viewed against the King’s Fund (2008) description of effective communication within the maternity services, it can be concluded that the findings of this study point to a lack of effective communication between pregnant women in this study and their antenatal healthcare providers. For effective communication in antenatal care for pregnant women with high BMI to take place, the teams involved in their care, as well as individual members of the teams, should all be sending the same messages to women. This study did not find evidence that healthcare professionals send the same

information to pregnant women with high BMI about its risks. Reports from women following their meetings with their midwives during booking and subsequent visits indicate that their midwives while mentioning that their weight would constitute complications to their pregnancies, did not effectively tell them that their weight constituted a risk to their pregnancy. However, on referral to an obstetrician, the main focus of the communication between pregnant women and the obstetricians they are referred to, turns to risks of high BMI to pregnancy. This is evident in the account below as provided by Agnes:

“ ...Well yeah, more with my err with the consultant more than my midwife because I mean that were the first time I saw him, was when I saw you at the hospital, so that was the first time I met him and in that appointment he just kind of said to be honest I did feel it wasn't it wasn't an appointment that was individual to me if you know what I mean, it was more just more about “right this is what the issue is, right, this is the BMI, right you've gone for this test, right you've gone for this test, right ok at so-and-so weeks you need to come see the anaesthetist you know to discuss you know options for pain relief because- because of your excess weight there be problems with the injection and this, and this, then this” and I'm like wait a minute, and then something about if you have to have a caesarean, and you could bleed out, and I were like what! It's so obviously I then burst into tears ...” (Agnes)

Using further guidance from the King's Fund (2008) description of effective communication and highlighting its submission that:

“Communication is effective only if the relevant information is actually made available to, and understood by, those who need to act on it” (King's Fund, 2008, unpaginated).

The finding of this study suggests that there was a clear lack of effective communication between women and healthcare professionals.

While there is agreement about the difference in the content and nature of the discourse of the risks with women by midwives and obstetricians, there is a varying and different rationale for midwives and obstetricians to communicate the risks differently. A study conducted by Keely et al. (2011) found women with high BMI were aware of the existence of risks associated with being pregnant with an above average weight, but did not become aware of these risks before becoming pregnant. Also, it has been mentioned earlier in this report that women reported using the Internet and other fora to make themselves aware of how BMI may impact their pregnancy before their first booking appointment with a midwife. Findings by Keely et al. (2011) and reports by women about using the Internet and other sources to make themselves aware, may have informed the decisions of midwives, as in the case of Agnes' midwife not making an issue of her weight and the risks it poses to her pregnancy, though the consultant did. It has also been reported that midwives choose not to dwell on risk discussion because they did not want to jeopardise the woman-midwife relationship which they wanted to establish with the pregnant woman. Also, midwives may be doing this to avoid the stigma that is associated with maternal overweight (Puhl Heuer, 2009; Fuber and McGowan, 2011; Lindhardt et al., 2013). So, when midwives refer pregnant women to obstetricians, they just tell the women that it is a routine antenatal appointment. This supports the view that midwives do not discuss risks with women in order to avoid hurting their feelings, as Tessy explains here:

“ ...there has never been anybody complaining about being told about told what risks are, we've just had a few women that say I've

finally reached the point where I'm happy with myself and now somebody is saying I'm fat again, and so that's been a real issue for them but no, not really. I think sometimes, to be honest, it's a hard one really because women know that they have a raised BMI for the ones that are over 35 and the ones that are over 40 – it's not surprised that they do know, and I think we pussy-foot around it, and we try to be politically correct, and if you say to a woman because of your weight there are risks associated with anaesthesia in labour so we refer you to an anaesthetist. ...” (Tessy, midwife).

So, midwives may unconsciously adopt the role of protecting pregnant women with high BMI by shielding them from the uncomfortable feelings that a discussion of the risks from high BMI evokes in pregnant women. This view is supported by some findings reported by Heslehurst, 2010; Heslehurst et al. (2011), Oteng-Ntim et al. (2010) and the response provided by Tessy above. They indicate that some barriers exist; such as the sensitivity to obesity; to midwives discussing risks of high BMI with pregnancies. Another reason for this protective way of working with women is the fact that women have complained in the past about highlights of the risks that their weight brings to their pregnancies (Heslehurst et al., 2007; Schmied et al., 2011). These explanations indicated a gap in what, how and when risks are communicated to pregnant women who are deemed to be at higher risks generally and pregnant women with risk from high BMI in particular. The result is that midwives are able, whether deliberately or not, to avoid discussing the risk to pregnancy with women, about being overweight while obstetricians take the view that discussing the subject is important for women's care and should not be avoided even on the grounds of it being sensitive, uncomfortable or difficult. Though some previous studies found that obstetricians reported finding the conversation and that it is also very likely to distance the obstetrician from women, they still believe

that it is an important duty of care to have the discussion with women as obstetrician B commented, below, that it would be of benefit to no one if the truth is avoided and not spoken:

"...I say listen there is going to be a problem, you can perceive how your lady is how she is, how far and how to say it, some people need to be told in blank words fat, they need to be told they know what obese is I sometimes say you've got much fat around your tummy which limits our examining you ok. So it's how you deliver the information, it depends on upon your relationship with the patient at that point, but most certainly, I would never encourage anyone or my juniors to refrain from being open about the risk just because of the fear of being insensitive to err, I agree communication is very important, it's a skill, it doesn't come easy, and communication with each individual is very different ..."

(Obstetrician B).

Obstetrician B explains how they try as consultants to effectively deliver risks messages to these women, to drive home its significance. They achieve this aim most of the time by tailoring information to suit the individual woman, by carrying out checks about their background and this according to the Obstetrician has proved to be successful. Here is her explanation:

"...each lady is so different, some are really educated, they are professionals you know, they already know more, some are not, some are easy to talk to, it just depends on the person, the way I talk depends on patient to patient how? My tone and the words that I use vary from patient to patient. You have to tailor it to the individual to the lady you are dealing with, looking at her background, it's only the standard sentence that I use, some lady may just say there are lot of calories ... and go around it, and they

laugh, they giggle and they say we know what it is, and we are guilty we know, and they will say it, the more you bond with them as you go along they will actually admit to it, they accept it, they are adult, they accept it, they are not in denial about it..." (Obstetrician B).

The Obstetricians all reported telling the women about the risks associated with their pregnancies due to their weight. They all unanimously expressed their willingness to tell women about risks irrespective of how they felt about the conversation. This finding corroborates Knight-Agarwal et al. (2014) submission that obstetricians reported that although the conversation is a less acceptable one, they will still need to have it with women because it is important, irrespective of how it made women feel. The argument shows that those who subscribe to the authority of the medical gaze believe that the source of medical authority lies in the knowledge claims of the medical profession about the human body, health, and illness in general (Foucault, 1973). It is under the authority of this knowing that obstetricians can put a greater premium on the risks discourse with pregnant women ahead of how the women felt about the discussion.

Midwives' risk communication with women: more than just talking

How to improve safety in maternity services is a subject in the toolkit put together for antenatal care teams by the King's Fund (2012). Part of the suggestions in the toolkit states that "the safety of maternal services is of paramount importance and maternity teams face many challenges in delivering safe care to mothers, babies, and families" (Thomas and Dixon, 2012, unpaginated). Achieving safety depends a lot on how well issues relating to safe or unsafe antenatal care is communicated to women

especially those being provided with a high risk-focused care. High-risk practice in antenatal care is highly recognised (Raine et al., 2009), and given that midwives are the first healthcare practitioners that pregnant women encounter in their antenatal care journey, there is a need for midwives to build a relationship based on trust.

Pregnant women should be able to obtain a clear understanding of the purpose of routine antenatal care. They should also be able to freely contact their midwives to discuss any concerns they may have about their pregnancy (DoH, 2007). Since midwives are the first antenatal care team members that pregnant women make contact with, they are expected to let pregnant women with high BMI know why they are in the shared antenatal care pathway. Communicating risk at this stage will provide women with the knowledge of why they are in 'high-risk' care pathways and why their pregnancies are ascribed higher risks. Engaging in a frank, complete and transparent discussion about the reason or reasons for taking women's weight and height measurements, calculating or establishing their BMI will be effective communication. Also, the discussion of the probable risks of high BMI to pregnancy, in the view of the King's Fund engender effective communication between pregnant women and their midwives as well as provide the relevant information for pregnant women "who need to act on it ..." (King's Fund, 2008, unpaginated). Effective communication will, therefore, provide women with a good understanding of the classification of their antenatal care pathway and will reduce the incidence of women feeling frightened during a consultation visit to the obstetrician.

Most, of the midwives, interviewed, reported not emphasising the risks associated with high BMI to women because they did not want to upset these women. However, the finding from this study indicates that because of midwives' avoidance of engaging in effective communication with pregnant

women early in their antenatal care journey, women did not fully understand what to expect. So it can be argued that midwives set women up to be frightened of the outcome of their visit to the obstetricians by failing to fully discuss the topic of risk with pregnant women.

Some midwives also commented that some of the pregnant women came to them knowing that they are 'high-risk.' In which case, communicating risks associated with being pregnant with a high BMI became easier. Also, midwives reported that the response from women during discussions of their risk status depended on how the women perceived themselves. They stressed further that if women are not comfortable with their weight, it makes communication difficult. Otherwise, some of the pregnant women are happy with the extra care that comes with being in the high-risk category of antenatal care as presented by Becky in the following:

"...sometimes they do realise, and they say, I know I have a heavy weight, I think it just depends on how the woman perceive herself. If she feels she has a problem being pregnant with a high BMI, then communication will be difficult, some even before they meet the midwife, already classify themselves as "high risk". Some of them like the extra support given that they are high risk, while other women do not believe they do, it depends on the woman really..."
(Becky, midwife).

Another midwife also confirms that some women respond to risk communication at face value, suggesting that they accept what the midwives tell them, whereas other women tend to get offended by it. Here is what the midwife said:

"... Most women tend to kind of accept it on face values when you're

speaking with them about it, it's a bit of 50/50 whether they like it or not, things like "Up Beat Mums" obviously some women can be a bit of offended, they think it might be an issue when you speak to them about risk and some women have already recognised themselves ...the thing again is very much depended on the woman. You got some women who are quite eager for information; they want to do the best for themselves and the baby whereas to some women are not so much of a problem, and they don't see why we're bothered about it ... again it depends on the woman ..." (Sophie, Midwife).

The views expressed by Sophie and Becky above indicates that midwives are open to discussing weight and the risks associated with it in pregnancy with women, but they are mindful of how women will react or respond to the discussion. Overall, this study has established that midwives and obstetricians are willing to discuss the subject of overweight and its deemed risks to pregnancy with overweight pregnant women. Similarly, this study also established that while midwives may be concerned about how women will respond to discussing weight and risk, which may influence whether they go through with it, obstetricians see it as their duty to have the discussion with women. This finding is different to and similar to certain aspects of findings from a previous study in which midwives and physicians were not willing to talk about obesity and its risks because of their unwillingness to worry women during pregnancy (Nyman et al., 2010). While midwives in this study demonstrated a similar reaction about women potentially feeling uncomfortable with discussing risks, obstetricians recognised the concerns of women but judged the need for women to be aware of their risk status and its potential impact as having an over-riding value and benefit. Another finding that is contrary to the existing study is that following communication

by midwives about risk with pregnant women, the women in turn, blame themselves for allowing the situation to develop. For example, Charly was critical of herself for allowing her BMI to rise to the point where it was deemed to be of concern by her antenatal healthcare team.

Michelle explained that the women that she provided antenatal care for accepted the risk discourse positively. According to Michelle, the women accepted explanations of the health risks associated with high BMI and were positively open to the advice from midwives regarding how to mitigate the health risks associated with being pregnant with high BMI. She noted that the downside of such acceptance is that women usually shroud it with ascribing blame to themselves. Below is Michelle's portrayal of the reaction of women to the advice midwives give to them:

"...Err pretty much say positively, some women say regardless of the BMI, "I know I should be eating better, or I'm struggling to eat at the moment err, and I think sometimes if you are saying something to somebody who's got a higher BMI, whether they are taking it more personally, I'll like to hope not, but there are times when you can feel they are getting a little bit agitated ..." (Michelle, midwife).

The view expressed by Michelle is converse to the findings in the study by Keely et al. (2011) where women with high BMI reported that they were not aware of the risks linked with high BMI and pregnancy. In Michelle's response, it is evident that women perceive the 'at risk' status as a punitive antenatal category of care, hence, the apportioning blame to themselves as seen above. A reaction such as this that provokes self-blame and feelings of helplessness (Crossley, 2007; Lobel and Deluca, 2007) may be indicative of the lack of empathy and sensitivity in the way the risk discourse is carried out by health professionals who occupy a position of relative power or

authority to women. Michelle presents how the women she provides care for feel responsible for the medical gaze and surveillance of their pregnancies; holding themselves culpable for their inability to adhere to eating better or follow a healthy diet. This is consistent with Parker's (2014) suggestion. She identified a feeling of maternal responsibility for obesity amongst pregnant women with high BMI and declared that comments like these hold moral undertones. It is characterised by feelings of 'blame' for women as they are perceived by the socio, political, medical or health institutions, or other stakeholders to have actively contributed to and framed being responsible for, being 'obese' and engendering the condition for 'overweight or obese children'.

Parker (2014) stressed that this framing creates a form of moral panic. It has, also in recent years, become a measure of good mothering resulting in the appropriation of blame to women of childbearing age for the "obesity epidemic" (Boero, 2007, P.41). For some midwives, high BMI has become the norm in their experience of caring for pregnant women. Having been providing antenatal care for women for several years, they felt high BMI is now perceived to be the norm as they tend to see a lot of pregnant women with high BMI hence a normative meaning is shaped. This is indicated in the extensive account from Tessy, a midwife:

"...I think, unfortunately, I've been discussing this with colleagues a lot lately, I think raised BMI is now the norm it is, and that's really, really sad ... obesity is the word that women find offensive, words like; large BMI, raised BMI, they don't find offensive because their peers, their relatives, their neighbour, society as a whole is getting bigger, so it's not until you probably start getting women with BMIs in the 40+ you know 45, 50 range, err most women are not offended because they think is not abnormal problems comes when sometimes ...I've probably had a couple of issues ...where women

come along and have been referred to anaesthetic pre-assessment, and they've probably struggled with their weight and at this point in their lives, have finally reached, psychologically, a point where they are happy with themselves and they get pregnant, and someone tells them they're overweight ... so that's an issue but I think that's a totally different issue with that woman and her life and health in general. But most women do not seem concerned that they've been referred because of their BMI" (Tessy, midwife).

Although most of the midwives reported not emphasising the risks ascribed to pregnancy in women with high BMI, Michelle confirmed that she routinely discussed and communicated risks to pregnant women in her care without thinking about its potential to hurt their feelings. However, it is of importance to note that Michelle had only been qualified for two years. Here is her comment:

"...I honestly don't know how they would feel, some ...one person may feel fine about it, another person might feel and take offence at it, but I can't say how the person might feel. I've only come across women when I say because your BMI is 31 we recommend that you would go and have a GTT at 26 weeks and give the women the information, it's not my place not to give it to women because of their BMI because it might hurt their feelings, if I gave it, so far as I'm concerned it's my job to inform to inform women at the end of the day because of their BMI they are at increased risk of certain things, so, I don't certainly know how that person feels ..."
(Michelle, midwife).

The views expressed by Michelle regarding the content of and how she discusses the issues of BMI and risks with women is indicative of the impact a midwives' prior experience of providing antenatal care for pregnant women

with high BMI on their willingness to engage in the discussion of the subject with women and their capacity to actually carry it through. It is a theme that this study would have wanted to explore further, but the sample selection prior to data collection did not take into account how long midwives had been in practice and Michelle was the only relatively recently qualified midwife that participated in the study. Clearly, from Michelle's account of her experience of providing care for women with high BMI, as well as most midwives in this study, none of her clients has openly expressed dissatisfaction at the communication of risk associated with them being overweight in pregnancy. Michelle also went ahead to report that it was not in her place to make decisions about the specific aspects of their care, such as the discussion of the risk of high BMI, to ignore or de-emphasise as part of the antenatal care provision for pregnant women, however sensitive it may appear to be. However, this might be as a result of the reassuring conversation that follows, after letting women know that they are in the high-risk category of antenatal care as relayed by Becky here:

"...I just tell them having a high BMI does not necessarily affect their pregnancies...some women say they don't know why having a high BMI should affect pregnancy. I do tell them it may not be easy to palpate them, and there's no advice that I will give them that will be different from anybody else..." (Becky, Midwife).

Similarly, Gemma another midwife stated that:

"...The first time I saw her when I told her what she scored on her BMI, she said she knew and said she'd got big bones and everything, but then when she saw what they wrote in her notes, she just shut down and everything, yeah... honestly, they have a bit of joke about it when we discuss their weight and laugh about it, you know when

we first see them they do, they do honestly, and then they get upset when they go for their scans, most of them ..." (Gemma, midwife).

A finding from the interviews with most of the midwives in the study is that midwives do not view the antenatal care they provide for pregnant women with raised BMI as significantly different to the care they provide for women with low BMI. Midwives reported that, although they discuss the issue of high BMI and its risks to pregnancy with pregnant women that have high BMI which they do not do with other pregnant women, they assert that they approach the topic sensitively, which makes it easy for pregnant women to joke and laugh about it. This finding is contrary to past studies conducted by Heslehurst et al. (2007; 2010), Furness et al. (2011) and Schmied et al. (2011) where they found midwives reported that it was difficult for them to talk about women's weight as they provide antenatal care for them. In the studies cited, midwives emphasised that the stigma around obesity made it difficult for them to broach the topic. A possible explanation for the difference in the observation of midwives in this study and those of Heslehurst et al. (2007; 2010), Furness et al. (2011) and Schmied et al. (2011) is that midwives in this study used the term high BMI contrary to the medical term, obesity in the prior studies cited. Also, the midwives in the studies cited alluded to the stigma around obesity making the discussion difficult. The possibility that the use of the term obesity and high BMI may have accounted for the differences in the observation and is strengthened by the reflection of Tessy, a midwife that was previously quoted in the discussion on *'Midwives' communication with women about risk'* in which she commented on how the use of the term high BMI may be affecting how women respond to discussion about weight as indicated in the excerpt below:

"...I think, unfortunately, I've been discussing this with colleagues a lot lately, I think raised BMI is now the norm it is, and that's really,

really sad ... obesity is the word that women find offensive, words like; large BMI, raised BMI, they don't find offensive because their peers, their relatives, their neighbour, society as a whole is getting bigger" (Tessy, midwife).

Medical Surveillance and its negative effects on pregnant women

Sonographers are members of the care team that attend to pregnant women during their ultrasound scan. According to the NICE (2008) guidelines for antenatal care ultrasound scans should be used to determine the gestational (unborn baby) age, the likelihood of Down's syndrome and multiple gestations (check for number of babies in the womb), the gender of the baby and for any abnormalities. Midwives inform pregnant women of these tests and screenings during the booking visit. They also inform pregnant women of the period in their antenatal care that they are expected to undergo these checks. These routine checks are for every single pregnant woman cared for by the NHS maternity services. During ultrasound sessions, women are shown their unborn babies and as the sonographers navigate the whole process of the scans, they take women along with them. For example, they communicate with women about the activities of the unborn child at the point in time. This for some women makes it all real, seeing their unborn child for the first time, which is an exciting experience for women especially in Kelly's case as she had not felt her baby move and was a bit worried but was relieved when she saw her unborn baby on the ultrasound screen. She expressed how she felt in the following statement:

"...Oh I was yeah, it was lovely yeah it was really nice yeah, cos I've not I've not actually felt baby move yet, and everyone was telling me, you know "Oh have you not felt them move yet? Have you not felt anything?" and I was getting quite worried that there was

something wrong, erm so it really put my mind at ease and I found out that my placenta's lying across the front which is why I won't feel anything, so, but yeah..." (Kelly).

The above reaction epitomises the assertion by Van der Zalm and Byrne (2006) that when women experience ultrasound examinations, it makes them feel connected to their unborn baby. They contended that the experience also gives women reassurance about the health of their baby as the details were documented and measured. This position is reaffirmed by the following comment from Piper:

"...yes, they took the measurements, I also had the err, the check for Downs as well where they do the measurement at the back of the neck, she got that fine, they got all the measurements straight away fine, no problems what so ever but then on the print out it said scan difficult due to whatever they call it, habitus or something ..." (Piper).

In this way sonographers brought the feelings of motherhood closer to them. During ultrasound examinations, sonographers refer to the unborn as 'baby', which gives the unborn a personal identity (Mitchelle, 2001). According to Morgan (1996) giving the foetus or unborn child an identity has evoked debate from different angles of the society. There is no consensus of views regarding the acquisition of separate identity and rights for the foetus or unborn child. The debate is shaped by the views of groups which are either pro-life or pro-abortion. Pro-life groups are made up of mainly religious groups, while the pro-abortion group hold the belief that women should be able to decide for or against abortion of their unborn child. Pro-life groups believe and assert that at no point from conception has the foetus ever been anything less than a separate human being, hence the foetus or unborn has a right to life from conception (BBC, 2016). This position is refuted by the

pro-abortion campaigners. Though neither of these groups accepts the position of the medical profession, which suggest a threshold before a foetus can survive outside the mother's womb as a period when a woman can no longer elect to abort a foetus (Ashcroft, Dawson, Draper, McMillan, 2007). The position in England, Wales and Scotland today is that a woman has the right to undergo elective abortion up to 24 weeks of pregnancy after which it can only be performed on medical grounds (BBC, 2016). I chose to refer to the unborn as an unborn child (not foetus), because my participants are all women whose pregnancy was between 16 and 30 weeks and at the time of the study were not considering elective abortion. Every pregnant woman I interviewed referred to their unborn, as unborn child or baby as did their midwives. To reflect the perception and construction of the women and midwives I interviewed, I considered it necessary to continue in that terrain of referring to the unborn child or baby implying that they have acquired the identity of a human being. The women in the study talked with pride at the sight of their unborn children for the first time during the first of the series of ultrasound scans that they had. For example, Charly referred to the experience as a pleasant one that was very special for herself and her husband. Here is her account:

"...we did as many checks as she could ... the baby wouldn't move so we wanted to know the sex of the baby we couldn't see so she sent us away for a walk to eat something sweet errm came back and try it again and the baby had moved and she seen already all she needed to see and there was a trainee in and she asked if she could have a go as well [laughed] errm which was fine and so we ended up with quite a long scan which was lovely because by the end of it we were getting good at spotting things yeah. We do, both me and my husband really love the scan experience errm so it was fine yeah ..." (Charly).

Most of the women talked about their ultrasound examination with excited voices, and smiles about being provided a copy of their unborn baby pictures. Sonographer's approach to the examination even makes the experience more interesting for women. This is because they describe babies' anatomy to them which made them express positive and enthusiastic comments on sighting their babies on the screen, especially for the first time (Mitchelle, 2001). It is important to note here that the positive feeling that women expressed on seeing their unborn child during scanning is a product of what has been described by other commentators; and in this study; as medical surveillance. This experience, which gave them a meaning and the reality of their new motherhood status, especially in the case of first-time mothers to be, followed from one of the activities of what has been described as a product of the medical gaze of surveillance. It can be argued, therefore, that the output or result of surveillance is not intrinsically negative but is determined by the intention of those who deploy it. This is evidenced in the picture they carry with pride. Agnes said the following about her scan picture:

"...she did the measurements fine and she were showing me that's the stomach, that's the this that's the that, this is the spine and the picture that is so clear I'll show you, well I've got a picture- I've got a picture of the picture erm yeah so that's a picture of the picture ..." (Agnes).

Most of the pregnant participants interviewed reported on what they saw on their notes or reports from ultrasound examiners as surprising. Women said they were surprised at the report because it did not reflect the examination process. They asserted that the picture painted of how the activities of their scan unfolded in their notes was contrary to what they actually experienced. This is because their notes portrayed difficulty in carrying out the scan which they attributed to their BMI as well as reporting that their weight indicated

danger and uncertainty. They insisted that the sonographers never alluded to any difficulty on account of their weight during the scan or mentioned any danger or uncertainty and so to have made issue of them in their notes made the women worried and drew a shadow of uncertainty over their pregnancies. These pregnant women also expressed feelings of dissatisfaction towards sonographers as the women felt that they were not totally honest with them in the way reports were presented in their notes. Women questioned the motives of the sonographers regarding the contradiction in the view they presented as the scan was in progress and their official report. They wondered why, if they knew or found a medical condition in the unborn during scans and examinations or had difficulty in obtaining accurate measurements of the unborn child or getting a scan picture, they did not say so during the scanning session. Here is Pat's account:

" ...yeah I think it yeah at first she had trouble getting erm a good picture because of the way baby was lay and I had to roll on my side slightly to make baby move so that she could get a proper- and I think that's what it referred to, but the terminology they've used I'm not quite sure so at first I thought oh had I done something wrong erm maybe that's just my paranoia but erm I was a bit worried when I read it part of me thinks it can't be that bad because otherwise they would have said something so..." (Pat).

Another pregnant woman also has this to say regarding the content of her ultrasound report:

" ...yes I was yeah, yeah, my very first scan I had, my twelve week scan erm there was just one line in it that sort of said they couldn't see something because of patient, and I forget the word and I kind of thought when I read it I thought oh have I done something

wrong? Alternatively, did I do something wrong at the time you know, I've chosen to let it go by, but I just wondered at the time what that wording meant, and perhaps would have liked it explained to me ..." (Alison).

Alison felt she would have liked her notes explained to her given the use of the jargon within it. This expression by Alison, suggests that some medical terminologies that were not clear to her had been used to describe the result of her ultrasound examination. This finding is similar to findings from Furber and McGowan (2011) where women reported being told that everything was fine during ultrasound procedures, only to read in their notes that "it was difficult to scan, one of the women felt she thought "it was a kick in the teeth" (Furber and McGowan, 2011, p.5).

In a study conducted by Fields et al. (2008) about patients' understanding of medical terminologies, they argued that healthcare practitioners should be aware of this gap that exists between them and their service users and adapt their language to suit the service user. In a way, pregnant women have to validate their understanding about the sonographer's report.

What is different from the findings of previous studies regarding women's ultrasound scan experiences is the fact that women felt that the sonographers were not totally honest in their report. Women felt sonographers made up their reports to cover their backs, since the facts in it did not reflect the actual scan procedure. Agnes recalled:

"...But what they did say is that they normally do say that to cover themselves, so if anything, you know say he's born, and anything was missed, then they could say you know "well, it was technically difficult because of the" and that's what I've- that's what I've read on the blogs d'you know what I mean that people have said you

know yeah it's- it's- it's to cover their own backs, because to me, he did the measurements fine and he were showing me "that's the stomach, that's the this that's the that, this is the spine and the picture that is so clear I'll show you, ... do you know what I mean and obviously to read that in the scan that it was you know technically difficult because of the mother's what habitus or whatever it said you know high BMI and it was like well, you did- so if that was the case why didn't you say to me..." (Agnes).

All the pregnant participants reported joy and elation upon seeing their unborn on the screen during their various ultrasound examinations. Charly recalled:

"... by the end of it, we were getting good at spotting things yeah. We do, both me and my husband really love the scan experience errm so it was fine..."

The women who expressed disappointment did so about the lack of transparency of the sonographers regarding the challenges that sonographers reported they had experienced in carrying out the scan. This was after women read their notes which they however suggested were not a reflection of their own experiences of the scan. Piper also said:

"...Yes, they took the measurements, I also had the err, the check for downs as well where they do the measurement at the back of the neck, she got that fine, they got all the measurements straight away fine, no problems what so ever but then on the print out it said scan difficult due to whatever they call it, habituous or something..."

Philomena confirmed the views expressed by Piper,

"...during my scan, there was no struggle at all; everything was fine and clear for her (sonographer) to explain to us (herself and husband), the measurement at the back of the neck, the one for downs, and everything came back as ok. But guess what when I read my notes at home, "difficult to scan due to something habitus", my husband asked, are they really serious, because she did not struggle at all. So why was it difficult? I was upset, and at the same time it made me laughed as it was exactly what other women had mentioned on the internet ..."

The reports of pregnant women regarding the inconsistency between their experience of scans and interactions with sonographers could not be directly explored with sonographers as the initial research design did not make provision for inclusion of sonographers as participants in the study. This would have allowed a review of their perspectives regarding women's reaction to the communication of ultrasound scan, examination results in reports which were challenged by most of the participants in the study. Piper's statement is a pointer to the fact that the outcome of surveillance is largely dependent on the intention and objective of those behind its design and implementation. Despite the feeling of elation expressed by women on seeing images of their unborn child, the form, and content of the sonographers' report about the same scan experience they were elated about, caused women distress. This is consistent with the view expressed by pregnant women with high BMI in Fuber and McGowan (2011), where participants reported feeling distressed after reading their notes. This lack of transparency in medical surveillance and gaze has been questioned by sociological scholars (Wray and Deery 2008; Macdonald, 2006; Lupton, 2012a). Drawing from the study of Jenks (1995) on the subject of visualising the internal body, it can be argued that proponents of the medical gaze are

using the power of visual imagery to prepare those who are the target of its scrutiny to accept the outcome of the scrutiny as people relate more positively to what they can see. Jenks (1995) argues that biomedical science put forward vision-appealing images to our sense of seeing while gathering information which it regards as autonomous and objective. This vision as asserted by Jenks (1995) is used to observe and construct our social world and thus integrates elements of seeing and knowing, as evident in the ultrasound examination experiences of the pregnant women in this study. The Ultrasound examination sessions represented a focal point for all pregnant women in their antenatal care journey, irrespective of their perceived risk category. Biomedicine has socially constructed this internal visibility of the unborn as an important aspect of caring for pregnancy and for producing legitimate, medical knowledge as the authoritative knowledge (Jordan, 1997) as the "eye of the science" (Jenks, 1995, P. 10). Linking visual knowledge to the concept of surveillance and social control, Lupton (1995) explained that it is routinely used in healthcare settings in the West as a system for social control which projects certain images as acceptable worldviews (Jenks, 1995). This worldview renders a means by which alternative visions can be portrayed as deviant and dangerous. The adoption of this method of care in the twenty-first century by modern medical imaging of the body was the onset of the process of surveillance of the body (Foucault, 1972).

Language use to enhance understanding whilst building a trusting relationship

Women want normal pregnancy care rather than a medicalised provision which employs a form of language that hinders full engagement with women during discussions of risk. This provision does not use the language that matters to women (Puhl et al., 2011). The use of suitable and appropriate language to discuss risks during consultation with women was discussed

with obstetricians, and they affirmed that it is necessary to capture the background and medical history of pregnant women and to carefully evaluate them to understand the situation and need of each woman. Here is a comment from one of them:

"...so when the referral letter comes to us, if the body mass index is identified as being greater than thirty; 30, then I put a plan in place for her own pregnancy, so, pertaining to the mother, I look at the other background, you know medical conditions, drug history, allergy, previous pregnancies which would influence what the plan is but given that this is all negative..." (Obstetrician B).

According to the CMACE/RCOG document (2010), health risks are discussed every day in our society but, this could be carried out poorly or in a manner that is out of form. This makes it the responsibility of healthcare practitioners to identify ways by which risk discussions can take place with women at the level that they can understand. For example, Obstetrician A explained that good communication with women enhances understanding and promotes a trusting relationship and brings about a positive outcome. Obstetrician A also highlighted the fact that women are treated as individuals given that their backgrounds are considered when risk is communicated to them. She explained further that by considering these factors, they are able to get to women.

"... It's not easy, the level of education especially to assess straight away but you know you start talking you don't go straight into these problems I think that's the main thing as you start generally asking about the pregnancy ...So you got a bit of you know time and then after that , we will say the reason why you are here is because you know , this result that we have and we have 1 or 2 things that we need to do, and especially if they are sort of below 40, you don't

stressed on everything that much because you know that because they are thirty- something they are coming, but the problems usually are not there, but if they have a much bigger BMI, like 55, 60 and so on, then you have to tell them a bit more and other things, like I said before, they do know why they are here ..."
(Obstetrician C).

This is contrary to findings in previous studies on how information regarding risk is discussed with women. In those studies, healthcare practitioners felt that it was difficult to broach the issue of risk regarding weight with pregnant women during antenatal booking and visits (Heslehurst et al., 2010). Obstetricians said they try as much as possible to avoid the use of terminologies that would make women with high BMI feel uncomfortable. Words such as 'obese' and 'fat' are not used during the consultation so as not to make women feel that they are being judged. Ogden and Taylor (2009), Dutton et al. (2010) and Gray et al. (2011) talked about avoiding the use of the term 'obese' and advised that in its place, a more pleasant word could be used. They also stress that the term 'obese' make the lay population feel the health condition is serious. Here is the account of obstetrician A.

"...Because I don't want to make women feel bad about it, it's not a judgement thing, it's just about information giving, erm I find it quite difficult to raise the subject actually because some women are very touchy about what their weight is or their BMI is and other woman aren't, and it's quite difficult to say well you'll have to come and see me because you're fat (short laugh) I can't say that (short laugh) I use sort of very what terminology like BMI it's less pejorative or it's less you have to be careful about the language you use, put it that way..." (Obstetrician A).

Although there are clear guidelines from NICE (2008) on additional antenatal care for pregnant women with high BMI, studies have shown that it is a difficult time for women (Nyman et al., 2010; Fuber and McGowan, 2011; Heslehurst et al., 2011) because obesity has been portrayed as a sensitive topic to discuss, especially with pregnancy (Keenan and Stapleton, 2010). Thus, Puhl and Brownell (2003) suggests that it would help if healthcare practitioners provided antenatal care for these women without making reference to their weight and the risks therein. Nyman et al. (2010) and Furber and McGowan (2011) also added that pregnant women with high BMI dislike continuous references to their size during appointments because constant mentioning of women's body size may invoke shame and make women avoid making contact (Puhl and Brownell, 2003). For example, Agnes reported how an obstetrician reminded her to...:

"...I hope you are taking your aspirin ... Well I've only seen him once and he didn't- it's not like I keep you know like he checked me out or anything, he just read my notes on you know what other people have read and then especially as well that's when I were thing that upset me because in my notes it had said that erm that I was supposed to be erm prescribed aspirin from between eight and twenty weeks or whatever to be taking that every day to help the blood flow to the placenta is what he said and I said no, I've not received a prescription for that and he says "well it says in your notes that a prescription's been sorted for it" and I'm saying well no one's told me...apparently, he did not bother reading my notes because he saw me and felt, oh, she is a big one!" (Agnes).

Ways of knowing

Another key theme that emerged from the data was women's experiences of knowing and their assertion that they are knowledgeable with regards to their health during pregnancy. Most of the women felt that medicalisation undermined their perception of pregnancy. Women in this study specifically sought information from various Internet fora, such as blogs by other women, to acquire some awareness about the kind of antenatal care they would be provided with given their high BMI. This is because they suspected that their weight would be an issue as they went through antenatal care because of their past experiences with the healthcare setting where their high body weight was frequently mentioned. The women felt that obtaining information from various Internet fora regarding how other women who had experienced pregnancy with above average weight, would not only provide them with the knowledge about the antenatal care for women in their category of care but also help them to identify issues they may want to discuss with antenatal healthcare professionals. Besides seeking information from these various Internet sources, women also used them to seek reassurance and support as it offers an outlet for them to talk with other women who have either undertaken the journey through antenatal care or those who were still receiving antenatal care from the health service. Women were told about the way both their midwives and obstetricians would relate to them as a result of their weight.

On the part of the healthcare professionals who provided antenatal care for women, knowledge was shown through their provision of care. This is the knowledge they had derived from training and experience, as a woman suggested during an interview that:

"...doctors make it look as if women don't know their bodies, ...I know what I feel, and I understand my body more than what any science can say ..." (Pat)

This comment, by Pat, highlights Barker's (1998) notion about pregnancy, that before science became the main source of knowledge about the human body and health, "folk wisdom" (Barker, 1998, p. 1071) was given credibility. Barker also suggested that the non-medical nature of physical discomfort experienced by women during pregnancy, for example morning sickness, if explained to women as normal, may provide them with relief. However, with the dismissal of 'folk wisdom' as backwards and dangerous and the wholesome acceptance of expert and scientific knowledge as 'authoritative knowledge' which now dominates the process of childbirth (Jordan, 1993), the woman's knowledge of her body is discounted. According to Jordan (1993) authoritative knowledge derives from and is perpetuated by a social process that legitimises one approach of knowing as well as making it compelling and more valid with a complete dismissal of any other way or method of knowing.

Women's knowledge about constructing 'normal'

Pregnant women tend to seek information regarding their pregnancy and the nature of antenatal care that exists for them by using various media tools (Lupton, 2016). They do so as a way of acquiring knowledge, which Foucault (1980) defines as a circulating force. A force which enables individual to achieve or attain what they want and which is used by institutions to get people to behave in a certain manner to achieve what the Institute set as targets, objectives or goals. The desire to acquire knowledge may be triggered by a certain event that individuals perceived to be significant in their lives. For example, when Agnes realised that she was pregnant, she went out to seek information and to acquire knowledge about pregnancy and

what will be expected of her during her pregnancy. She also wanted to be aware of what is available in the healthcare setting as her comment below indicates:

"...Yeah, my first one I was- was I twelve weeks? I think I was eleven weeks, eleven plus six I was when I had my first one (scan) erm and obviously you're- you're worried aren't you, because obviously when I found out I was pregnant I went on, you go on blogs and stuff, and it's like you know, which I did obviously other people have said you know ...how they've been treated and stuff and like.... quite you know offensive really about their weight, but the woman (midwife) that I had, she were fine obviously she didn't mention it (my weight), erm, I think maybe cos she was a bigger woman herself maybe, erm if it had been a slimmer woman (midwife) that might have been a different experience ..." (Agnes).

Given that it was her first pregnancy, Agnes felt that it was necessary to seek information to gain knowledge regarding the kind of healthcare she would be provided. Similarly, Kelly displayed the same response (see quote below), and according to Sz wajcer et al. (2007), the desire to gain knowledge is triggered by the need to have some understanding of something or individual circumstances. For example, to be aware of how the media have presented 'fatness' as bad, other people's or personal experiences of healthcare practitioners in the past. The desire or trigger to understand these experiences and construct made Kelly decide to seek information about her status as a pregnant woman that is big, and how she would be treated. She offered the following about how she responded to her anticipation that her weight would be mentioned when she attended for antenatal care:

“...Well, just because of the way- you know weight in the media and things you’re kind of made to feel as if you’re not normal, and then when I’ve been to the doctor’s previously about other issues, say perhaps when I’ve had erm a problem with me knee, well the first thing they say is well, you need to lose weight for the issue-...it kind of made me sad really instead of being a thing of joy. Because I know my weight would be mentioned I checked on the internet to see what other big girls are saying about the care they get. I was petrified, I almost didn’t want to get to book for a midwife, but my husband was worried and advised I went...” (Kelly).

As Kelly explained in her response, the media had presented high BMI as abnormal and in the past, her experiences with her healthcare practitioners had also shown that her weight had always been brought into any health condition she went to see the doctor for. Given that she was pregnant; she was not sure of what awaited her. Hence, she went on a knowledge gaining mission on the Internet; probably to gain the knowledge that would help her address her ‘petrified’ state. This expectation that gaining knowledge from others, who have experienced what she was feeling, would empower her to manage her fears and expectations is consistent with dominant discourses on knowledge. These discussions suggested that knowledge reinforces power, as those with knowledge use it to exercise power (Fox, 1993). However, knowledge could also make its recipients become overly aware of a gap in their knowing or their perceived failings or inadequacies. This was the case with Kelly as ‘knowing’ made her not want to go for antenatal bookings until her husband prevailed on her to do so. This finding is contrary to previous studies on pregnant women with high BMI, where women only seek information on what happens during the ultrasound session.

Midwives' knowledge use: Providing information whilst maintaining relationship with women

The philosophy of midwifery states that pregnancy and childbirth should be built around the woman and her family (International Confederation of Midwives, undated). Midwives attempt to provide quality antenatal care to women by building a relationship with them. Knowledge themes in this study showed that midwives used their knowledge and experience to develop a rapport with women which they then used to build a relationship that enabled them to identify and avoid events that would hinder communication with women. This relationship helps throughout the antenatal period. While some midwives talked about how they joked about women's high BMI, others said they encouraged women to make choices about the place of birth of their babies:

"...Yeah, they say that honestly... they have a bit of a joke about it when we discuss their weight and laugh about it, you know when we first see them they do, they do honestly..." (Gemma, midwife).

Midwives use their experience to create an environment whereby women can focus on the pregnancy rather than women's weight and the risks associated with it. As a result, midwives and pregnant women with high BMI can joke about their high BMI during booking; this rapport provides women with a sense of security to connect with their midwives and focus on their antenatal care journey instead of the perceived risks associated with pregnancy and high BMI. This both confirmed and refuted certain aspects of findings from Schmied et al. (2011) and Heslehurst et al. (2013) where midwives reported that they do not broach the issue in order to prevent upset of the women especially at the beginning of their pregnancy. In the above, Gemma was mindful of the need not to upset women but found a way to talk about women's weight in a manner that it did not upset the women or threaten the

prospect of developing a trusting relationship. However, one of the midwives interviewed affirmed the findings of Schmied et al. (2011) and Heslehurst et al. (2013) by asserting that she does not dwell on the issue of risk while providing antenatal care for women with high BMI as she does not want to put any negativity into their heads. She said:

"... I don't want to put it into these women's head about a negative – the more positive thinking you're, the more positive thinking you're, the more likely you're going to have a normal birth. Research has shown that women who have continuity of care with midwives are more likely to have a normal birth..." (Becky, midwife).

Becky's comment above, suggests that she wants to engage with the pregnant women and sustain this engagement throughout the antenatal care journey. As a result, she refrained from telling them anything negative so as to be able to ensure the benefits of continuity of care. She pointed out that pregnant women with continuity of care, in a midwifery-led pathway, are more likely to have normal births and are also less likely to experience preterm birth (Begley et al, 2011; McLachlan et al., 2012; Sandall et al., 2013). Midwives reported how they are open to women with regards to the care they are provided and how this openness made women voice what they wanted to the midwives:

"... I'm honest and open, I listen to them, and I think the care that I give them is an agreement between both of us. Sometimes you get that they don't want to have shared care, and you get around that err, and we'll let the Obstetrician know. I've got this lady she's got a BMI of 40 she doesn't want to attend antenatal clinic she knows about glucose tolerance test (gtt) what it is, why we offer it, she doesn't want to have it, and that's fine ..." (Tessy, midwife).

As emphasised in chapters 2 and 3 the different maternity policies of the DoH (1993 and 2007), and the recent NMR (2016) all emphasised that maternity services should be one that facilitates which informed decision making, one which enables women and their families to feel safe, respected and listened to. Midwives use the knowledge gained from years of experience to discuss with women and reach a decision that is safe for both mother and the unborn baby while ensuring that the emphasis of the maternity reform reports is delivered by following necessary procedure and protocol. Below is a midwife's comment which attested to this:

"...If it comes to that (a pregnant woman not wanting shared-care), I'm a supervisor of midwife anyway I work with midwives and mums to make sure ... their care is safe, what I would probably do is explore with her what her issues are, why she doesn't want to be a to be seen by a consultant, is it because of a previous experience, is it something somebody else told her, does she not like, you know if she'd already seen an obstetrician does she not like that Obstetrician..." (Tessy, midwife).

The knowledge enables midwives to achieve the provision of quality midwifery services which is what the maternity services aims to achieve; to provide every woman with the best possible antenatal care (DoH, 2007; Sandall et al., 2013).

Obstetricians' Knowledge: Obstetrics power in the justification of medical intervention in pregnancy and childbirth

Some of the women in my study admitted resigning themselves to a state of acceptance of whatever the 'doctor' says. This however, was only common with first time to be mothers, for example, Alison, who relayed her experiences of being a big girl all her life but perceives herself as healthy. She was confident in her health and fitness to carry out her daily activities before and during her pregnancy. However, while she did not understand the need for the categorisation of her pregnancy as being high risk, she resigned herself to the knowledge of the obstetrician as a professional who 'knowing it all' was better placed to make an assessment of her health status. This construct was shaped by her previous experiences and belief and may have been re-enforced by her encounter with healthcare professionals in the antenatal care system, presenting themselves as having authoritative knowledge (Jordan, 1997). Jordan (1997) asserted further that this same construct of authoritative knowledge is used to sustain an unequal power relationship between groups of healthcare professionals as well as between healthcare professionals and their clients (Jordan, 1997; Hunter and Segrott, 2014). For example, Alison unequivocally accepted whatever the obstetrician says to her as they (obstetricians) are constructed as having authority. She explained her willingness to accept consultant obstetricians' views irrespective of her beliefs and convictions by reiterating that "you know being doctors ..."

Obstetricians are also quick to rationalise their provision of care by drawing on the authority of their professional bodies. For example, here is what obstetrician C said:

"...at the end of the day it's protocol isn't it, we have to follow protocol isn't it we can't go against protocol and guidelines, and

when it comes from NICE or RCOG or something, we have to do it..."

This reliance on the guidelines of the health regulator by healthcare professionals while necessary and remain in a position to encourage, will if followed by obstetricians and/or other healthcare professional without a critical evaluation based on the outcome of deploying them in practice, result in missed opportunities for enhancing the efficiency and effectiveness of outcome. As professional, obstetricians have a duty to comply with guidelines from regulatory bodies but also to exercise professional judgement and to make representation to regulatory bodies on the impact of guidelines on their practice if the need arises. It is this responsibility and privilege that professionals have that make their clients feel that they can trust and rely on their views and advice as encapsulated in Alison's statement:

"...and the doctors they've cos it's- it's been I've had it you know most of my life, "you're a high risk, you're a big girl, you're a high risk, you're a big girl, you've got this because you're a big girl" it kind of becomes drilled into you and you don't - I don't second guess it cos they're the higher authority with it- you know with being doctors ... and you take what they say as kind of like their word ..." (Alison).

Alison did feel she had to resign herself to the authoritative knowledge of the medical practitioners who were providing antenatal care for her. However, the decision to take this position emanated from her past experiences with the healthcare setting regarding how her weight was perceived and framed in relation to other health challenges. The concept of authoritative knowledge is constructed through the unequal power relationships between medical practitioners and their clients (Jordan, 1997; Liamputtong, 2007).

This compliance by Alison to the authoritative knowledge in medicine showed that she believes her weight is a potential risk factor that could have a negative impact on her pregnancy. A finding that is similar to studies of women with high BMI by Heslehurst et al. (2015) and Mills et al. (2013) where women who are overweight perceived their weight as a risk to their pregnancies. Explaining this perception, Jordan (1997) stated that medical knowledge which constitutes authoritative knowledge by medical practitioners superseded and discounted other possibly relevant forms of knowledge, for example, the women's prior knowledge of their bodies. Given that society, in general, has constructed consultants to be the ones with authoritative knowledge, I wanted to ascertain how the consultants positioned themselves in this notion. Though, consultants sometimes volunteered information about this, questions that would probe this further were asked. Here is a response from Obstetrician A:

"... the thing is from a medical point of view I think again, it's my responsibility to tell whatever is appropriate is done base on the medical evidence that is available...because there are new guidelines, new protocols which state that you know, you need to have a GTT at 26 weeks, you need to have a scan at 34 weeks, and it's just for that they are being sent in, now that's one way of looking at it. ...at the end of the day it's protocol isn't it, we have to follow protocol, we can't go against protocol and guidelines when it comes from NICE or RCOG or something, we have to do it ..."
(Obstetrician C).

Obstetrician A did feel that her knowledge as an obstetrician has positioned her to suggest that women should be referred to her clinic due to high BMI. Although she stressed that she would not highlight the risks associated with women's weight and pregnancy, she still did because she explained women's referral to them, by telling them that there are increased risks in the

designation they have been assigned. This assertion was further confirmed by similar responses from the other obstetrics consultants interviewed when the issue of why healthy women with above average weight, that have already had previous successful pregnancies and childbirth, were being referred to them was raised:

"... I'll say the risks still stand, it is a good thing she's had 3 normal birth, the risks still stand, risk is never a 100%, it's very good that it hasn't occurred to her, my advice will still remain for her to come for a scan, and she can decline if she wishes to, she is fully informed, that's not to go by, but that's ok. We are not there to incriminate them but here to advise and recommend ok ..." (Obstetrician B).

The medical model constructs birth as normal in retrospect and this is the reason for the focus on risk (Mackenzie Bryers and van Teijlingen, 2010) before birth. It is evident that obstetrician B categorically stated that irrespective of the pregnant women's past experiences, the antenatal care she would be provided was still going to be inherently embedded in the medical model. This claim is usually supported by the professional medical knowledge, suggesting that it is best for women (Jordan, 1997). In this instance, Obstetrician C, for example, made suggestions as to why medical intervention was the appropriate option for women in the high BMI high-risk classification. The Obstetrician again used the authority of the medical profession claim to knowledge to justify an obstetrician's position to willingly ascribe risk to pregnancy and support interventions using professional medical knowledge: Here is his comment:

"... the thing is from a medical point of view I think again, it's my responsibility to tell whatever is appropriate is done base on the medical evidence that is available...because there are new guidelines, new protocols which states that you know, you need to

have a GTT at 26 weeks, you need to have a scan at 34 weeks, and it's just for that they are being sent in, now that's one way of looking at it. ...at the end of the day it's protocol isn't it, we have to follow protocol isn't it, we can't go against protocol and guidelines when it comes from NICE or RCOG or something, we have to do it ..." (Obstetrician C).

The use and wielding of authoritative knowledge is demonstrated in the comment by obstetrician C as he justifies heightened intervention for women with high BMI and their designation of antenatal care. Evidence from this study also supports the claim from previous reports which suggest that obstetricians are known to use risk as a justification for intervention by bringing it into discussions of various forms of technical and clinical intervention (Kaufert and O'Neill, 1993; Mander and Murphy-Lawless, 2013). All the obstetricians in this study confirm that they are conscious of the risk profile of pregnant women with high BMI and that it is reflected in how they provide care for women that have been classified as high risk due to weight by making reference to authoritative knowledge which is endorsed by their professional bodies as well as citing evidence from medicine. Waldenström (2007) has optimistically contended that evidence-based practice (EBP) gave rise to the demand for the increase in the incidence of normality in pregnancy and childbirth. However, EBP is largely eagerly promoted by obstetrics consultants so as not to appear to be in favour of normalising intervention in pregnancy and childbirth.

Conclusion

A review and evaluation of responses to interview questions from midwives revealed that antenatal care for pregnant women with high BMI emphasises the 'high-risk' status of being pregnant with high BMI. Most of the healthcare professionals acknowledged harbouring some level of reluctance in embracing the discussion of how high BMI poses risks to pregnancy and

childbirth. So rather than have this discussion in a sensitive manner with women they roll out a litany of conditions without explaining the link between the conditions and high BMI. The result is that pregnant women are left anxious and worried. Interviews with midwives who have the primary responsibility for raising the issue of risks with women during consultation meeting indicates that they do not actively engage in this discussion because they do not want to hinder the trusting relationship they want to build at the early stage of the woman's pregnancy. The result is that women lack the necessary awareness and understanding of risk of high BMI even after being referred to other healthcare professionals.

This chapter showed how communication around risks, risks factors and risk status are carried out with women by midwives and obstetricians. Findings from pregnant participants showed that women felt that midwives did not discuss details of how their BMI poses risks to them and their pregnancy. Similarly, they reported that obstetricians over emphasise the issue of risk but did not actually engage with them in a discussion that would enhance their understanding of the position of healthcare professionals. They reported instances where healthcare professionals constantly mentioned several medical conditions that they could develop because they have high BMI. Healthcare professionals did not explain the link between their weight and the medical conditions mentioned to women, and in the responses received from women, this scared them emotionally. The chapter discussed communication between healthcare professionals and pregnant women using the King's Fund (2008) definition of effective communication within a healthcare setting as a guiding framework. The chapter highlights evidence and indicates a lack of detailed, complete, accurate, objective and transparent discussions between pregnant women in the study and the healthcare professionals that participated in the study.

Chapter 7

Risk Concurrence and Resistance

Introduction

The main focus of this chapter is to discuss how women construct, view and accept the risk status ascribed to their pregnancy by healthcare professionals. The acceptance; by women; of the risk to pregnancy because of weight or BMI alone is not universal. While prospective first-time mothers are more likely to accept healthcare professionals' assessment of such risk, women who have had experience of childbirth are less likely to accept the risk ascribed without questions. The decision of first-time mothers to accept the assessment of healthcare professionals is made from a position of serious information asymmetry between them and healthcare professionals. So, without access to independent, complete, accurate, objective and comprehensible information that they can use to make an informed decision, women without previous experience of pregnancy felt that exercising their choice of a place to give birth was out of the question. They therefore, accepted the outcome of risk discourse and assessments, as framed by healthcare professionals. The result of such acceptance is that they positioned themselves in the medicalised status of uncertainty and were keen to avoid anything that could happen to their unborn child irrespective of how remote the chance of any negative occurrence might be. As a result, women who were anticipating becoming first-time mothers felt it was wise and prudent to accept the advice and guidance of obstetricians rather than exercise their choice.

This acceptance of and belief that healthcare professionals have what could be described as a monopoly of complete, accurate and reliable knowledge about their pregnancy is why pregnant women who have embraced

obstetricians' framing of the likelihood and impact of the risk of high BMI to pregnancy make themselves complete recipient of information dictated by biomedical views of being overweight, through obstetricians as suggested by Alison:

"...it cos they are the higher authority with it- you know with being doctors and midwives and you take what they say as a kind of like their word."

The belief by pregnant women that healthcare professionals are custodians of complete, accurate and reliable knowledge about their pregnancy and childbirth is reaffirmed by Renee' who asserted:

"...To be honest I do not know, I have to trust the health professionals that they know what they are doing because [pause] it might affect, you know by being told by other people that it kind of affects you... I planned to lose weight before being pregnant, but it came before that ..."

These prospective first-time mothers, however, reported that they felt that the framing and communication of risks to them was scary and to some extent a source of worry about their unborn child. This tendency for women to feel fear and anxiety, which could be exacerbated by pressure from their partner or spouse, has a real potential to make pregnant women feel powerless about making the decision regarding where and how they want to give birth.

On the other spectrum, women with some experience of antenatal care and childbirth were more likely to assert themselves. They were more probable to demonstrate a determination to do what they felt was right for them and

their unborn. This is not to say that experienced mothers discounted any risk to themselves and their unborn child or were more likely to be careless about their unborn babies or themselves, but they were able to draw some confidence and assurance from their experience of prior antenatal care and childbirth, which made them feel more confident about their pregnancies and their ability to give birth relative to women who were experiencing pregnancy for the first time. They are likely to ask more questions about the rationale for the position and recommendations of healthcare professionals. As a result, experienced mothers are empowered to uphold their right to make an informed decision about their choice of the place where they want to give birth to their unborn child. They also felt happier about their choices. The chapter will explore the responses and views of women to questions and discuss how women identified themselves as either concurring with, questioning or resisting the perception and framing of risks by healthcare professionals. It will also consider the factors that impact the readiness of women to adopt new perceptions.

Antenatal care for overweight pregnant women 'the Hobson's choice'

Birthplace for pregnant women is an aspect of the pregnancy and childbirth journey that women look forward to, and this is mostly influenced by the social, cultural and political context in which women and their family live (Grigg et al., 2015). Most women in this study had developed a birth plan which was fundamentally linked to and designed around their preferred birthplace for their babies. They had planned to give birth to their babies in the midwifery-led unit, but due to the risks ascribed to their pregnancies, they were assigned to the shared antenatal pathway designated for women deemed to be at higher risk. These women, as part of their care, are referred to specialist, healthcare professionals such as obstetricians and anaesthetists. Women, in shared antenatal pathways, have reported that

their consultations with obstetricians were mainly used for discussing risk, and the chances of something going wrong. This often resulted in some women changing their decision or choice of a birth place and accepting to put aside a key aspect of their birth plan to accept the recommendations of obstetricians to give birth in the obstetrician-led medical units. The present understanding of health for overweight women during pregnancy is dominated and shaped by the biomedical construction of fatness and the impact it can have on the woman, her unborn child, and the birthing process. This is the understanding and knowledge that obstetricians have subscribed to, and it is what shapes their practice as they deliver antenatal care to pregnant women with high BMI. The content of this understanding, its inherent potential to create and sustain information asymmetry between groups of healthcare professionals, and between healthcare professionals and pregnant women, have been identified as some of the reasons most women have felt they needed to accept the obstetrician's preferred choice of where they should give birth to their babies. Other reasons include the terminologies adopted and how healthcare professionals communicate their beliefs about how fatness can impact women, their unborn child, and the birthing process even when they do not have any other health concerns other than having a high BMI (Houghton et al., 2008). The feeling expressed by pregnant women who participated in this study, and which is supported by previous studies (Ahluwalia, 2015), is that the emphasis or focus of healthcare professionals on risk during encounters with women in antenatal care only helps to disempower women by eroding the confidence of women in the ability of their bodies to give birth (Edwards and Murphy-Lawless, 2006). This diminished confidence affects women's ability to make a choice.

The notion of choice differs from one individual to another and may be influenced by the structure of reciprocity and social obligations (Scott, 2000). It is also determined by the active interaction between wants and

goals expressed as preferences, constraints that limit probable outcomes and the information available to the individual. According to Scott (2000):

“In rational choice theories, individuals are seen as motivated by the wants or goals that express their 'preferences.' They act within specific, given constraints and on the basis of the information that they have about the conditions under which they are acting. At its simplest, the relationship between preferences and constraints can be seen in the purely technical terms of the relationship of a means to an end. As it is not possible for individuals to achieve all of the various things that they want, they must also make choices in relation to both their goals and the means for attaining these goals. Rational choice theories hold that individuals must anticipate the outcomes of alternative courses of action and calculate that which will be best for them. Rational individuals choose the alternative that is likely to give them the greatest satisfaction” (Scott, 2000, p.127–p.128)

Pregnant women in this study, make birthplace decision using key elements of rational choice theories which allow them to base their decision on their social knowledge and construct of safety (Griggs et al., 2015). By associating negativity to pregnancy and outcomes in women with high BMI, biomedical construction of fatness and by implication of high BMI, seek to use a key aspect of the Rational Choice Theory (Scott, 2000) described as psychological conditioning to make women accept obstetricians preferred choice of a birthing place, which they present to women as recommendations. This is consistent with the psychological view that human actions are not free but determined (Homans, 1961). While feminist commentators have concerns (Kirkham, 2004; Lupton, 2012b; McAra-Couper et al., 2012) about using risk discourse to justify medicalising women’s pregnancy, they cannot describe the actions of obstetricians, or

indeed the women who accepted to rank the desired or preferred choice of the obstetrician higher than their own as irrational. This is because the decision and actions of both the obstetricians and pregnant women conform with the concept of rational egoism. This concept asserts that an action that promotes self-interest meets the necessary and sufficient conditions for it to be categorised as rational (The New World Encyclopaedia). While the position of Obstetricians, which feminist commentators argue has used over exaggerated risk images of high BMI to discourage women from making and implementing their own choice cannot be perceived or framed as being irrational, their action albeit indirectly, undermine the objective to safeguard women's ability to make choice and provide women-centred care for all pregnant women (Maternity Matters, DoH, 2007; NMR, 2016).

In summary, there are some suggestions from women that the way risks of high BMI to pregnancy and childbirth is construed and framed by healthcare professionals can play a strong and active role in getting women to discount the plan and desire they had, for their pregnancy before they accessed antenatal care services, for what healthcare professionals deem to be better for them and their unborn child. For example, Pat (worrying about whether she will be allowed to make the decision regarding her birthing place) said she had decided to give birth at the birth centre because she had, so far, had a straightforward pregnancy and did not have any health issues before or since her pregnancy. Her statement, below, however, suggested that though she has considered the issue of where to give birth and had identified several good reasons for the choices, she is concerned about not being listened to by healthcare professionals regarding her decision, and is open to the possibility of abandoning that decision should healthcare professionals recommend it:

...I planned to give birth at the Birth Centre because firstly, it is close to where I live and secondly, my family and friends can easily

come into in to see baby and me and thirdly, I heard that the midwives are really nice there from other women who have been there ...I really hope they will listen to me, high BMI or not, I really want to go there, thank God my pregnancy has been a very healthy one ...I am healthy, I am active, so, I don't see what could possibly go wrong ...as so far nothing has gone wrong ..." (Pat)

Though Pat's perception, construct and framing of risk is consistent with the findings from earlier studies which reported that pregnant women's construct of safety was deeply rooted in their beliefs and values from their personal experiences and influences from a range of factors such as family, friends and their own knowledge (Coxon et al., 2013 and Noseworthy et al., 2013), this was not enough for Pat to be confident in her decision to give birth in a midwifery-led unit in the event that an alternative option is preferred or recommended by healthcare professionals.

Reports from other women corroborated the suggestions that the way risk is framed and communicated to women has a potential to erode or diminish their confidence in their ability to give birth without medical intervention or at the Birth Centre, which is a midwife-led facility. This induced lack of or diminished level of confidence is attributed by women to be linked to how risk discourse by healthcare professionals with pregnant women with above average weight is conducted. The pregnant participants who fell into this category were women experiencing pregnancy for the first time and who had no prior experience of childbirth or antenatal care to draw confidence from. They adopted the advice given by healthcare professionals and by so doing delegated their right to choose to the obstetrician in charge of their care. This study found that, contrary to what would be the expectation on account of Rational Choice Theory (Scott, 2000) the women's description of how and why they accepted to give birth in consultant-led units did not convey a feeling of satisfaction which should be the logical outcome if they acted in a

rational manner; that is in their self-interest as suggested by Rational Choice Theory (Scott, 2000). This is amplified by Alison in the following:

"...I really would have loved to have my baby at the Birth Centre ...but I can't now due to this risk and that risk. I've even been told that I'm at risk of blood clots. DVT this, DVT that, ... I'm a woman whose work demands is such that I'm on my feet eight hours every day ...six days a week. High BMI or not I'll still have DVT anyway. I have decided I'll follow through with them to give birth at (named town) ...especially as my husband is worried as well about me not going there. I don't really have a choice do I?" (Alison)

A philosophical review of the response given by Alison is thought-provoking. It can be argued that she is mindful and in control of giving up her right to choose where she wants to give birth. It can also be asserted that the decision is not made because of the benefits to herself as Rational Choice Theory (Scott, 2000) would suggest but is made on account of the expected benefits to others, albeit very significant others such as her husband and her unborn child. This is consistent with the position of the predominant form of psychological egoism. Explaining Alison's behaviour with this concept of predominant egoism (Kavka, 2006) one can submit that her decision to accept the recommendation of healthcare professionals was not influenced by the risk discourse but by her recognition that the sacrifice involved in giving up her desire to give birth at a midwifery-led unit is relatively small compared to the benefit that will accrue to her husband and her unborn child. Similarly, the same framework can be adopted in formulating an argument that the healthcare professionals in their focus on risk and their recommendation for women with high BMI to deliver their babies in consultant-led units do not act in the interest of pregnant women but rather in their own interest to acquire better results and more recognition. So, both healthcare professionals who, according to pregnant women, use risk

discourse to get women to accept giving birth in consultant-led units and the women who accept the recommendation to give birth in those units are all acting in their self-interest and so viewed by the Theory of Rational Choice as being rational and in control of their choices. As a result, it is philosophically untenable, when considered within the context of the Rational Theory of Choice and predominant egoism, to assert that women have not exercised their right of choice. However, despite this philosophical discourse of choice, Foucault's concepts of knowledge and power (Foucault, 1980) can be used to analyse the position of healthcare professionals relative to pregnant women regarding the protection of and the exercise by women of choice about the antenatal care they are provided as recommended by the Maternity Matters (DoH, 2007) and the NMR (2016). For, example' Kelly stated:

" ...I think actually I wouldn't have had the choice because they- because I'm consultant-led they would not have want me to go in a midwife- in a midwife led centre, so I think really I might have fortunately it would have been my choice anyway, if it hadn't have been I think I would have lost my choice there, erm but they've not go- they've not gone into the birth really, just err all the consultant mentioned was "you'll be at high risk of blood clots, so you'll have wear stockings", you know, "they'll have to give you a injection" and erm that kind of put the fear of God into me a little bit ..." (Kelly).

Similarly, Philomena also said:

"... I would really like to just go up the road to (named town) midwifery led unit to have my baby, but don't think I have that choice now, as the doctor has said he has recommended that I go to (mentioned town) the consultant led unit. I don't think it is fair, but

I cannot argue, who can argue with a doctor, my husband has said that I should do whatever they say..."

In Kelly's view, making a choice, for her was no longer an option given the classification of her antenatal care pathway. But if she was given the option, she would like to birth at the midwifery-led unit. This decision was no longer; in her view after her consultation meeting; in the interest of the wellbeing of her unborn child. She could not navigate her option beyond the risks analysis of her pregnancy as communicated to her by the consultant during a consultation booking. This is similar to the findings by Cooke and Loomies (2012). In their study, they found that women's initial birth plans changed due to control and influence from their healthcare practitioners. Martin (1987) argues that languages used in childbirth reveal assumptions about women's perception of their pregnancy and childbirth journey. Martin (1987) relying on Foucault's (1980) concept of power and knowledge argued that obstetricians use medical discourses to represent women's birthing process in a manner that portrayed their bodies as not being able to carry out the birthing job. As a result of this assumption the medical professionals use their knowledge and power to make decisions for women by using the discourse of risk to put fear into women (Bordo, 1993, Martin; 1987; Lupton, 2012b) especially prospective first-time mothers who because of their lack of knowledge and experience about pregnancy could not resist suggestions by obstetricians.

Demonstrating self-knowledge and striving to create healthy pregnancy and childbirth identities

Another theme that emerged from this empirical study is resistance. Women discussed how they experienced more activities that they perceived as an effort to increase the medicalisation of their pregnancy as they got closer to childbirth. They had more scans and visits to their obstetrician where

discussion focused on getting them to have their babies in a consultant-led unit which some women resisted. This theme is consistent with the notion of 'docile bodies' (Foucault, 1972). Foucault described 'docile bodies' as a transformation in the exercise of power which occurs with the emergence of liberalism. Foucault, (1972) used it to refer to the focus of the modern state on the life of its population through the subjugation of bodies which he described as 'docile bodies' so as to be able to control them. For biomedical science, the pregnant body is a suitable 'docile body' to deploy its medical tools to produce desired social bodies. Biomedical and epidemiological sciences and studies view excessive fat as a source of increased risk to individual health. Biomedical and epidemiological scientists seek to get the general population to acknowledge the risk that being overweight represents, by putting forward information and arguments against fat in the public domain whilst using the media as an effective vehicle. The result of framing fatness, as epidemiological science has done, and putting that framing in the public domain through the media, is that almost every member of the population now sees fatness as a condition that needs to be reversed, with some commentators actively, while others half-heartedly, calling for measures to address or turn around the statistical trend in the number of overweight people in the national and global population.

In this context of general acceptance by local, national and global communities that fatness is bad, biomedical science feels confident about measures that are akin to disciplining pregnant women's bodies as well as regulating the health of the future generation; the unborn babies. Most of the women in this study, who had previous experience of pregnancy and childbirth, rejected being the docile bodies and resisted efforts aimed at the medicalisation of their bodies and childbirth. These women arrived at this decision by drawing on the learning and experience of antenatal care they had received in their previous pregnancy. The result is that they resisted the exercise of power, which Foucault (1972) described in his notion of 'docile

bodies,' by healthcare professionals over them in their present pregnancy. The women in this group who had undergone the antenatal care system during previous pregnancies. These women, like obstetricians, were able to draw on the knowledge from their previous experience of pregnancy and antenatal care for women with high BMI to exercise power. Women who were experiencing their first pregnancy lacked this knowledge or the experience of antenatal and were more submissive to the expectations of obstetricians. The power to resist obstetricians, which women that have previously experienced pregnancy and antenatal care displayed, can be ascribed to their knowledge and conforms to the expectation of Foucault's (1972) discourse of knowledge and power, and is supported by the finding of Westfall and Benoit (2008), that experienced mothers are more likely to resist medicalisation compared to prospective mothers who are experiencing their first pregnancy.

Responses from women who resisted the hegemonic medical management of their pregnancies showed how they positioned themselves regarding the decision on where and how to give birth to their babies. These women sought out and maintained a good knowledge of what is 'normal' childbirth using various Internet forums, personal experiences and tapping into the knowledge and experiences of relatives and friends. This combination of experiences and knowledge transformed the women in this study from passive recipients of information and beliefs communicated by healthcare professionals about fat or 'docile bodies', to become active agents in conceptualising their own bodies and pregnancies as well as empowering themselves to take steps to resist medicalisation (Kornelsen and Grabowski, 2006; Walsh, 2007). This hindsight awareness and knowledge that their previous pregnancies were medically controlled made them defiant and resolute about holding on to their preference for a midwifery-led birthing centre rather than a medicalised birthing unit. The confidence or reassuring value of women's previous experience of antenatal care, knowledge of their

bodies and their awareness that it did not negatively impact their previous pregnancies and childbirth put them in a position of relative power to make informed and independent decisions. This is expressed in the following response by Piper:

"...Every time I see somebody, we go through the same things the same questions three normal deliveries, any other problems, any other health issues, ... that's it my blood pressure's fine, everything's always been fine ... I've got other children through normal deliveries. I've had three previous that's fine, there's no reason it should cause a problem this time, but these policies are that I have to see these people that and ask all these points, and they it changes all the time, and they seem to focus on it more every year, and so I've got to have these extra things ..."

Piper is convinced that she is very well in her pregnancy irrespective of her high BMI. She has learnt from her previous pregnancies, and that knowledge has helped her to be unwavering in confidence in the capacity and ability of her body to give birth 'normally'; that is with the traditional support of midwives, which exclude medical intervention.

Rita's response below also reaffirms the assertion of Piper. She supported the view that the content and form of obstetricians' communication regarding risk can potentially cause women to doubt their decision about having their babies in midwifery-led units. Rita and Piper agree that the doubt created by obstetricians in the ability of pregnant women with high BMI to deliver their babies in midwifery-led units without exposure to significantly high risks is a strong motivation for women to reconsider their decision to give birth in a midwifery-led unit. Women who submit to doubts and fear effectively yield or give the power to make the decision to their obstetrician. Her response below painted her experience and how she

navigated making the decision to act against the advice she received from the obstetrician:

"...won't say I'm not worried especially after you've been to see the obstetricians, they kind of scare you a bit. They start by saying you know this can happen because of your BMI, that can happen because of your BMI. You understand that as a result of this ...you can have blood clot and It got to point; I said to myself you know what? I don't give a ...I'm not going there to have my baby. I'm going to the midwifery-led one. ...and I'm going to pray that everything go well. What? They just scare you; I don't want to give them that power to that at the point of birth. Oh no, not again ..."

Piper's expression showed that her previous pregnancy was highly pathologised though her actual experience of childbirth called into question the accuracy of the advice she was given. As a result of the learning from her previous experience, she was able to use the power that knowledge created to safeguard her decision. The extent to which she had to exert that power is seen in her submission below:

" ... I had to argue last time when I had (mentioned name), who is two to be able to go to the birthing centre at (mentioned name), I had to go to the other consultant midwife for her permission to give birth in the birth centre, due to my BMI and I had to request if I could have a water birth, I had to have her permission to be able to have a water birth, because they had to be happy that I could get out of the pool by myself if I needed to get out quickly because I was such a high BMI would I'll not be physically capable of getting out of a bath, I had no idea how they think I was myself and everything beforehand, if I can't get out of a bath! On my own, then there's something wrong, but anyway, I got their permission,

but I didn't need it in the end anyway, because I only had half an hour from getting there to actually giving birth so I didn't use the water birth anyway but I had her at the birth centre ..." (Piper).

This concurs with Heslehurst et al., (2013) where women reported that they were denied access to services such as birthing pools. Piper adopted a strategy to manage her risk status identity, by drawing on lines of events in her past consultation whereby risks factors were mentioned again and again even though she felt good about herself. She arrived at a healthy status identity based on the fact that she ruled out diabetes, high blood pressure, and other health issues that would have made her a potentially high-risk, pregnant woman. This awareness of self that makes one adopt and manage designated status has been referred to as "management of a fat identity" by Degher and Hughes (1999, p. 11). Responses from the women in this study attest to their awareness of the risk status that has been ascribed to them but also demonstrates the strength, determination and belief that women use to counter the risk-identity they had been given by healthcare professionals. They perceived themselves as women with a high BMI but also as being in very good health given that they do not have any medical or health condition to prove them otherwise, and this could be observed in their confidence and eagerness to want a 'normal childbirth.' A similar comment was given by Khadijat who also insisted she would want to have a home birth because she felt she was up for it:

"... I can't be bothered with their scare tactics...I'm going to the birth Centre irrespective of what they say. Like I said before, I've had three children before in Africa and all normal delivery ... so why should I be worried about another one. It amazes me what they do in this country. I can't really be bothered me ...Back then home (Africa) I was even fatter than this but very active. I don't understand really; I think it's all scare tactics. I've decided, its Birth

Centre for me ...like I said before, we are big people in my family, and all my sisters are big so, I'm just ok with my decision. Besides, I pray too, and my mum is also praying for me..." (Khadijat) .

Khadijat's account and conviction which showed that she is capable of having a normal childbirth is an indication that she rejected pathologisation by every means. It is also a strong reaffirmation of her trust in the capability and ability of her body. Drawing on the Foucauldian concept of resistance, it can be asserted that these are instances of resistance against the biomedical perception and framing of fat or big bodies and the discourses of uncertainty and risks ascribed to the perception and framing. Khadijat, in assuming or adopting this position of relative power, drew strength from an awareness of family genetics as an added justification to what seems to be normality to her. She also drew on her faith in prayer to remain steadfast to her decision to go to the midwifery-led birth centre.

Another pregnant woman who had experienced the maternity system, and was concerned about the lack of support for her decision to have a homebirth from her obstetrician is Emma. She stressed the fact that in her last two pregnancies, she was not versed enough to resist being guided to the consultant-led unit. Here is an excerpt from her data:

" ...it's just been the fact that every registrar ...has had a slightly different viewpoint on whether I should be in hospital or whether I should be allowed, 'allowed' to birth at home ... when umm when I pushed for the home birth option this time err my midwife I was referred to a consultant midwife and my midwife discussed it with her and she said well "as long as she stays as active as possible I don't have a problem with it" and actually that makes a huge difference to your frame of mind because I think there's this- this gap between ,midwives and consultants where quite often, midwife will go "yeah there are loads of choices here" and an obstetrician will

go "no I want you on labour ward in case something happens..."
(Emma)

On how she decided to choose to have her baby at home, Emma had this to say:

" ...I'm at an advantage because I've got a friend who is an independent midwife and who is very pro homebirth and very pro-choice and ... (sighs) sort of alternative options and I think probably she's helped me a lot because she said "well you don't have to so it that way" and until I- until I met her I probably would never have thought about having a baby at home, it would never have entered my head, that it was safe and possible and a real option and so I think it's difficult I and so far, my midwife has been very supportive of my choice..." (Emma).

Emma's source of knowledge and confidence is different to Piper's. For Piper, she learned from her experience and became determined not to leave the decisions regarding her birthing site to others. Having previously had experience of a successful birth, and in the pool and safely too, she was resolute in her present pregnancy to repeat the same. As demonstrated by the responses of Piper, Khadijat, and Emma, the sources of confidence and determination to independently exercise the power to choose can be in various forms. For Piper, the construct of safety in her request of 'normal childbirth' emanated from her past experiences and the knowledge about her body. It was a family experience, and the knowledge and beliefs in her family genetics that Khadijat relied on to justify her request for normal childbirth, while for Emma the support of her friend and midwife was an additional motivating factor in her determination to exercise her power of choice in her present pregnancy. Her friend encouraged her to engage with

her midwife about her desire for a home birth, and she was encouraged by and relied on the support from her midwife in her decision to have her baby at home. Piper, Khadijat, and Emma gave reasons why they felt they would not succumb to the biomedical construction that is shaped by a claim to the authoritative knowledge about childbirth (Fox, 1993). These women validated that knowledge and the power it engenders, or a lack of it, can impact the decisions and choices made by individuals. To ensure that all pregnant women are empowered to make free, independent and informed choices regarding the antenatal care they receive and to ensure that a woman-centred service is provided for women, efforts should be made to ensure that pregnant women can access objective, accurate and complete information regarding their particular situation so that they can make meaning of the concept of risk regarding health and wellbeing. Also, they should be provided risk information which includes the nature and attributes of risk. This should include the statistical application of risk concepts to health outcomes, for example, is a particular risk expressed as absolute or relative risk or does a particular risk have an associative or a causative link to a negative outcome (Renner et al., 2016).

Understanding this complexity of the concept of risk will help pregnant women to evaluate and validate their decisions to go for a particular birthing pathway. The ways of making meaning in relation to having 'normal childbirth' are what they have explained in their excerpts, and it makes clear their rationale for refusing to conform to the controlling power of the medical gaze which creates docility (Walsh, 2010) in women.

The findings support the argument that women who have a construction of 'normal' birth outside the prevailing medical construct and who, because of their knowledge, experience or associations, are confident in their ability to give birth normally presents as relaxed in their feelings and emotions, which in turn evoke an attitude of confidence throughout their pregnancy and

during childbirth contrary to the feeling of fear and uncertainty that initially set in after the risk discourse with consultants. The likelihood and potential for risk discourse to evoke uncertainty and arouse emotions of fear in women is attested to by Reiger and Dempsey (2006).

Though the majority of the experienced mothers in this study were determined to ask for, and stuck to the decision to have, their babies to be delivered in the midwifery-led unit; it was not the same for Charly. Charly has had two previous pregnancies but reported a different perspective of her high BMI risk status contrary to those of the other six women who have had experiences of previous pregnancy. In her view, the fact that heightened antenatal care is available to her is a good thing, and she believes that the suggestion that she has to give birth in the consultant-led facility is equally necessary to guarantee the safety of her child's birth. She conformed totally to the hegemonic medical construction of risk in pregnancy with high BMI as she commented that medical science has figures for a reason. Here is her comment:

"... I don't have an issue with err knowing that there is provision in place, and there is a recognition that I may need access to provision, if that means, if statistics say that I may need provision more because of my BMI then I would much rather than knowing that there is provision, and there is the recognition that I need to access it..." (Charly).

Charly's assessment of her meeting with her obstetrician reflected total acceptance of the risk communicated to her as well as the advice given by her obstetrician as a result of the risks profiled by reason of her BMI. The acceptance of the hegemonic medical construction of risk in pregnancy with

high BMI is not always accepted by women who have previous experience of pregnancy as Charly has done. A plausible reason for the exceptional stance taken by Charly is found in the explanation offered by the Rational Theory of Choice (Scott, 2000) discussed early in this thesis. According to the Theory, Charly has ranked her desire for a midwifery-led birthing site lower than the premium she put on the security of having her child delivered at the obstetric birthing site, because of the provision in the obstetric unit and the increased certainty it offered. Other women with a similar experience may also accept the construction of risk to varying degrees and as a consequence be willing to accept the advice to allow their pregnancy and antenatal care to be medicalised or consultant-led against their preference for a midwifery-led antenatal care setting. This is demonstrated in the response given by Nikky:

"...No I mean I just want to prove that my last pregnancy delivery was absolutely fine, and I just want this one to be exactly the same. And everything be okay, and me not put any extra strain on the NHS or anything. But I'll do my bits to go to (mentioned name) rather than (mentioned town) you know to make sure the care is there if I need it but it does seem a little unfair that I can't just go into a Birth Centre because of my weight..." (Nikky).

The contrast in the responses from Charly and Nikky is indicative of how different personality is shaped by knowledge of self, individual's risk propensity and the value ascribed to the views and advice of an expert. These factors may also have varying significance in persuading an individual in their willingness; or otherwise; to shift ground in their decision making. Individuals may, therefore, feel a need to reduce uncertainty by accepting alternative options, backed by expert knowledge even if it conflicts with personal preference. In this case, the uncertainty about self and the subjectivity of the probable risk profile was enough for Nikky to adopt a

submissive position and cede the decision to the advice of the obstetrician (Harper and Rail, 2011). They asserted that 'women's self and subjectivity' emanates from several discourses and construction that shape society and experiences within it. They further emphasised that this could involve conflicting desire as suggested in Nikky's comments. Harper and Rail (2011) explain that the willingness of some women to accept the preferred option of obstetricians to their own options comes from women's ability to recreate or entertain patriarchal controlling relations. Additionally, women position themselves within fault lines of maternal responsibility as they would blame themselves for not being able to maintain what they feel is the supposed healthy weight before getting pregnant if something did actually go wrong. Feminist scholars have raised concerns about the "de-responsibilisation" (Harper and Rail, 2011 p. 9) of neoliberal government about the health of its subjects and the willingness to allow pregnant women to be held responsible for the health of their unborn child and their entire family (Lupton, 2012b; Rail 2012). Raphael (2003) pointed out that neoliberal order has failed to recognise the day to day challenges that face the lives of these women, and which is the result of framing social issues like health or medical problems which then affect people's lives by piling additional pressure on them. Charly clearly stressed how the continuous emphasis of how BMI risk would impact on the unborn child and could evoke feelings of guilt in women and make them hold themselves responsible for the health of their unborn children and families.

"...I mean ...after this – you know I have my own ideals of whether I want to lose weight or not at this point is not about me it's about the baby ... I get the benefit as a bi-product, it's a bit of looking out for the baby, so I gain, there's a double gain err, because you feel, yeah my responsibility, for the rest of our lives [she laughed] my responsibility now for the rest of my pregnancy is to make sure that

actually is about the baby needs, but I benefit because it is good for me as well, but it's based on what the baby needs..." (Charly)

Nikky also made a similar comment:

"...I supposed I was a little bit cross with myself because with my higher BMI with my second child, and I should have learnt from having my first child, the experiences with the local Trust in terms with the extra care you receive with the BMI err, so I could have done something between pregnancies but time and life gets in the way doesn't it? [Laughed] ... yes, the reason is being because of my weight really, nothing else because of my health because I've got a total clean house, no history of any health issues ... I had a perfect normal pregnancy last time and a normal delivery ..." (Nikky)

The stance adopted by Nikky and Charly suggests strongly that pregnant women with previous experience of pregnancy who chose not to assert their desire regarding how and where they would want to have their babies did so because of several reasons. Women apportion blame to themselves for failing to attain the body weight recommended by biomedical framing for a healthy BMI before becoming pregnant. As a result, pregnant women hold themselves responsible for the unborn child and to others who are perceived to have an interest in the wellbeing of the unborn child. This feeling of self-blame and self-imposed responsibility compels women to do whatever is necessary to ensure the safety and wellbeing of their unborn child. The result is that, though women may hold contrary views to obstetricians, they still submit to their preferences which increasingly results in the pathologisation of women's bodies and pregnancies. This response by some women is further motivated by and is a reflection of the mounting pressure on pregnant women to self-regulate their bodies (Harper and Rail, 2012).

Biomedical discourses promote the idea that a woman should regulate her body to achieve a healthy pregnancy to protect the unborn child (Martin, 1987; Lupton, 1999; Weir, 2006), and this creates added pressure for women to conform to this medical expectation, which is equally shared by the wider society as evident in the response from Charly.

According to Parker (2014) responsabilisation is an initiative of the government to get individuals to actively embrace full responsibility for their health. Participation is through the regulatory interventions in how society and how individuals manage health risks and safety. Biomedical science used the same premise to ensure that individuals are 'responsibilised' (Parker, 2014.p. 104) into thinking that the management of these risks are in the terrain of individual control by means of self-discipline (Foucault and Rabinow, 1984).

Scholars who raise questions about the justification of 'the obesity myth' and its uptake by the popular media and adoption in health policies (Wray and Deery, 2008; Rail, 2012; Lupton, 2012b) view the focus on obesity, not as an objective to advance biomedical knowledge but, as a bio-political agenda. They believe that the mission of the bio-political agenda is to discipline the population and create a state where citizens will not be a burden on the national healthcare system (Rail, 2012). The political establishment seeks to monitor and control the weight, food choices and intake (Lupton, 2013), and perceived risky behaviour such as smoking and alcohol consumption of members of the state. This is done through regulatory interventions or through the medical gaze and surveillance in the form of guidelines and rules. These health rules and regulations are meted out to pregnant women during visits to their healthcare professionals with justification drawn from professional bodies as well as highlighting reports from evidence-based practice within healthcare settings in general as well as in maternity care, in particular.

Women's integration of knowledge: Religion and science

Interestingly, a theme that emerged during data collection is prayer and superstition among women. While some women reported they trusted in prayers as part of the means of coping with having their pregnancies classified as high-risk, others depended on other forms of superstition. Renee' said due to stress from work, she was unwell, then she stopped working, and they moved house, and somehow because she now had a new kitchen, she began eating well, and they prayed, and she became pregnant. Recalling events at about the time she became pregnant, Renee' indicated that:

"she was happy that she got pregnant at the time. She and her husband were ready for a child. Renee' said that they had moved house to their present home where the interview took place, and she was happy that she had a new and beautiful kitchen, where she hoped to cook healthy meals. Then she went further to reveal that having been married for a while, it was time they had a baby. She said they prayed, and she became pregnant. She went ahead to comment on not being able to find a church she and her husband would love to be attending. The reason for this was that the church they used to attend had moved to a bigger accommodation as it had become a very big church. According to her, they made an effort to attend at the church's new location, but they could not feel the same about the new church as they felt in the old church. So they stopped attending that church, but they still pray at home". (Field notes)

Renee', like other participants, did not dwell a lot on religion but the power of prayer. She expressed disappointment at not being able to find another church to attend, but she was happy to keep praying at home with her husband. It has been found that people pray for health, wellbeing and

respite in times of illness (Andrade and Radhakrishnan, 2009). Also, prayer is often used interchangeably with spirituality by scholars (Koenig, 2012; Blando, 2006) and has been portrayed as having a foundational impact on healthcare for centuries. However, this belief or perception became overshadowed by the arrival of technological advancements in diagnoses and treatment around the early 20th century (Qidwai, Tabassum, Hanif and Khan, 2009). According to Qidwai et al. (2009), despite the fact that these advances save lives, it moved the traditions of medicine away from holism and service-oriented paradigm to a technological and reductionist approach. Some women expressed heavy reliance on praying for a positive outcome from their pregnancy through to childbirth. For example, when Khadijat gave an account of her experience, she mentioned the fact that her family back home in Africa were praying for her, as they are all aware that she was expecting a child. She went on to relay how her mother was praying for her daily and that she would continue to do so until she gave birth to her child. She states:

“...I’m just ok with my decision (to go to the birth centre). Besides, I pray too, and my mum is also praying for me, it’s a family tradition we all pray for one another, and now that I am pregnant it’s an additional reason for everyone to pray for me .. I’m a Muslim, and I have strong belief that with Allah everything is possible I pray five times a day” (Khadijat).

Pat reaffirmed Khadijat’s views and beliefs. She emphasised her faith and reliance on the providence of God, and asserted that:

“...I am a Christian, so I just pray about these. Because I’ve had babies before, with this same body weight, so why should I worry, but sometimes, you can’t just help it, you still find yourself worrying about it especially after visiting the obstetricians ...besides my

family back home are aware that I'm expecting, and they are all praying for me... with God all things are possible...so I'm not worried like I said before science is good, but it is not everything, God will help me, He helped me with my other children so He will also help me with this one. I always pray without ceasing; I always pray so ..." (Pat)

Rita, the third participant to affirm drawing strength from her faith in prayer, described how she reacted to the feeling of doubt and anxiety that her visit to the obstetrician evoked in her when she said:

"...Whenever I return from my obstetrician's appointment I just go on my knees to pray; those people will scare you to death. The things they talk about, none that I've heard of before, my midwife was a bit lay back about it, all these issues about DVT and the rest ...I just pray, and I believe strongly in the power of prayers, and I have people who are with me in prayers as well ..."

The proportion of women participants, 5 out of a total of 12 women, that professed their belief in the efficacy of prayers to help them cope with the fear and anxiety which came with the association of high-risk with their pregnancy, as well as drawing confidence that they will have a safe childbirth is significant enough for the faith and spirituality of pregnant women to be considered by healthcare professionals when they conduct assessments of women. Qidwai et al., (2009) also suggested that people, who have belief in the power of prayer, sometimes rely on others to pray for them. For Khadijat and Pat, they pray frequently, and it is quite clear that they believed in the ability of God or a Higher Being to intervene and ensure they received an outcome that they would be happy with. This is also congruent to the study by Aziato et al. (2016) where meditations were connected to positive health and wellbeing. However, some previous studies

of pregnant women with high BMI (Nyman et al., 2010; Furness, et al., 2011; and Furber and McGowan, 2011) which were reviewed for this study did not reveal this phenomenon of women seeking solace in prayers and reliance on the benefit of other family members praying for them.

Obstetrics and midwifery: Competing or complementary knowledge

Constructs of professionalism frequently represent character traits and attitudes rather than behaviours (Mason, Vitkovitch, Lambert, and Jepson 2014). Professionalism demands that a member of a profession can demonstrate a commitment and ability needed to ensure that his or her practice demonstrates the values that will achieve the objectives that members of the profession agree to and adopt, as the key to quality outcomes for the profession. According to the Department of Health (2013, 2015), healthcare practitioners are regulated to ensure that high quality care is provided for service users in the UK. The professionals that are involved in the provision of antenatal care for pregnant women in this study are mainly midwives, obstetricians, and sonographers. These professionals, who have been collectively referred to in this study as healthcare professionals, all work within principles and pronouncement that are provided by institutional bodies invested with the responsibility of ensuring good delivery of healthcare. One such body is the Department of Health (DoH) which in the bid to provide women with the best individual antenatal care that suits each particular woman's circumstance, recently produced a document, entitled NMR (2016), which is aimed at enhancing antenatal care and childbirth for women. It recommended a new maternity care approach for midwives to adopt in caring for women. The document calls for women to be provided with continuity of care. Also, part of the objective of the NMR (2016) is for women to be enabled and encouraged to exercise choice and control over the antenatal care that is delivered to them. The approach, which because of

its radical style was described as new, also opened up the opportunity for midwives to practice beyond doubt as autonomous professionals (Sandals, 1995). The Changing Childbirth Report (DoH, 1993) was followed-up over a decade later with a renewed recommitment to women, which guaranteed women and their families high-quality maternity care (DoH, 2007). The document recommended that women should be given a choice of the birthplace of their child. In doing this, information that women needed to know in respect of decision-making regarding where they want to give birth to their baby, should be provided to them. As part of ensuring that women received relevant and appropriate information, the report emphasised the expertise of midwives who provide care during pregnancy and birth. The choice for women and their families was a key objective in the 2007 DoH document. Despite the various recommendations (DoH, 1993, DoH, 2007; and NMR, 2016), women in this study reported a lack of recognition of their views, aspirations, and expectations regarding choice and involvement in decision-making about their care and how they give birth.

Despite the high premium that has been accorded to women exercising choice and getting involved in the decision-making about the care delivered to them from the publication of the initial document, Changing Childbirth (DoH, 1993), which was followed by Maternity Matters (2007) to the recently published NMR (2016) this study found that women have not been able to actively participate in decisions affecting them or exercise choice. The findings from this study reveals that though most women, even after they had been advised of their high BMI classification and the risks associated with it, reaffirmed the choice to give birth at the midwifery-led unit, their choices were discounted and they were assigned to consultant-led units to deliver their babies. It is important to state that the decision to overrule pregnant women's decisions as they go through the antenatal care system was more often from obstetricians. Women in this study reported that their midwives were open to their choices and decisions and actively

supported them in their decision to give birth at their preferred birthing site but they were however overruled by obstetricians as they generally deem it safer for women to give birth in the obstetric consultant-led unit. This report by women that their midwives who directly provide them with antenatal care do not have the authority to evaluate and validate their decision is substantiated by Tessy, a midwife. She agreed that midwives do not have the final say whether a woman, because of high BMI only, should or should not give birth in the midwifery-led units as stated below:

"...at the end of the day, we let women explore every option there is, in order for her to make an informed decision,if a woman's BMI is 40 for example with no other health issue, and she wants a pool birth, I'll will tell her it's ok but we'll need to speak with the consultant midwife and the obstetrician about her decision...that's protocol because she is perceived to be a high risk due to her high BMI. We even have one at the moment ...her BMI is 45, and she has no other risk factor, and she wants to have her baby in the midwifery-led unit. We'll give her every support that she and her family needs". (Tessy, midwife).

To validate Tessy's agreement for the woman to have a pool birth, an obstetrics consultant agreement had to be obtained through the consultant midwife. Tessy's account of support given to women in the decision-making process about birthplace is not absolute in the sense that she still needed to consult with either the Trust's consultant midwife or the obstetrician providing antenatal care for the woman, about her decision. This raises a few questions regarding professionalism and the status of the various professions engaged in the provision of antenatal care for women in the shared antenatal care pathway. One of the questions is whether midwives have autonomy in every aspect of their practice of providing care for pregnant women if they can be routinely overruled in their professional

assessment by other professionals, or if they need obstetricians' authorisation of their professional assessments before it can be implemented. The second question is whether the benefits to service users, in this case, pregnant women, can be deemed to have been optimised when different teams of professionals do not explicitly agree to a single optimal option for women, but rather uphold different opposing positions that can neither be aligned nor reconciled.

Midwives interviewed in this study mentioned their discussion with pregnant women in their care about the options available to them as to where they wanted to have their babies. According to Blix-Lindström et al. (2008) such discussion regarding options helps to include women in decision-making regarding a key event in their pregnancy and antenatal care journey and it is empowering for pregnant women as they see their input in the decision about their choice of a birthing site as valued and respected. The midwives in this study did not express an inability to ascertain whether women in their care were not able to give birth in the midwifery-led unit, but their accounts painted an environment within the antenatal care setting where professionalism, at least from the perspective of midwives, is being undermined as enunciated by Becky's comment:

"... a lot of them don't want to be shared care ... err, and I tell them that they can actually say ... to the obstetrician they don't want to be shared care and nobody can force them to do it ... I tell them why they should be shared care; it depends on the woman really ... some women believe that they're not different from anybody else why should they be classed as high risk just because they've got high BMI, ... but I still refer them to see the obstetrician ... due to protocols and policies I have to refer them if their BMI is over

certain level... due to policies, protocols and procedures I have to book them for glucose tolerance test ...if I don't do that, I will get in trouble for that even though I don't agree with that cause – most of those majority of the time come back as negative ... you don't have to have a high BMI to have diabetes ..."

In Becky's account, she expressed the need to take seriously her responsibility to the pregnant women she was providing care for as well as respecting and adhering to her professional boundaries as a midwife. This is an aspect of professionalism; it allows professionals to seek a balance between the regulations and guidelines of their professional bodies as well as the value needs of their service users or clients. As a result, Becky ensured that she followed due procedures, protocols, and policies including those she did not believe in.

Women in this study reported a lack of support from obstetricians when discussion of the topic of choice about where they would be having their babies took place. They reported receiving more support from their midwives compared to obstetricians. Pregnant women asserted that obstetricians and consultant obstetricians focused excessively on the risk of high BMI, which they used to justify the recommendation of a consultant-led birthing unit. Women, in general, agreed that they came out of consultation with obstetricians feeling that they would not be doing the best for their unborn babies if they refused the advice for a consultant-led birthing site. This feeling explains why the majority of women who accepted obstetricians' advice recommending consultant-led units, were first time mothers to be.

This finding emphasises the need for clear professional boundaries within antenatal care to be established for decision-making regarding the care of

pregnant women in shared antenatal care pathways. For example, midwives and obstetricians should independently assess and produce a report of their assessment for suitability of how women's childbirth should be managed. This should take into account the woman's views and expectations. These two separate reports should be combined by highlighting areas where midwives and obstetricians agree in their assessment and where they differ. This final report should then be made available to women and used in confirming the discussion and decision about the birthing site with women. This will initiate a conscious effort to address the conflict inherent in identifying where the authority for specific tasks or procedures lie in shared pathways of antenatal care, which has up to now been given limited attention in healthcare (Hunter and Segrott, 2014). The maternity setting is a terrain encompassing a mix of different interests or focus which include; amongst others; medical science, midwifery philosophy and structural forces (De Vries, 2004). According to Hunter and Segrott (2014), the maternity setting is characterised by conflicting perspectives to childbirth and competing claims to knowledge and professional jurisdiction. By exploring the authority boundaries in shared antenatal care for women, the issue of contested boundaries, claims and counter-claims to knowledge advanced by midwives and obstetricians and how they are played out can be reconciled. Where the positions are so divergent that they are irreconcilable, it will afford a reduction of the gap or differences that exist between the two groups historically and which dates as far back as the 19th and 20th century (Witz, 1992). Arguably, the tension within maternity care is such that while midwives support 'normal birth', the obstetricians look for abnormality using scientific evidence (Hunter, and Sergrrott, 2014). However, evidence from this study points to midwives being the subordinate group in maternity settings historically, working behind the scene and shrouded with the impression of compliance, as they do not challenge biomedicine openly. This

shrouded strategy is believed to form part of the negotiated order which exists in organisations or departments within entities such as the maternity setting (Strauss et al., 1985) of the NHS Trust. Midwives and obstetricians employ the principles of the professional boundary to carry out their duties and tasks, and as they do so, they engage in their different professional discourses to legitimise their authority and expertise by demonstrating different ways of working with women as reported by participants in this study. For example, when obstetricians were asked whether it is in all cases, that women with high BMI have poor outcomes during pregnancy and childbirth the response from an obstetrician was:

"...I do have some women who are disappointed they don't fit the criteria to go to the birth centre, and some women who have had normal deliveries before with a BMI of thirty-six or thirty-seven they really think why they can't go to the birth centre, but we've got to have a cut-off, we've got to have a guideline, and it is just a guideline, it's not set in stone....we usually come to a decision that the women are happy with either way, but don't want to put the midwives in the birth centre under stress and make it difficult for them to care for a woman down there you know they've got to be protected as well as the women, and that's why we've got guidelines in place to protect everybody really, the midwives and the babies and the mums..." (Obstetrician A).

The view expressed above views midwives as needing protection that obstetricians did not have need of. In other words, obstetricians as the senior partners in shared care assume in addition to delivery of care to pregnant women, the additional role of safeguarding midwives. This display of power and authority has been observed by pregnant women as encapsulated in the submission by Emma:

“ ...it's just been the fact that every registrar ...has had a slightly different viewpoint on whether I should be in hospital or whether I should be allowed, 'allowed' to birth at consultant midwife and my midwife discussed it with her and she said well “as long as she stays as active as possible I don't have a problem with it” and actually that makes a huge difference to your frame of mind because I think there's this- this gap between midwives and consultants where quite often, midwife will go “yeah there are loads of choices here” and an Obstetrician will go “no I want you on labour ward in case something happens...”

They do this because of an inherent belief in their position in the hierarchical structure of power and authority. Obstetricians justify ways of working with scientific-based evidence and guidelines, and they tell women what they perceive and believe is based on biomedicine hence, obstetrician A, suggested that some women ended up disappointed after being refused birthing at the Birth Centre. This obstetrician acted, based on biomedicine with an emphasis on risk, danger anticipation and an interventionist approach which is embedded in the medical terrain. Obstetricians insisted on working within guidelines and professionalism as seen below in obstetrician B's declaration that:

“...I talk about the carbohydrate and protein proportions I say to them there is no excuse, it's not a reason to eat more in pregnancy, I tell them that there is good evidence about exercise in pregnancy if they ask there is a guideline on our RCOG give them the website for them to read it themselves, I encourage going for walks or swimming I don't expect them to go for marathon ...” (Obstetrician B).

When asked about how women are approached about their weight during pregnancy, obstetrician C reaffirmed obstetricians' inclination to use pronouncement in guidelines to ensure that they meet the criteria set for delivering care to pregnant women. Obstetrician C submitted that:

*"...I think that's the most important thing so they need to be just told that they are being sent here because there are new guidelines, new protocols which state that you know, you need to have a GTT at 26 weeks, you need to have a scan at 34 weeks, and it's just for that they are being sent in, now that's one way of looking at it. Now, the other way of looking at it, is there's no reason for a patient to come to the clinic for a GTT to be arranged, the community midwife would arrange it with the hospital, unless they feel for example this woman is only a BMI of 32, which to me by itself is not a problem .
"...at the end of the day it's protocol isn't it, we have to follow protocol isn't it we cannot go against protocol and guidelines, and when it comes from NICE or RCOG or something, we have to do it ..."* (Obstetrician C).

Analysis of the responses from obstetricians reveals the same theme observed in the submissions of midwives regarding compliance with some aspects of applicable guidelines without truly subscribing to the substance of the provision, protocols or directives within the guidelines. This is a reduction in the capacity of healthcare professionals to exercise professional judgement which is a key aspect of acting professionally and ensuring that clinical or healthcare decisions are always made for the benefits of the individual, pregnant woman who is the service user. This may also explain why obstetricians justify their decision and action by invoking authoritative medical knowledge (Jordan, 1997) as a means of validating their decisions and actions rather than seeking to rely on their professional skills, attributes

and values, judgement and experience when making decisions regarding women's pregnancies, their choices of the type and setting of their childbirth and the childbirth process itself. Midwives, on the other hand, though they emphasise holism, physiology as well as emotional support for women (McKenzie Bryers and van Teijlingen, 2010), are not able to use their beliefs, experience and knowledge of years of caring for pregnant women, and their observation of individual women to make an assessment of the suitability of an individual, pregnant woman to be able to give birth without medical intervention. The data from this study also demonstrates a lack of clear professional boundaries on how they provide antenatal care for women; however, there were instances where women felt that their midwives were more supportive of their high-risk status than obstetricians. This is because obstetricians focused more on risk in their consultation with pregnant women contrary to the communication women have had with their midwives. It can be argued that the lack of professional boundaries within antenatal care settings is in part responsible for the conflicting view of risk perceived by pregnant women. Midwives, who view themselves as the junior member of the partnership in the provision of shared antenatal care, unconsciously or deliberately ignore or avoid the full discussion of risks in pregnancy, leaving it for obstetricians who view themselves as the senior or superior partners in the shared antenatal care team to pick up. This finding is congruent with the Hunter and Segrott (2014) study about professional characteristics in maternity care. They found that professional boundaries enabled midwives to exercise relative power within the midwifery-led care, but they lacked the autonomy to uphold the decisions of women in shared antenatal pathways to give birth in midwifery birthing centres unless it is approved by an obstetrician.

Conclusion

This chapter focused on the experiences and perceptions about risk discussion, concurrence, resistance, as well as the beliefs in the power of prayers by pregnant participants. The chapter also analysed the concept of professionalism within maternity settings as the two models of antenatal care is perceived to be overlapping.

The chapter discussed the impact of a lack of effective communication and how it impacts on the manner of risk discourse. It asserts that because the risk of high BMI to pregnancy or how high BMI poses risks to pregnancy was not effectively discussed, women were disadvantaged when they needed to make a decision or exercise a choice about their care.

The analysis showed how a number of pregnant participants; particularly first-time-to-be mothers complied with medical surveillance on account of their pregnancies. Pregnant women provided evidence of them accepting that doctors and midwives are the experts because they are medical professionals, and therefore, they know best and whatever antenatal care is suggested by healthcare professionals should be okay for them. As a result, prospective first-time mothers showed no resistance to any form of surveillance around their pregnancies. Although women in this group mentioned that they were not particularly happy about the extra screenings and tests.

Meanwhile the other group of women, made up of experienced mothers, resisted medical surveillance and asserted themselves. The chapter identified the reason some of the women in the study were able to make a choice outside the recommendations of obstetricians while others accepted it as the only safe and prudent option. Those who resisted, challenged subjecting their pregnancies and childbirth to extra medical screening and

surveillance. These women resisted medicalised antenatal care by relying on experience gained from previous encounters with healthcare professionals and previous experience of pregnancy and childbirth. These experienced mothers characterised themselves as knowing because of their learning from previous experience of pregnancies, encounters with healthcare professional and childbirth. So when the time came for choices about birthplace, these experienced women resisted and held on to their knowledge about knowing their bodies better than anyone else. A number of women expressed beliefs in the power of prayers. Women's concerns about the risks status emanating from risk discussion with healthcare professionals appeared to have resulted in women seeking solace in prayers. Findings in the data analysed asserts that apart from praying for themselves, they also have other family members who pray for them.

In line with the literature, pregnant women with a high BMI encounter various healthcare providers during their pregnancy. Women in this study only discussed their experiences with three of the healthcare professionals that they came into contact with. They are midwives, obstetricians and sonographers. These three groups of healthcare professionals do not meet to discuss the care of pregnant women they provide antenatal care for, and this both resulted in overlap and conflict in how women perceived the care they received. The construct of professionalism as discussed in the chapter supports the position that midwives and obstetricians demonstrate a commitment and the ability to do their utmost for women. However, this is limited by a desire to work within guidelines and regulations which they view as limiting professional judgement at best and excluding it, at worst.

Chapter 8

Reflection on my journey

As I approach the completion of my thesis, I still wonder whether or not a simple yet unassuming curiosity about the perception of fatness in a different culture could instigate a study at a doctoral level. The beginning of my journey was not what I would refer to as a smooth one. Just three months into my study my second supervisor with a specialisation and interest in midwifery left the University. Shortly after, my main supervisor at the time felt he had a high workload and suggested bringing in another supervisor to act as the main supervisor, while he acted as a second supervisor.

Fortunately, the lecturer he approached agreed, and after we had our initial meeting, he felt there was a dire need to get a midwife on board to act as a gatekeeper as I did not and still do not have a midwifery background. Again, just shortly after my new second and first supervisors settled into the supervisory team and started advising on how I could continue the journey, my first supervisor left the team. I was now left with my second supervisor (the midwife), a situation which prompted my initial or former first supervisor to come back and resume his role as a first supervisor. Again, there were still some unsettled times ahead as my initial supervisor who left and came back left my supervisory team finally just a few weeks after my first progression report presentation and my supervisory team as it is now, was put together. The team has since remained intact and provided me with much-desired stability, which is why I can truly say I have completed my thesis with an excellent team.

Upon reflection, it became apparent that I was inadequately prepared for the challenges that occurred while undertaking a thesis, especially one within a sensitive area such as overweight and pregnant women. Although I

participated in short courses about conducting qualitative research and the challenges that may arise, I was still concerned about how I would address the issue of high BMI or weight. This is because of the sensitive nature of risks communication and discourse about large body size or weight with pregnancy and the potential complications these may represent for women. As there was no course about handling sensitive issues during the early stages, my supervisory team made sure I was prepared for some uncertainties. For example, they ensured that I had a different telephone contact for my research participants, in order that they did not contact me randomly in place of their midwives. This established a boundary for me as a researcher, and I felt protected and supported. I also made sure my safety was paramount as I conducted my research. I achieved this by ensuring a family member or the research administrative staff members were aware of my research activities and were contacted before and after fieldwork for data collection. This is an aspect of research that that I found to be vital for safeguarding my safety and security and my research centre signposted me to the 'Social Research Association (SRA, 2003) Code of Practice for the Safety of Researchers' (SRA, 2003). It was reassuring to know that my research centre gave strong consideration to safety because the issue of maintaining boundaries and distance in field work was mentioned in passing during orientation at the beginning of the journey.

The Concept of Reflexivity

According to Parahoo (2014), reflexivity is a commonly used concept in qualitative research and it has been accepted as a method that qualitative researchers use to validate their research practices. Reflexivity is perceived to be a vital process in qualitative research as it allows researchers to reflect continuously on how his/her actions, values and perceptions impact upon the research process in terms of data collection and analysis (Gerrish and Lacey,

2006). Given the value that continuous reflexivity, and how the emphasis of reflexivity can moderate the impact of one's own values, perceptions and views, as well as that of their participants on the data collection and analysis, it has been emphasised as an essential element in the research process (Parahoo, 2014). The continuous reflection on how my proximity to the study may affect its outcome, was a constant reminder for me to present a comprehensive account that is representative of participants' accounts. This was essential preparation for me to understand my subjectivity in the research process. So when I met the overweight pregnant women I interviewed, I introduced myself to them as a mother who has had children outside this country. It is pertinent to make this introduction because the study explores how participants construct meanings of their experiences. It is also important to be mindful of the tenet of social construction, as it entails sensitivity to both the researcher and the participants' standpoint. In addition, recognising the role of subjectivity and bringing this as a tool in the whole research process did not only enhance the ethical integrity of the study but also enriched the analysis and interpretation of data (Mosselson, 2010). As much as possible I tried to maintain this social distance from my research participants, especially the women. This is because of the insider position that I shared with them as a mother. However, I particularly found maintaining this boundary with women blurry especially when they reported events where their pregnancies were positioned in risks and uncertain complications during visits to the obstetricians. Detaching myself from the effects of their feeling was particularly difficult because there were some blurred lines that kept reoccurring as women relayed their experiences, and these were taken into account especially with first-time-to-be mothers. I learned how, and used reflexivity to consider how my position interacted with my research participants. Discerning along the way what should be and what should not, and how this would improve the quality and whole research activity.

Reflections on the researcher/pregnant participant relationship

Though I would not claim to have developed a strong relationship with the women after discussions on the telephone and after interview in their homes and other places of their choice, I will state that I succeeded in creating a good rapport with the pregnant women, as evidenced in the depth of data that I generated from interviews with them. There were occasions when some personal information was volunteered by participants which I have classified as the 'off record' information. This has not been included in this thesis. Other evidence of participants feeling comfortable with me included when they left me alone in the living room to get dressed in appropriate clothes to walk me out of the house or when they offered me a ride to a point where I could access transport back home. Feminist studies have found that women interviewing other women have showed that the views of having an insider status, evokes trust and openness (Oakley, 1993; Hunt, 2004) and my experience affirmed their findings. While it is helpful to build trust and rapport with participants, Chaitali (2010) asserts that such situations can invest researchers with power that allows researchers the scope to exploit and prey on women's vulnerability. It was thus necessary to be aware of the possibility of preying on participants vulnerable state and not to pursue areas of enquiry that seemed distressing.

Like Bartholomew (2012) in her study of older African Caribbean women living in the UK, my embodied knowledge of pregnancy and childbirth, enabled a level of empathy which would not have been possible otherwise. Although there were subjective comparisons about how women felt about their experiences of discussions of weight by obstetricians, I was in most cases sincerely empathetic, though there were differences in situations. For instance, Agnes relayed her story about how an obstetrician told her off for

not taking aspirin, even when she explained to the obstetrician in question that the medicine was not prescribed. This made her cry, but it surprised me that she cried which indicates that she felt strongly about being told off by the obstetrician for not taking aspirin as at the time of her consultation visit. Whereas, it was a totally different story with Pat who said she laughed when her weight was mentioned during consultations as they sometimes sounded funny, and explained it stating that although she came out of the consultation room, sometimes feeling scared, there were occasions where she felt amused. I felt amused too, based on the fact that she took it the way she described it. Recognising the difference between women's views and feelings, and my response to their narratives drew my attention to the subjective nature of the experience of being overweight and pregnant. It also underlined to me the significance of not being judgemental of women's own standards, and reaffirmed the importance of seeing them as individual with unique experiences, assumptions, beliefs and needs. This is consistent with my initial intuitive position about individuals' perceptions and construction of experiences generally.

Intuitive knowledge in reflexivity

Intuitive knowledge implies an inner gazing which is different from a formal kind of knowledge (Alvesson et al. 2009). Most qualitative researchers are of the view that the researcher inevitably influences the production of knowledge by formulating research questions, attempting to and adopting particular methods and analysis and by interpreting findings (Yardley, 2015). The inevitable influence of researchers is unavoidable as any endeavour to completely eliminate the influence of the researcher, would make retaining the benefit of qualitative research difficult. Yardley (2015) further stated that the reflexive process, such as disclosure of subjective experiences during in-depth interviews, or insightful analysis of hidden or oppressed meanings which add to the richness of qualitative research would be lost.

Consequently, rather than trying to eliminate the influence of the researcher by strictly controlling the research process, qualitative researchers generally, seek to minimise the negative by actively engaging with research participants in the study. This thus, allows the participants in the study to influence the data through their responses to the open-ended questions asked.

When I started the journey I was aware and enthusiastic about the prospects of undertaking research around a topic I had a great interest in, and of course I knew too, that research would be difficult to complete, and I was not in any doubt that it would test my endurance. I had no awareness of where it would take me both on a personal level and in terms of my future career. Throughout the process, there were different kinds of emotions emerging. This ranged from excitement at the beginning to feeling low with the frequent changes in my supervisory team. I started feeling a different emotion when I started believing that my current team really wanted me to complete my research and would be there for me to the end. I felt enthusiasm as I picked myself up now and again to motivate myself to do what was needed to complete my thesis following periods of suspension. I suspended my study twice; first as a result ill-health and secondly to have and care for my baby.

I then saw myself as ready to complete the journey, as I did when I began the study. I did this by remaining positive and as much as possible, making the powerful, negative thoughts remain non-frightening. This allowed me to look ahead at the goal I had set myself. There were times I felt frustrated at not going beyond certain stages to achieve expected milestones. For example, the bottlenecks from the ethics approval process and the challenges to getting midwives for the study which was the only way of recruiting women for the study. Having encountered such challenges and successfully navigated them, and after collecting data from all the research

participants, I felt honoured to be given the opportunity to hear what women felt about their body size during pregnancy. The women I met during interviews expressed frustration; they did this because they were denied their choices. They relayed how they coped by using prayer and by chatting with other unknown pregnant women with high BMI on various 'pregnancy fora' and this was very enlightening for me. So, to relent and not to complete the thesis would have been disappointing to these women who confidently mentioned to me that they were counting on me for their voices to be heard.

Also, the view I held prior to undertaking the study was influenced by my cultural background. The African and Caribbean cultures that shaped my formative years does not perceive or frame fatness as a source of risk to wellbeing or as a factor associated with ill-health. While being excessively overweight was not encouraged, being moderately fat; which in BMI terms could be as high as 40 kg/m² was not a source of concern if it did not restrict the ability of individuals to go about their normal daily activities. Thus, I did not perceive or frame fatness as constituting ill-health generally or particularly being a source of risk to pregnancy. Epidemiologists ascribe to the view that being overweight whilst pregnant, constitutes risk to pregnancy but sociological scholars hold contrasting views about fatness and the individual's health or wellbeing. There are various sociological views of overweight, however, scholars such as Saguy and Gruy (2010), Puhl and Heuer (2012) contend that overweight is a body variation (i.e. occurs in various shapes and sizes which are seen as natural), a view that is also ascribed to by the researcher. The tendency to consider oneself overweight and healthy is congruent with my cultural view on fatness. However, I ensured this belief did not impact the way data was gathered by using continuous notes documented in my research journal/diary to enhance my reflection and ensure that I was constantly mindful of the need to be open and neutral. For example, selecting and re-wording questions before

and during interviews and ensuring participants remained on the important aspects of the interviews helped to keep the focus on the research. By being reflexive throughout the research process and making the research itself a focal point of analysis, I reduced the risk of being misled by my own assumptions, views, experiences during interpretations of data.

Reflecting on women's experiences as narrated by each participant also brought clarity to the point that most of the overweight pregnant women perceived themselves to be in good health irrespective of their BMI. Some women asked me why I was undertaking the study given that I was not overweight. I told the women that I was undertaking the study because of my personal experiences. Also, I informed the women that I was interested to know, if fatness constituted ill-health which in turn justified overweight, pregnant women being provided a different antenatal care to other women. It might have been beneficial to find out if caring for overweight, pregnant women under a different and dedicated pathway, was appropriate. I could not help but felt sympathetic towards women sometimes as they relayed their antenatal care experiences to me. Despite my feelings of empathy and my sympathy towards the women, it did not stop me from asking them the questions, that I had prepared to ask. Some of the women felt helpless and carried feelings of guilt, that if anything should happen to their unborn children, they were to be blamed for it. During interviews, some women asked me if it was fair that they were ascribed with the high-risk status solely because of their high BMI, I politely explained that I could not give any answer to their questions because I was a researcher and I was exploring their experiences and what it meant to them. As stated in chapter 1, one of the aims and objectives of the study was to explore the experiences of women with high BMI as well as those of their healthcare provider, it was therefore important to understand women's experiences in their own words and accounts. This helped to gain a better understanding from their own experiences as they had constructed it to me directly, rather

than through others. To have a complete understanding of women's experiences of antenatal care, it was also important to include their healthcare professionals whose experiences, of caring for overweight, pregnant women, were also examined.

The philosophy of care of most of the midwives interviewed is centred on the holistic model which acknowledges that women are at the centre of care provisions. Midwives presented a picture of helplessness sometimes as they gave account of their experiences about the care they provide for overweight pregnant women. This is due to the hierarchical nature of the organisational structure of the NHS. Midwives reported situations where their care decisions regarding overweight, pregnant women in their care were over-ridden by the decision of an obstetrician. Given this, midwives were left to support women using the word 'if' you are allowed. When asked why, they said the obstetricians had the final say about where women want to give birth to their babies, adding that obstetricians are perceived to be able to determine what is safer for women. When I asked midwives how women are supported in cases where women's choices were not granted, they mentioned telling women that, they could still make their choices irrespective of what their obstetrician had said to them.

Reflecting on the narratives of obstetricians showed that they held strongly to their assumptions and views about the association of increased risks with being overweight and pregnant. Upon further reflection on the assertion of obstetricians about risks of being overweight in pregnancy and how they communicated this to women, I could relate to how the women felt. Accounts of the obstetricians corroborated women's description of their meeting with obstetricians, which women alluded to as the cause of how they felt. They described feelings of fear and guilt, in case anything happened to their unborn. They continually mentioned the uncertainty of not knowing what could happen. Repeated reflection on my decision to interview

healthcare professionals, and to use data from their interview alongside data from interviews with pregnant women has confirmed that interviewing both pregnant women and healthcare professionals who provide them with antenatal care, brought clarity to understanding women's feelings, perceptions and experience of antenatal care. This clarity is significant to the achievement of the aim of the study, which is to better understand the perceptions and experiences of overweight, pregnant women receiving antenatal care from healthcare professionals who work in the NHS Trust where the study was carried out.

I understood from my interactions with the obstetricians in the study, that they want the best for women. However, this desire in part appears to have made them less sensitive to women's attempts to convey to them that they did not believe they were in need of medical interventions, because they (women) perceived themselves to be in good health. I also realised on reflection, that obstetricians were being cautious at telling women about all the increased risks associated with being overweight and pregnant. They emphasised the risk and made recommendations on the basis of the risk they had identified, but despite this they did not appear to explain all risks fully to women. This position is highlighted by the case of Lanarkshire VS Montgomery (The Supreme Court, 2015). The woman (Montgomery) felt that if she knew all the risks associated with her stature as a smallish woman with diabetes, she could have opted for a caesarean section. Her claim is that because she was not aware of all the risks, she gave birth to her son normally which resulted in the complication of shoulder dystocia because her baby's head was stuck in the passage and lacked oxygen for ten minutes, which led to the baby sustaining severe brain damage. This occurrence has led to the NHS Trust being sued.

My perception of how antenatal care providers perceive and frame fatness when delivering antenatal care to overweight, pregnant women has changed

from what it was when I started my study. Initially I thought women without complications were provided antenatal care for by midwives while women with complicated pregnancies were attended to by obstetricians. However, that notion has changed. I am now aware that women need not have complicated pregnancies to be provided with antenatal care by a midwife or an obstetrician as there are different criteria in place to measure and put women into antenatal care pathways, that may warrant heightened care. For example, women who are 35 years and over, medical conditions such as; diabetes and hypertension, women who are involved in social issues such as domestic violence, and lastly, women whose BMI is 30 kg/m² and above. I came across the view that midwives who work in obstetrics-led units are more likely to perceive medical interventions as routine. This is contrary to the foundation and basic principles which shape midwifery training which is based more on the social model and culture of care. This contrasts with the medical model of care that obstetricians are more likely to subscribe to, which views medical intervention as normal. Having read about and observed the environment which prevails within obstetrics-led units; and which places significant premium on masculine or patriarchal attributes of being grounded and in control of challenges and outcomes; it can be inferred that the views and perceptions of midwives who work in obstetrics-led units represent a mix of the social and medical model of care which they have been exposed to by their training and work experiences.

In addition, I realised now that most overweight women who are pregnant carry some burden with them on a day-to-day basis. Having been told that being overweight with pregnancy, carries increased risks, I understood from interviews with women that most of them just want to be given the same care that women perceived to have 'normal' body weight have. I found too that women compared their experiences with other pregnant women; relatives or neighbours and make judgements from the experiences of others. My experiences of discussions with women also showed me the

importance of the language style and terminology one chooses to use when undertaking a sensitive study such as this. The women in this study were all classed as overweight according to their BMI. It was clear from my interaction with them that they did not want to be referred to as 'obese' women and I respected that and still do. After learning about it from my first interview, I was cautious not to refer to the women as obese. As I replay my first interview and as I reflected on the way the participant was referring to herself as a 'big girl', I realised that I had to refer to her as a 'big girl' throughout the interview. Reflecting on my first interview, I thought to myself that I would have to wait for women to refer to themselves in whichever way they deemed fit and I will adopt their chosen description of themselves. Other participants referred to themselves as big women, overweight women, and as a woman with a large body frame. The knowledge I gained at this point revealed how sensitive the issue of body weight are when discussing it with overweight individuals. As I reflected on the reports women gave regarding their encounter with sonographers about their scan reports, I sense why they were distraught about the language and terminology used by sonographer in the women's reports.

Finally, as a researcher in the social sciences, I accept that the knowledge produced from my study is only a version of the social truth. The selection of a research topic, the philosophical underpinning employed, the methodological approach, data analysis and the interpretation of data to an extent, is a reflection of my interest, beliefs and values. The data generated are inter-subjective constructions; shaped by myself and the research participants. This is exemplified by Finlay's (2003, p.212) assertion that '... research is co-constituted, a joint product of participants, researcher and their relationship'.

Additionally, this thesis contributes to the body of sociological knowledge and understanding of pregnant women who have high BMI regarding their

experiences of antenatal care. I stress that the women in my study who are pregnant with a high BMI are all healthy women. They have no health issues as a result of their weight. As a consequence, my thesis has presented the views and assertions of the women, their experience of being provided medicalised antenatal care even when they have not been diagnosed with any medical condition, and are presented as being healthy pregnant women. This study also shows the dilemma midwives find themselves in as they negotiated supporting women in this category of antenatal care. They struggled to reconcile their beliefs that the choice of healthy women regarding antenatal care pathways and birthplaces should not be undermined, with what seems to be the ultimate decision from consultant obstetricians about the actual care women received and birthplace offered to women in antenatal care. Hopefully, my study lays bare the situation as it currently exists and will instigate further research into identifying the expectation of healthy pregnant women and how they can be effectively responded to within antenatal care settings, in a manner that integrates the knowledge and views of all professionals who care for pregnant women during their antenatal journey.

I intend to publish papers from this thesis. I have already started to disseminate the research findings through national and international conferences. I also expect to present my research findings to the managers of the midwifery units and obstetricians in the Trust in which this research was undertaken, besides giving a summary of the research findings to all the participants.

Chapter 9

Conclusion

Aims of the study

To understand the experiences of pregnant women with a high BMI with regards to the antenatal care they receive.

To identify and examine the impact, if any, that the body weight of pregnant women has on how healthcare professionals deliver care for pregnant women and how this impact has shaped the manner healthcare professionals communicate and interact with pregnant women with high BMI.

Objectives

To explore the perspectives of pregnant women with high BMI about their pregnancy and their experiences of maternity services.

To critically explore the perspectives of healthcare professionals about the care of pregnant women with a high BMI.

To investigate the advice that healthcare professionals give to pregnant women with a high BMI about body weight, particularly in relation to communication about possible risks.

To identify ways in which antenatal and midwifery care for pregnant women with high BMI might be enhanced.

Introduction

This chapter brings together key experiences, observations, challenges and findings encountered during the course of carrying out this study. It revisits how key issues were identified, how research questions that the study aimed to answer evolved, the framework for generating, analysing and making

sense of the data and information produced by the study, and how it provided answers to the main questions. It also provides key information and suggestions on how to enhance the content and form of policies. As a result, this chapter appraises the degree to which the primary ambitions and the purpose of the research project have been achieved.

A key focus of this chapter will be the discussion of the findings of the research study, the challenges and constraints that impacted or may have impacted both the direction and findings of the study, and the limitations of the study. Also discussed, is the contribution the study makes to knowledge and practice, to theory, to training and to education. Any potential for future research identified by the study will also be discussed.

Overview of study

This study explored the experiences of pregnant women with a BMI of over 30 kg/m² as they accessed and received the antenatal care services delivered by a trust of the NHS to pregnant women in this BMI category. To design and execute key elements of the study which is necessary to generate adequate data of appropriate quality, which answered the questions regarding the experiences of these women, the concerns and challenges they were faced with, and which impacted their experiences in NHS antenatal clinics, several pieces of literature were reviewed, analysed and evaluated. Key amongst this literature was guidelines published by the Changing Childbirth Report (DoH, 1993), NICE (2008, 2010), CMACE/ RCOG (2010), Maternity Matters (2007), and the recently published National Birth Review (2016). Also, reports of research findings published in peer-reviewed journals, reports of review studies, published text providing guidance on research methods and methodologies amongst others were also used to shape the focus and direction of the study.

The initial review of NICE guidelines (2008, 2010), provided a clear indication of the relevance and appropriateness of conducting a study into how women experienced and felt about (their experience of) the antenatal care delivered to them, as pregnant women who are overweight. Though NICE (2010) provided guidelines which are intended to ensure that overweight pregnant women receive antenatal services that both deliver their desired and perceived value proposition, there is no indication from the data provided by pregnant women and healthcare professionals that NICE (2010) guidance is effectively used to guide practice by both midwives and obstetricians. While providing guidance on the care of pregnancy generally, NICE documents single out pregnancy in women with a BMI of over 30kg/m² for specific consideration. According to NICE (2010), the following should apply and be considered by healthcare professionals when they provide antenatal care for pregnant women with a BMI of 30kg/m² and above:

- Explain to women with a booking appointment BMI of 30kg/m² or more how BMI poses a risk, both to their health and the health of the unborn child. Explain that they should not try to reduce this risk by dieting while pregnant and that the risk will be managed by the health professionals caring for them during their pregnancy.
- Offer women with a booking appointment BMI of 30kg/m² or more a referral to a dietician or appropriately trained health professional for assessment and personalised advice on healthy eating and how to be physically active. Encourage them to lose weight after pregnancy.

Also, the guidelines specifically mentions that while healthcare professionals measure weight and height, and discuss BMI and its risks, the healthcare professionals should be mindful of the concerns women may have. Also, NICE clearly advised that women should not be repeatedly weighed. It can be implied that in line with this advice, it is insensitive to repeatedly highlight or overemphasise the risk of BMI regarding specific adverse

medical conditions to women as the study revealed healthcare professionals routinely do as they deliver antenatal care to overweight pregnant women. A primary focus of this study was to generate empirical evidence for establishing the degree of effort made by healthcare professionals in delivering the expectation of this guidance. Another document which had a fundamental influence on the form, content, and direction of this study, is the DoH document, *Changing Childbirth Report* (DoH, 1993), and *Maternity Matters* (2007), which has since been reviewed resulting in a newer version entitled *National Birth Review* (2016).

Findings from reports indicate that the topic of how overweight pregnant women experience antenatal care services, as delivered through the shared antenatal care pathway of the NHS maternity services, had not been previously accorded adequate attention regarding research conducted on the topic. Also, there was a lack of individualised antenatal care for pregnant women with high BMI. A major re-occurring claim found in the literature reviewed is that epidemiological studies lay claim to poor outcomes for pregnancy in women with high BMI (Rauger-Martin et al.; 2010 and Lindhardt et al., 2013) and use this as justification to draw pregnant women with high BMI into a series of screenings which was ultimately used to medicalise women's pregnancies and childbirths (Lavender and Kingdon, 2006; Nyman et al., 2010; Fuber and McGowan, 2011). The medicalisation of pregnancy and childbirth created room for increased monitoring, surveillance and intervention mainly for the purpose of complying with guidelines and protocol and for protecting healthcare professionals should anything go wrong (MacKenzie Bryers and van Teijlingen, 2010). While there is evidence from the literature that the position of epidemiological scientists, made popular by the media, was and is still being challenged by feminist scholars and commentators. The effort has mainly focused on refuting the claims of biomedical and epidemiological scientists and has not produced alternative verifiable evidence or evidenced-based conclusions. The efforts

and activities of those oppose epidemiological claims and its use to support medicalisation has not engendered, or led to an increase in commissioned, research activities which can generate verifiable evidence that refutes the claim of epidemiological reports. While the lack of research into the risk of high BMI and the risk it poses to pregnancy does not validate the claim of epidemiological scientists, it does allow them to continue, with the collaboration of the media and powerful interest groups in pharmaceutical industries and government, to continue to frame public opinion against increasing trends in weight, of members of the population. The evidence from this study is that epidemiological framing of weight is used to support increased monitoring, surveillance, and intervention in the provision of healthcare services to overweight, pregnant women.

There is significant evidence from pregnant women; in this study; that suggests that women believe medicalisation is the main reason their pregnancy is shrouded in perceived risk. They asserted that healthcare professionals over-emphasise the risk that high BMI poses to pregnancy and childbirth and this creates feelings of fear and anxiety in them which will, in turn, secure their acceptance of the medicalisation of their pregnancy. The majority of the women who participated in this study reported instances where obstetricians over-emphasised the risk from high BMI, with many, reporting that they felt fear and anxiety after their visit to obstetricians. Similarly, women reported that they did not feel the risk ascribed to their pregnancy took account of their particular situation and health status, with many remaining unyielding and insisting that despite the views expressed by healthcare professional to the contrary, that they believed that the position portrayed by healthcare professionals did not apply to them.

Many pregnant women that participated in this study construed themselves to be healthy and believed that healthcare professionals perceived them differently because of their weight. They reported occasions where a litany

of risk exposure was rolled out by healthcare professionals while they had little or no opportunity to engage with healthcare professionals to understand how it applied to their specific situation. The narratives by pregnant women with high BMI are substantiated by claims from the literature reviewed that there is a lack of individualised antenatal care for pregnant women with high BMI (Nyman et al., 2010; Fuber and McGowan 2011; Smith and Lavender, 2011; Furness et al., 2011; Mills et al., 2013; and Heslehurst et al., 2015).

Framing of the form and substance of guidelines by healthcare professionals

The study did not identify a specific irrefutable reason for the observed partial or token embrace of the spirit of NICE (2010) guidance to explain to women at the earliest opportunity how their high BMI poses a risk to their health and the health of the unborn child. There is empirical evidence in this study that both midwives and obstetricians did not fully embrace the spirit of the guidelines because they did not fully agree or subscribe to the view and belief that high BMI is indicative of a higher probability for women to develop adverse conditions. A further observation from the evidence provided by participants is that obstetricians use guidelines from healthcare regulatory and monitoring bodies such as NICE and RCOG as cover to avoid making the professional assessment that is unique and personal to an individual pregnant woman with high BMI. Data from obstetricians affirm that they use guidelines from these bodies as rules, which exclude them from making professional assessments based on each woman's situation and need. However, a review of the guidelines demonstrate that it does not have enough content or details for it to be intended as a rule-based framework but rather to act as a set of principles suggesting how the exercise of professional duties and responsibilities to service users can be enhanced.

Healthcare professionals undermine the objective of NICE guidance (2010) when they roll out a litany of medical conditions and this creates the wrong perception in women where the conditions are caused by high BMI (CMACE/RCOG, 2010; Athukorala et al., 2010; Arrowsmith et al., 2011; Morgan et al., 2011) and so fail to meet the expected levels of sensitivity in risk discussion with women. Empirical evidence from pregnant women in this study demonstrated that the lack of effective discussion of how BMI might pose risks to pregnancy is the reason the awareness of women about the risk of high BMI in pregnancy remained vague after their encounters with midwives (Keely et al., 2011). As a result, healthcare professionals were not sensitive to the needs of overweight pregnant women to understand why they were cared for differently in comparison to other pregnant women. The failure of healthcare professionals to fill the gap in women's understanding of the risk of high BMI may be the reason why healthcare professionals, especially obstetricians feel the need to further discuss the topic of risk with women before carrying out any additional assessments and surveillance activities, which they require to manage perceived risks.

The study also found evidence of passive compliance with the spirit of the requirement of guidelines issued by healthcare regulatory and monitoring institutions. For example, Obstetrician C asserted that the motivation to carry out some of the scanning tests or activities is because it is protocol. Becky, a midwife, also alluded to tests being requested and carried out even when the outcome is consistently negative, because it is required by guidelines and protocol. While this does not add value to service users, it is also a significant waste of resources that could be better deployed with other aspects of the NHS. Midwives and obstetricians in this study repeatedly indicated that at the end of the day it is protocol and when it come from NICE (2010) and CMACE/ RCOG (2010) they have to be seen as complying. The willingness of healthcare professionals to comply with the form rather than the substance of these guidelines is intensified by the environment that

exists with maternity services, where there is a subtle scramble for recognition and power between two professional groups that are charged with the delivery of antenatal care to pregnant women, with high BMI. This further exacerbates the confusion and dissatisfaction of the pregnant women with high BMI who receive NHS antenatal care. There is evidence in this study which points to claims of superiority or power by one team of professionals over another in an arrangement that is described as shared care. This result in one group, midwives, consistently feeling disempowered, and so adopting a submissive or passive position to obstetricians rather than engaging in collaborative and/or cross functional negotiation processes to achieve optimal results for pregnant women in their care.

Impact of a lack of effective engagement with women at the start of antenatal journey

The study found that most of the pregnant women in this study anticipated that the risk of high BMI would be discussed with them. What they did not anticipate was that a list of medical conditions would be laid out without being given the opportunity to discuss, ask questions about and understand how their BMI posed a risk to their health and unborn child. This lack of effective engagement with women at the start of their antenatal care journey impacts the way they experience the entire antenatal care delivered to them. The lack of effective engagement meant that they could not contribute to decisions about their care and did not understand the rationale for the extra monitoring and surveillance activities that were carried out to safeguard their pregnancy and unborn child.

This study also noted that the concerns expressed by pregnant women regarding how obstetricians excessively focused on risk and medicalised their care was in part due to their lack of understanding of the risks of high BMI ascribed to their pregnancy. Midwives did not use the initial booking

appointment to engage in an effective discussion of the risk of high or excessive BMI to pregnancy. As a result, women failed to acquire the necessary understanding of why obstetricians intervened and what nature of intervention to expect. Neither did they have the right information and knowledge to question and evaluate the actions of obstetricians. The consequence of not knowing why obstetricians wanted more screening and monitoring was the display of aversion to their recommendations. They also reported that the sole reason that obstetricians focused on the risks of high BMI was to scare them into a submissive position where obstetricians would assume control and medicalise their pregnancies.

Effective engagement with pregnant women in this study by healthcare professionals in the form of complete, accurate and transparent discussions around the risks of high BMI, would not have resolved all the issues women alluded to as negatively impacting their experience of maternity services. However, such an exercise would have empowered them to manage the feelings of anxiety and fear, which they encountered after consultation with the obstetricians, and mitigate the tendency to ascribe blame to themselves for failing to manage their BMI. While this study did not find any evidence that engagement with women would have eliminated the anxiety, fear and a feeling of self-blame, engaging in such a discussion with sensitivity as advised by NICE (2010) would have equipped women to better engage with antenatal care providers, rather than feeling disempowered, ignored, not listened to, or that they were being conditioned by risk-discourse to accept the medicalisation of their pregnancies and childbirth. Evidence from midwives and pregnant women in this study alluded to women ascribing blame to themselves following discussions of the risk of high BMI to their pregnancy and childbirth. A secondary consequence of the lack of engagement which comes from women ascribing blame to themselves is that it has a tendency to create both personal and social pressure for women to reverse their weight measurement and the associated risk status. This

finding is also consistent with the assertion of Heyman (2010a) which describes the effects of women ascribing blame to themselves because of social perception and framing of BMI. Some midwives in the study also reported this tendency for women to ascribe blame to themselves but other midwives in the study reported that some of the women confirmed that they already knew, before attending booking appointments that their weight and the risk it poses to pregnancy would be mentioned and so were not particularly impacted by it. This finding by this study is consistent with the report by Nyman et al. (2010), Keely et al. (2011), Mills et al. (2013) and Heslehurst et al. (2015), that pregnant women understood that their weight poses a possible risk to their pregnancy and some even reported that they expected some form of prejudicial treatment at some point in their antenatal care journey. It, however, raises the further question as to the reason they still experience the strong emotive feeling of fear, anxiety and self-blame when the topic of risk is discussed with healthcare professionals to identify options for mitigating the risk of high BMI.

The study found that it is within this background of risk alleviation or eradication that pregnant women with high BMI feel 'lumbered' with the added social and moral responsibility, outside of the natural demands of their pregnancy, to manage their risky bodies (Lupton, 2013). This construct of risk as a phenomenon that needs to be alleviated and eradicated in modern society, according to pregnant women in this study, puts additional pressure on them during pregnancy and often limits their ability to tap into the positive emotions and feelings that women of 'normal body weight' enjoy during pregnancy.

Understanding the experiences of pregnant women who are overweight with regards to the antenatal care they receive

The empirical evidence from the data analysed for this study also found that pregnant women, even after their booking appointment and consultation meeting with obstetricians, had no understanding of the concept of BMI. Some pregnant women interviewed asserted that it does not mean much, and so they do not have concerns about it while others think it is a kind of measure of how much weight they are carrying. This lack of understanding of why healthcare professionals are interested in pregnant women's BMI and why it is of concern to them is further indicative of the failure of healthcare professionals to engage pregnant women in a comprehensible discussion of the claimed attributes of high BMI and how it poses a risk to pregnancy and the unborn child as directed by NICE (2010). The evidence of the willingness of women in this study to embrace options which will benefit their unborn child suggests that if the opportunity identified by NICE (2010) to discuss the risk posed by high BMI to pregnancy and the unborn child or children, had been taken by healthcare professionals, then the understanding of pregnant women in this study regarding the risks of high BMI and the efforts and specific actions that are needed to mitigate the risks would have been created and/or enhanced. The understanding would have in turn created a desire in these pregnant women for the screening, scans and other activities described as medical surveillance, to ensure that it is not a missed opportunity for healthcare professionals to have delivered a key aspect of the antenatal care service which has the potential to shape desired and perceived value of service user expectation. Ensuring that pregnant women understand why healthcare professionals are concerned about the potential impact of high BMI on pregnancy, may enable them to be open to, and receptive of actions that healthcare professionals discussed and explained to them as necessary to safeguard their pregnancies and unborn children. The

result of the understanding of high BMI and how it can potentially undermine their pregnancies would have enhanced their acceptance of the rationale for the focus of the shared antenatal care delivered to them. This would then have created better appreciation by women in the study and reduce the negative feeling that they associated with their experiences of antenatal care services.

Investigating the advice given to pregnant overweight women particularly in relation to communication about risks

The King's Fund (2008) categorically stated that effective communication is a key to all clinical care and emphasised that it is fundamental to the delivery of maternity care especially where it involves multiple handovers of care as in the case of shared antenatal care services delivered to pregnant women with high BMI. The Fund (2008) emphasised further that communication in this context can only be effective if and only if the relevant information is made available to those who need to act on it in a form and manner that will ensure that they understand the information.

The majority of pregnant women in this study did not understand how the risk of high BMI poses risks to themselves, their pregnancies and childbirth after meeting with healthcare professionals and passing through booking and consultation appointments where both healthcare professionals and pregnant women reported as occasions where the risk was mentioned, discussed or overemphasised. The different perceptions of what happened as part of the risk discourse by all the parties is indicative that effective communication did not take place during those opportunities which NICE (2010) identified for healthcare professionals to discuss how high BMI poses risks to pregnancy and the unborn child of pregnant women in the high BMI category. Evidence abounds in the studies (Nyman et al., 2010; Fuber and McGowan, 2011; Keely et al., 2011; Mills et al., 2013) which clearly

demonstrates the differences in how midwives, obstetricians and pregnant women described the form and content of risk discourse between healthcare professionals and pregnant women. In addition, it can be deduced from the empirical evidence provided by healthcare professionals that the midwives and obstetricians that form the team providing antenatal care under the shared pathway team, for an individual pregnant woman, do not have any arrangement to discuss together and agree how they will deliver antenatal care to a pregnant woman in their team. Evidence of this was put forward by midwives when they asserted that this lack of collaboration may in part have resulted in the inadvertent display of insensitivity by some obstetricians, as reported by the women, while midwives were portrayed as sensitive and supporting. The result is that while healthcare professionals actively seek to maximise their individual efficiency and effectiveness they actually only deliver sub-optimal benefits to the service user or the pregnant woman.

This study also found evidence of information being conveyed to, rather than discussed with, women (see pages 180 – 182). The consequence of adopting this method of communication by healthcare professionals is that the form and content of the encounter, which should be used to “explain to women with a BMI of 30kg/m² or more at the booking appointment how this poses a risk, both to their health and the health of the unborn child” (NICE, 2010 p7), is used instead to roll out a list of medical conditions that are associated with high BMI without showing, accurately and clearly, how the mentioned conditions are linked to BMI, or how BMI poses a risk which may manifest in these conditions. In failing to recognise this key value measurement criteria (Porter, 2010) used by customers or service users, healthcare professionals undermine the opportunity for pregnant women to form and sustain a positive feeling of their experiences of antenatal care as delivered through the shared pathway. According to Porter (2010, unpaginated), the “goal is what matters for patients and unites the interests of all actors in the system.

If value improves, patients, payers, providers, and suppliers can all benefit while the economic sustainability of the healthcare system increases”.

Need for compliance

Another key finding is the inconsistencies in the attitude of healthcare professionals towards the perception and framing of the risk of high BMI to pregnancy and pregnancy outcomes. The inconsistencies identified by the empirical evidence generated from healthcare professionals about their attitudes towards having the discussion of how high BMI poses risks to pregnancy and the unborn child, creates confusion for pregnant women. The pregnant women in the study, especially women who were experiencing pregnancy for the first time could not adopt a clear position about the threat of high BMI to pregnancy. While there is agreement that the topic of risk is an emotive issue for pregnant women, and so healthcare professionals are encouraged to be sensitive to this feeling (also see Fuber and McGowan, 2011; Mills et al., 2013; Heslehurst et al., 2015), this study noted that the sensitive nature is viewed by healthcare professionals as being an issue to be mindful of and was used as an excuse by some healthcare professionals for evading the discussion of how BMI poses a risk to women and their unborn children, while others who had the discussion reported that women responded well to the discussion so long as the risks were not overemphasised or continuously reiterated. Against this background, there is a need to ensure that an accurate account of how high BMI poses a risk to pregnancy is determined and agreed by healthcare professionals, healthcare regulatory and monitoring bodies. Healthcare professionals need to then adopt the agreed version consistently when providing care for women in the shared pathway of maternity services.

Surveillance and clinical gaze

Another finding, which is neutral in terms of how certain clinical surveillance is viewed, and to that extent interesting, is the theme from the data collected from pregnant women; especially prospective first mothers

regarding their scan at 8 to 14 weeks of pregnancy where they see the image of their first born child for the first time. The study found that women reacted with a significant display of positive emotion to the immediate outcome of their scan experience. The only downside reported regarding their scan was not as a result of its purpose being a surveillance activity, but of their perception that healthcare professionals were not upfront and transparent with them about their experience of how the scan had played out. This suggested that women have generally come to accept invasive visual scanning of their unborn children as a part of the natural process for ensuring their health and wellbeing. It mirrors the phases in the perception of lay service users regarding the use of epidural and forceps during labour to aid childbirth. Healthcare professionals have been able to rely on expert medical knowledge to take a position of power to move boundaries and shape what is perceived to be and accepted as normal as in the case of the use of epidural (Beech, 2002/2003). Though women complained about going for more scans, they were equally excited about the scan that afforded them the opportunity of sight of the visual image of their unborn child, and at that moment did not express any inhibition towards scanning as a surveillance activity but embraced its outcome. This is how the medical profession also obtained the acceptance of pregnant women to the use of other interventions such as epidural and forceps while insisting that such delivery constituted normal birth. However, it can be argued that the medical profession is able to shift perception because of the use of activities which may fall under the umbrella of the medical gaze and surveillance but are not inherently activities that service users will object to if they are deployed in an open, frank and transparent manner. As a result, the data analysed for this study indicates that women do not hold the view that the output or result of surveillance is intrinsically negative as existing literature readily suggests but is determined by the intention of those who deploy it.

Knowledge and Power

Another finding of this study is the impact knowledge has in shaping human exchange relationships. The findings supports Foucault's (1972) assertion regarding the interaction between knowledge and the exercise of power. Obstetricians were able to exercise power over women experiencing pregnancy for the first time by exerting the authority of their knowledge but met with resistance from experienced mothers who drew power from knowledge of previous pregnancies to resist the obstetricians and safeguard their decisions. It is also consistent with the discourse of the Rational Theory of Choice as it allows the individuals who are making a choice to consider all the options open to them from a position of knowing; whether relative or absolute. Women with prior experience of pregnancy and childbirth were able to independently safeguard their decision as they had the knowledge of what they perceived as their specific situation or position. They also believed that they had knowledge of the given constraints and, on the basis of the information, that they have about the conditions under which they are acting, were able to process the advice of obstetricians and made an informed decision regarding their choice of birth place.

First time mothers on the other hand, also acted in line with the Theory of Choice (Scott, 2000) and Foucault's (1997) concept of knowledge and power, but the impact of their lack of knowledge in exercising human exchange relationships about their choice of birth place is very evident in their post choice reactions where they bemoaned themselves for not doing enough to manage their weight and so had to subjugate their desire for a choice of birthplace. It is within this context that claims by various commentators, stating that the importance attached to availability of choice in childbirth by various policy statements is at best token as asserted by Earle (unpaginated, 2005) in the following statement:

“Many have argued that choice in childbirth is merely an illusion and that we often talk about choice as though it were the single most important factor when thinking about women's experiences of birth. However, when medical interventions are presented as routine and when women are encouraged to make 'choices' that will be better for their babies, then it is easy to see how women's choices are being managed within a medical model of childbirth”

The relevance of the relationship between knowledge; shaped by perception and beliefs; and power is again demonstrated with the way obstetricians exerted their claim to a higher level of authority regarding where power resides between them and midwives on the issue of where women with significantly higher BMI should give birth. Obstetricians believe in the superior knowledge embedded in the guidelines of their regulatory body, the RCOG (2010) and are therefore keen to comply with it emphasising that

“when it comes from NICE or RCOG or something, we have to do it or at the end of the day it's protocol isn't it, we have to follow protocol isn't it, we can't go against protocol and guidelines when it comes from NICE or RCOG or something, we have to do it”.

They ascribed authority to their professional bodies and then drew on that power in their relationship and interactions with midwives and pregnant women.

Implications of research findings and contribution to knowledge

Methodological Implication

The methodological framework adopted for the study reported in this thesis is a qualitative research framework which synthesises the guidance and recommendations provided by various qualitative researchers. The outcome and experience of reviewing literature, before the actual design of the study revealed that the framework adopted by notable qualitative researchers (Charmaz, 2006; Mason, 2002) were all variants of an overarching methodology base on the general principles of qualitative research. This realisation, afforded the opportunity to design the study in a manner that it was able to incorporate the guidance and reported experience and reflection of other qualitative researchers into it, thereby achieving greater reflexivity and flexibility. This was particularly useful in navigating barriers to the execution of the initial study design. As a result, the study, though designed with the intention to use grounded theory was seamlessly migrated to a form that was conducted using relevant concepts from Foucault with key guidance from a wide ranging list of other qualitative researchers. This both added diversity to the outlook of the study and the direction and form of data collection for the study.

Another benefit of the flexibility afforded by the adoption of a hybrid of qualitative principles and guidance was the relative ease with which it was possible to switch between being an insider and an outsider as the data collection progressed. This was also helpful when, contrary to the plan to record initial bookings between pregnant participants and their midwives, all but one pregnant woman withdrew consent for their consultation to be recorded. Again, the flexibility inherent in using guidance from different

qualitative researchers was very valuable when two other pregnant participants felt uncomfortable with having their voice recorded and the switch to note taking was made, though this was not in the initial design for data collection. The design of this study has therefore demonstrated how to achieve efficiency and effectiveness with the very fluid, mutable, adaptable and versatile environment of qualitative research. It has demonstrated that synthesising a plethora of guidance and principles within the overall qualitative paradigm or framework can deliver optimal outcomes when the study environment is relatively fluid. This is achieved by identifying the key elements and attributes making up the overarching framework of qualitative research paradigm, and is followed by a focused deconstruction of qualitative research frameworks and reconstruction of a study design with specific objectives and goals in mind.

Implications for the role of health monitoring and review institutions

Health regulatory and review bodies such as NICE (2010) and RCOG (2010) should be obligated by their charter to commission regularly, a review of their guidelines and the level of compliance by professionals under the jurisdiction of their guidance. Such a review should be conducted by an independent group made up of independent researchers from across various stakeholder groups with interest in different areas of research. This will both challenge policies and guidelines and evaluate their effectiveness in shaping and guiding the actual delivery of care by healthcare professionals. Evidence abounds in the study that healthcare professionals in the antenatal care teams delivering shared care to pregnant women did not follow the guidance of NICE (2010) on a fundamental aspect that affects the actual delivery of care and how the delivery of antenatal care is perceived by service users. This is both a failing of the regulatory and review bodies which need to pick up on the non-compliance with both form and substance of its guidelines and

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the healthcare professionals who have not fully engaged with the applicable guidance to safeguard and enhance service users' value of their experiences.

Implications for the midwifery profession

Midwives need to actively promote the social model of care. This study identified two different models of care in how antenatal care is delivered to pregnant women with high BMI. Midwifery training is influenced by the social model of care which most midwives subscribe to. Obstetricians on the other hand subscribe to the medical model of care that is promoted by the medical profession (where obstetricians situated themselves). There was also a pervasiveness of evidence from obstetricians demonstrating their awareness of the medical model and a readiness to draw authority from it, to validate their practice. The situation however with midwives portray a contrary position where midwives did not seem confident and/or keen to adopt, promote or project the social model of care which shaped their training and should guide their practice. It is important to be clear here about this assessment of evidence from midwives who participated in the study. While midwives demonstrated awareness and understanding of the social model of care and recognised that pregnancy is a non-medical event which should only be subject to medical intervention where there is substantive medical evidence, not speculative epidemiological supposition, of threat to the pregnant woman and her unborn child, midwives did not assert that belief like obstetricians in decision-making about how pregnant women would deliver their babies.

To strengthen the position of midwives, the Royal College of Midwives (RCM) should actively and regularly re-advocate the distinctive position and view of the midwifery principles and ensure that their position is visible in every social and political context of society. They can also provide implementation guidance for their members on the implication for midwifery practice and

how to apply the guidance issued by health monitoring institutions in practice.

The midwifery profession should seek to develop a partnership with the media to create and sustain a viable and veritable platform for putting forward its version of the truth and beliefs. It should actively work with the media and the public to promote views, perceptions and how it frames events and issues of interest to the profession in the public domain, to ensure that all pertinent information relevant to discourse of public health and wellbeing are available to members of the society. Further, it should ensure that the version of the truth in the public domain is not only shaped by business directly and indirectly through its association with political authority and commentators on wellness, who rely solely on epidemiological reports.

Midwifery education and practice

The Nursing and Midwifery Council (NMC) and RCM must do more to support the activities of pressure groups, including the National Childbirth Trust (NCT), the Association of Radical Midwives (ARM) and the Association for Improvements in Maternity Services (AIMS), amongst others that have and continue to campaign against the medicalisation of childbirth. This support should aim to make midwives more proactive in promoting pregnancy, and especially childbirth, as a natural life event that is viewed as safe prior to clear evidence to the contrary.

While the pressure groups who support pregnancy as a safe natural event have been very vocal and critical of the effort to increasingly bring childbirth within the remit of the medical profession so that childbirth is presumed to be a medical condition until proven otherwise rather than the reverse, a greater support from all stakeholders in preserving the status of childbirth as a non-medical and natural event is required. The NMC and the RCM should continue to actively engage with the media and the government; and where

necessary use lobby groups; to put across their beliefs that childbirth is first and foremost a natural life event that should only involve medical intervention when real and clear risk is identified rather than perceived. The training of midwives should also focus more on aspects which will equip midwives to be able to project the beliefs and principles of the social model of care and sell its values and benefits even to those who hold contrary views. It should aim to make every midwife an ambassador of the profession regardless of where they work.

Additionally, the NMC and the RCM should actively collaborate with the RCOG to promote childbirth as a natural non-medical event and encourage active communication and collaboration between midwives and obstetricians in a shared antenatal care pathway to enhance the value derived by pregnant women which is made up of desired value and perceived value (Woodruff, 1997). The NMC should lead in the effort to create the necessary arrangements that allow or ensure that all the different professional groups in the shared antenatal care pathway for pregnant woman, actively collaborate to avoid suboptimal tendencies which will erode the value of the service delivered to pregnant women. This should include proposals which make it mandatory for regulatory and review bodies such as NICE to put forward guidelines that will ensure that all members of the team that deliver care within a particular antenatal care pathway regularly collaborate to agree on the care package. This will also ensure that women perceive a unity of intent and purpose from the various groups of healthcare professionals involved in the delivery of their care, and enhance their confidence in what is on offer and delivered as part of their antenatal care package.

Limitation to my study

Characteristics of women who participated in the study are in Table 1 in

Chapter 4. The study apparently, did not appeal to all groups of women. While women who participated in the study were upfront and honest and articulated their feelings in the best way that they could, they did not represent the views of women from ethnic groups who did not participate in the study. Findings may have been different if overweight pregnant women of South Asian decent had taken part in the study. Most of the pregnant women in the study expressed disapproval in the way sonographers presented their experiences of their scans sessions. When the study was designed, it did not include sonographers as participants and by the time women began to mention them in the study, it was too late to include sonographers due to the long process involved with NHS NRES. This is a limitation in the design of the study because the narrative response of sonographers would have contributed to the quality of the study and the thesis report. Future research could explore the experiences of women of South Asian decent and sonographers, and maybe their input could bring in different perspectives to findings.

Conclusion

Undertaking this study, up to its completion has been an eye opening experience for me. As I reflect on my past experiences, I found that I have learnt much about myself, individuals who are overweight and their healthcare professionals. This discovery has changed the way I perceive the debate about overweight as a health issue in society and it has influenced my thinking, widened my knowledge as a social scientist and as a qualitative researcher in general and particularly within healthcare settings. The participants in this study shared a lot of information, and this has given me an opportunity to add to the body of sociological knowledge. Although participants, as pregnant women and health professionals, described their experiences based on the antenatal care services they received and provided respectively, I recognise the fact that I will never be aware of what was not discussed.

Areas for further research

The views expressed by Michelle regarding the content of and how she discussed the issues of BMI and risks with women is indicative of the impact a midwife's prior experience of providing antenatal care for pregnant women with high BMI, may have on their willingness to engage in the discussion of the subject with women and their capacity to actually carry it through. It is a theme that this study would have wanted to explore further, but the sample selection before data collection did not take into account how long midwives have been in practice, and only one participant who had recently qualified as a midwife participated in the study. Future research could be designed to include more recently qualified healthcare professionals to capture the impact, if any, that practice experience has on perceptions and framing of risk by healthcare professionals who care for pregnant women.

Another area of the study that can be explored as part of future research is how sonographers experience carrying out scan procedures with overweight pregnant women, the factors they take into consideration when writing the report of the outcome of the scan procedure and how pregnant women reacted and construed the report of sonographers.

Other areas that could be explored in future studies are the value of religion and prayer as coping mechanisms for service users of healthcare services who are exposed to anxieties and fear on account of their medical conditions or encounter with healthcare professionals such as 'overaged' and 'under aged' pregnant women.

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Appendix

Appendix 1

Your SREP Resubmission - Maria Iyekekpolo... - Maria Iyekekpolo (Researcher)

Page 1 of 1

Your SREP Resubmission - Maria Iyekekpolo (0352322) - APPROVED - 'The Experiences of Pregnant Women and Midwives with Respect to Body Weight'

Kirsty Thomson

Wed 12/09/2012 16:34

To: Maria Iyekekpolo (0352322) <Maria.Iyekekpolo@hud.ac.uk>;

cc: Joyce Marshall <J.Marshall@hud.ac.uk>; Sharon Wray <s.wray@hud.ac.uk>; Karen Ousey <K.J.Ousey@hud.ac.uk>; Nigel King <n.king@hud.ac.uk>;

Dear Maria,

Dr Karen Ousey, Deputy Chair of SREP has asked me to contact you with regard to your SREP resubmission.

Your resubmission has now been given full ethical approval.

However, please note the following:

- Please consider with your supervisors: What you will do if a woman says she doesn't have time to be interviewed after the consultation? Some women bring younger children with them to their appointments, so this may affect their ability to be interviewed after their clinic appointment. Will you offer her another time/venue?
- Information Sheet: Please check for typos prior to printing and distribution.

With best wishes for the success of your research project.

Regards,

Kirsty

(on behalf of Dr Karen Ousey, Deputy Chair of SREP)

Kirsty Thomson
School of Human and Health Sciences Research Office (HHRG/01)
University of Huddersfield
Queensgate
Huddersfield
HD1 3DH
Direct Tel: +44(0)1484 471156
Email: k.thomson@hud.ac.uk

Appendix 2

Telephone: 0113 3050128

31 December 2012

Mrs Maria Iyemekpolor
PhD student
University of Huddersfield
HHR 2/12 University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Dear Mrs Iyemekpolor

Study Title: THE EXPERIENCES OF PREGNANT WOMEN AND
MIDWIVES WITH RESPECT TO BODYWEIGHT ISSUES
REC reference: 12/YH/0533
IRAS project ID: 84590

The Research Ethics Committee reviewed the above application at the meeting held on 18 December 2012. Thank you for attending to discuss the application.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Covering Letter		08 October 2012
Evidence of insurance or indemnity		24 July 2012
Interview Schedules/Topic Guides	1	08 October 2012
Interview Schedules/Topic Guides	1	08 October 2012
Investigator CV		
Other: Academic Supervisor CV - Dr Sharon Wray		
Other: Academic Supervisor CV - Dr Joyce Marshall		
Other: Letter to midwives	1	08 October 2012
Other: Letter to pregnant women	1	08 October 2012
Other: Letter from funder		05 November 2012

1. The Committee queried whether there would not also be Consultant involvement in women in the higher BMI category and how this would affect the study.
2. The Committee is concerned that whilst the study may involve up to 36 transcriptions it is still a small sample of pregnant women.
3. The Committee queried whether the midwives currently raise the issue of weight with their patients.
4. The topic guide needs to be revised to include references to obesity in terms of weight, body image or other peoples attitude to their weight.
5. The Committee seeks confirmation as to how the confidentiality of participants will be ensured.
6. The Committee requires procedures are in place should the women disclose any instances of poor or unsafe care.
7. The Committee raised concern that by being in the study the midwives will re-think their language which will change the study.
8. The Committee queried how the researcher would ensure the midwives in the study were not atypical.
9. The Committee enquired how you would deal with the situation where only one of the pair wishes to participate
10. The Committee seeks confirmation that there is a Lone Worker Policy in place.
11. The following changes and clarifications are requested of the Information Sheet and consent form;
 - a. The information sheet needed to contain more details and that a longer Participant Information Sheet should be given out as well as the shorter leaflet style Information Sheet. The longer PIS and consent form should be re-written in line with NRES guidelines.
 - b. The description of the recruitment process in the PIS needs to be revised to reflect how the women will be recruited.
 - c. The use of direct quotes should be explained in the PIS and permission sought on the consent form.
 - d. The PIS should explain about the possibility for disclosure and how this would be dealt with.
 - e. Confirmation is sought that the phone number in the PIS is not the student's personal number.
 - f. The point in the consent form relating to recording of the interviews needs to be revised and if optional put separately from the rest of the points.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact the Co-ordinator (Rachel Bell) on 0113 3050128 or nrescommittee.yorkandhumber-bradford@nhs.net

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

Appendix 3



Health Research Authority

NRES Committee Yorkshire & The Humber - Bradford

Yorkshire & Humber REC Office

Millside

Mill Pond Lane

Meanwood

Leeds

LS6 4RA

Telephone: 0113 3050128

12 March 2013

Mrs Maria Iyekekpolor
PhD student
University of Huddersfield
HHR 2/12 University of Huddersfield
Queensgate
Huddersfield
HD1 3DH

Dear Mrs Iyekekpolor

Study title: THE EXPERIENCES OF PREGNANT WOMEN AND
MIDWIVES WITH RESPECT TO BODYWEIGHT ISSUES
REC reference: 12/YH/0533
IRAS project ID: 84590

Thank you for your letter of 31 January 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator at nrescommittee.yorkandhumber-bradford@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

A Research Ethics Committee established by the Health Research Authority

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		08 October 2012
Evidence of insurance or indemnity		24 July 2012
Investigator CV		
Other: Academic Supervisor CV - Dr Sharon Wray		
Other: Academic Supervisor CV - Dr Joyce Marshall		
Other: Letter to midwives	1	08 October 2012
Other: Letter to pregnant women	1	08 October 2012
Other: Letter from funder		05 November 2012
Other: Letter from sponsor		02 November 2012
Other: Risk analysis and management	1	28 January 2013

A Research Ethics Committee established by the Health Research Authority

Other: Topic Guide - Pregnant Women	2	28 January 2013
Other: Topic Guide - Pregnant Women referred to consultants	1	28 January 2013
Other: Topic Guide - Midwives	2	28 January 2013
Other: Topic Guide - Consultants	1	28 January 2013
Participant Consent Form: Pregnant women	3	07 March 2013
Participant Consent Form: Midwives	2	07 March 2013
Participant Consent Form: Consultants	2	07 March 2013
Participant Information Sheet: Pregnant Women - Leaflet	2	28 January 2013
Participant Information Sheet: Midwives - Leaflet	2	28 January 2013
Participant Information Sheet: Pregnant women	2	07 March 2013
Participant Information Sheet: Midwives	2	07 March 2013
Participant Information Sheet: Consultants	2	07 March 2013
Protocol	1	08 October 2012
REC application		07 November 2012
Response to Request for Further Information		31 January 2013
Response to Request for Further Information		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Pp Dr Ian Woollands
Chair

Email: nrescommittee.yorkandhumber-bradford@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to:

Appendix 4



The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Maria Iyekekpolo, 01484 471626

Email: maria.iyekekpolo@hud.ac.uk

My name is Maria Iyekekpolo and I am a PhD student at the University of Huddersfield. I am currently carrying out some research and would be grateful if you could take some time to read this information sheet, which will give you more information about the research, why it is being carried out and how you can help by taking part.

What is the purpose of this study?

This study forms part of a PhD research project, which is investigating the experience of pregnancy and maternity care as experienced by woman with a high body mass index (BMI). As part of this research I am interested in the interaction between you and your midwife with regards to bodyweight issues, and this will include audio-recording of your consultation with a midwife and a follow up interview.

Why have I been invited to participate?

You have been invited to participate in this research because you are pregnant and have a body mass index (BMI) of 30 kg/m² or more. You are not the only one in the study as other women with a BMI of 30 kg/m² or more have also been invited to take part. If you agree to participate, your midwife will also be approached and if you are referred to see a consultant in the course of your antenatal care, s/he would also be invited to participate in the study.

Do I have to take part?

No, your participation in the study is entirely voluntary. If you have any questions regarding the study, contact me and I will discuss them with you when I meet with you to discuss your participation. You are free to withdraw at any time without giving any reason and this will not affect the standard of antenatal care you receive.

What will happen to me if I take part?

If you agree to take part in the study, I would like to ask for your permission for your appointment that is about to take place between you and your midwife to be recorded. Please be assured that your appointment will not alter in any way as a result of it being recorded and you will not be required to do anything different.

I will be nearby during your appointment, but will not be present in the consultation room where your actual consultation and the actual recording will take place. Should you take part in the study, your midwife will switch on a small audio- recording device at the beginning of your appointment or at a time you feel comfortable for the recording to start and begin by stating your full name before continuing with your appointment. Once your appointment has finished, your midwife will switch off the device. The researcher will then arrange an interview with you at a place and time that is convenient for you and this will be for about 45 minutes to 1 hour. Your involvement in the study will be for a minimum period of 3 months.

How will participant's information and views be kept safe and confidential?

After your appointment has been audio recorded it will be typed out word for word by the researcher. During this process, any identifying and personal details such as names and places will be changed to ensure your identity remains anonymous. Please note that although your full name will appear on the recording, it will not appear on the resulting transcripts. The principal researcher will assign a participant number to your name and mark this on the transcript in place of your name. This will ensure that your information will be identifiable to the researcher only, and it is made identifiable should you wish to withdraw from the study at any stage.

The conversation shared between yourself and your midwife will then be analysed and the analysis written up to be used as part of a PhD thesis. The result may also be circulated more widely through academic publications and conferences. It is important to make you aware that in the process of writing-up and presenting the research some direct quotes from your conversations may be used. However, all personal details will be changed and so it will not be possible for those reading the write-up to identify you.

All data collected from your appointment, both digital and paper copies, will be kept strictly confidential. Only the researcher and her academic supervisors, who are fully committed to your identity and confidentiality, will have access to your data. Your information will be kept in secured location on site at the University of Huddersfield and will be destroyed no more than ten years after publication of the research. Meanwhile, it may be used for other research studies before it is destroyed.

Withdrawal from the study

Please note that though you have agreed to take part in the study you have the full right to withdraw at anytime, without having to explain your reasons. During your appointment you may ask your midwife to stop recording at anytime. Alternatively, if immediately after your appointment you decide you no longer like to participate you may inform your midwife or the researcher and the recording will be destroyed. If you decide you would like to withdraw after the date of your appointment please contact the researcher directly – again, your audio data, along with any paper copies, will be destroyed and will not be used in the study.

How do I take part?

If you are interested in taking part in the study you can contact me via email or phone so that we can discuss your participation and I can get an oral consent from you. On the day of your consultation appointment with your midwife, when the audio recording will take place, you will be given a consent form. This will check that you understand completely the aims of the research, what it involves and your rights as a participant should you agree to participate. You will be given a second copy of the consent form to keep for your records and information.

Thank you for taking time to read this information sheet. I hope that the findings of this study may be applied and used to improve maternity services for women like you. If you decide to take part the details of your experience may go some way to enhance the experiences of pregnant women in general. If you find that you have any further questions about the study, please do not hesitate to contact me using the details below.

Contact details of the principal researcher:

Maria Iyekekpolor

School of Human and Health Sciences, University of Huddersfield, Queensgate, HD1 3DH

Tel: (office hours): 01484 471626, Email: maria.iyekekpolor@hud.ac.uk

If you have any complaints about the research, please contact:

Dr. Sharon Wray

School of Human and Health Sciences, University of Huddersfield, Queensgate, HD1 3DH

Tel: (Office hours) 01484 472796 or Email: s.wray@hud.ac.uk

Appendix 5



The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Maria Iyemekpolor, 01484 471626

Email: maria.iyemekpolor@hud.ac.uk

My name is Maria Iyemekpolor and I am a PhD student at the University of Huddersfield. I am currently carrying out some research and would like your help to contact potential participants. This sheet is designed to give you information about the study in order to help you to provide information to potential participants.

What is the purpose of this study?

The study is part of a PhD research project, which is investigating the experiences of obese pregnant women and midwives in antenatal settings. As part of this research, I am interested in audio recording the interaction between midwives and pregnant women during antenatal booking visits.

Who can be included?

This study is specifically focusing on women with Body Mass Index (BMI) 30kg/m² and over. A pregnant woman whose BMI has been taken and recorded will be eligible for inclusion. In order to recruit women, a recruiting midwife will give out information sheets at the booking appointment at the antenatal clinics. All women who are likely to have a BMI 30kg/m² and over, and have such appointment over a period of time will be given information sheets. Those who are interested in participating in the study will contact the researcher who will meet them to discuss their participation and get them to give an oral consent if they decide to go ahead.

Why have I been invited?

You are invited because you are a practicing midwife in the Calderdale and Huddersfield NHS Trust and a pregnant woman you are providing antenatal care for has agreed to take part in the study. She has given me permission to approach you to see whether you will also be willing to take part in the study. You are not the only midwife that will be in the study as other midwives who practice in your clinic have also been approached.

Do I have to take part?

No, your participation is entirely voluntary. If you have any questions regarding the study, contact me and I can arrange to meet with you to discuss these questions and your participation with you. If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your position as a midwife.

What will happen if I take part?

If you agree to take part, the researcher will meet with you to discuss how she will accompany you to consultation appointment. It will involve an audio-recording of the consultation appointment between you and the pregnant woman if you consent to it. After the consultation, you will be interviewed by the researcher at a place and time convenient for you. Topics that will be discussed include the antenatal care you provide as a result of the fact that her BMI is 30kg/m² and over. You have the option to choose not to answer any particular question, to pause or to stop the interview at any time or to withdraw from the study at any stage during the research.

The research interviews will be arranged at a time and place suitable for you, with consideration given to ensuring your safety. Any travel expenses incurred by participants will be reimbursed.

What do I have to do?

On the day of the consultation appointment, you will turn on a small digital audio-recording device that the researcher will give to you to record the consultation if you both consent. The recording device can be turned off at any time if the pregnant woman request that it should be turned off.

How will participant's information and views be kept safe and confidential?

After your interview and consultation appointment has been audio recorded it will be typed out word for word by the researcher. During this process any identifying and personal details, such as names, and places will be changed to ensure your identity remains anonymous. Please note that although your full

name will appear on the recording, it will not appear on the resulting transcripts. The principal researcher will assign a participant number to your name and mark this on the transcript in place of your name. This will ensure that your information will be identifiable to the researcher only, and it is made identifiable should you wish to withdraw from the study at any stage.

The conversation shared between yourself and the pregnant women will then be analysed and the analysis written up to be used as part of a PhD thesis. The result may also be circulated more widely through academic publications and conferences. It is important that you are aware that in the process of writing-up and presenting the research, some direct quotes from your conversations may be used. However, all personal details will be changed and so it will not be possible for those reading the write-up to identify you.

All data collected from your appointment, both digital and paper copies, will be kept strictly confidential. Only the researcher and her academic supervisors will have access to it. The data collected from you will be kept in a secured location on site at the University of Huddersfield and will be destroyed no more than ten years after publication of the research. Meanwhile, it may be used for other research studies.

Are there any disadvantages to taking part?

It is understood that during these antenatal appointments the midwife will discuss medical history of the participants, including for example, a discussion of participant's sexual history. This may cause embarrassment, as well as coverage of potential sensitive or upsetting topics, such as discussion of previous miscarriage or risks to the pregnant woman and baby. Although the principal researcher will not be present during the recording, it may be that the recording of such information cause some concern for participants. If pregnant participants are not happy for their medical history to be recorded, but would be happy to take part otherwise, you are advised not to switched on until after the participant's medical history has been taken.

Given that midwives are not expected to do anything outside usual midwifery practice, I do not anticipate that they will suffer any psychological distress as a result of participating in the research study. However, in the event that a midwife becomes distressed and need counselling, the contact details of local counselling services will be given to her.

Are there any benefits?

There are no obvious benefits for you, the midwives and the pregnant women in taking part. However, your experiences and views will contribute to a better understanding of the needs of pregnant women with high BMI and pregnant women in general and hopefully lead to improvements in maternity services.

What happens to the results of the study?

The study will be written up for my PhD thesis. I may also write about the research in professional journals or give presentations at conferences about the results. Participants will not be identified in any report or publication. Anyone taking part in the study will be offered a copy of the summary if they indicate interest.

Who is organising and funding the research?

The research is being carried out by Maria Iyekekpolor, a PhD student from the University of Huddersfield. It is funded by the University of Huddersfield.

Who has reviewed the study?

The research has been reviewed by the NHS National Ethics Services (NRES) and the University of Huddersfield School of Human and Health Sciences Research Ethics Panel (SREP).

Contact for further information:

You can contact me by phone or email for further information to discuss the study.

Tel: (office hours) 01484 471626 or Email: maria.iyekekpolor@hud.ac.uk

If you have any complaints about the research, please contact:

Dr. Sharon Wray,

School of Human and Health Sciences, University of Huddersfield, Queensgate, HD1 3DH

Tel: (office hours) 01484 472796 or Email: s.wray@hud.ac.uk

Appendix 6

What are the benefits?

You will not benefit directly from the research in terms of the care you receive. However, sharing your experiences and views should contribute to a better understanding of the needs of pregnant women who are obese and hopefully provide evidence which will lead to service improvements. A summary of the main research findings will be produced and sent to you if you express an interest in the outcome. This will also give you the opportunity to comment on it before it is published.

Will I receive any payment?

You will be offered a modest payment of £20 in compensation for your time and reimbursed for any other expenses incurred.

Withdrawal from the study

You may decide at any time to withdraw from the study without it affecting your antenatal care in any way. If you do so, I will ask you to confirm whether or not you wish to have the information which I have obtained from your interviews and consultations to be destroyed.

What next?

If you want to discuss taking part in the study please phone or email me using my contact details below.

Contact for further information

Maria Iyemekpolor

Tel: 01484 471626 (office hours) email: maria.iyemekpolor@hud.ac.uk

If you have any concerns about the research, please contact:

Dr Sharon Wray
University of Huddersfield, Queensgate,
Huddersfield HD1 3DH
Telephone: 0148447 2795
Email: s.wray@hud.ac.uk

Thank you for your help.

The Experiences of Pregnant Women and Midwives with Respect to Body Weight Issues



Maria Iyemekpolor
University of Huddersfield



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Information Sheet for Pregnant Women

I am writing to request you to consider whether you might be able to help me with a research study which I am undertaking at the University of Huddersfield. I would be grateful if you could take some time to read this leaflet before deciding.

What is the purpose of the study?

This study is part of a PhD research project, which is investigating the experiences of obese pregnant women. I would like to find out how weight issues identify by the use of high body mass index (BMI) are raised by midwives during consultation visit and your response to them. I also want to learn about your views concerning your experiences of maternity services in general and to identify ways in which the services might be improved.

Who is supporting the project?

The project is funded by the University of Huddersfield and is fully supported by the Maternity Services at Calderdale and Huddersfield NHS Foundation Trust.

Who has reviewed the study?

This study has been approved by the NHS National Research Ethics Service (NRES) and the School of Human and Health Sciences Research Panel of University of Huddersfield.

Why have I been invited to participate and what do I have to do?

You are being invited to participate in this research because you are pregnant and have a higher than average BMI.

If you and your midwife consent to take part in the study, your consultation appointment will be audio-recorded. After the consultation, an interview would be conducted at your convenience and this should take between 45 minutes to 1 hour to complete.

Confidentiality and Anonymity

The information you provide will be kept confidential. It will not be shared with your Midwife or any other healthcare professional you are referred to, or used for any other purpose other than the research. Audio-recordings of interviews and consultations will be transcribed

and names changed so that no one will know who you are. The data collected will be kept in a secured location on campus at the University of Huddersfield and will be destroyed ten years after the publication of the research. Confidentiality would only be breached in the unlikely event that the researcher received an indication that you or your baby was at serious risk. In this case, I would discuss my concerns with you and your midwife before reporting it to the appropriate authorities.

The research findings may be widely circulated through academic journal publications and conferences. Some direct quotes from your conversations may be used in these documents. However, all personal details will be changed so that it will not be possible for anyone to identify you.

How do I say that I want to take part?

If you are interested in participating please contact me by any of my contact details on this leaflet. If you agree to participate, you will be asked to sign a consent form to ensure that the aim of the research is completely understood.

Appendix 7

How do I say that I want to take part?

If you are willing to take part in the study you will be given a consent form to sign at the beginning of the consultation. This will ensure that you understand completely the aims of the research, what it involves and your rights as a participant should you agree to participate. A second copy of the consent form will be given to you to keep.

Withdrawal from the study

You may decide at any time to withdraw from the study. If you do so, I will ask you whether you wish to have the information which I have obtained from your interviews and consultations to be destroyed.

What are the benefits?

By participating in this study, you will be playing a role in helping to promote high antenatal quality care to obese pregnant women. A summary of the main research findings will be produced and sent to you unless you advise otherwise. This will give you an opportunity to comment on it before it is published.

Will I receive any payment?

If you incur travel expenses by taking part in the study, it will be reimbursed.

What next?

If you want to discuss taking part in the study please phone or email me using my contact details below.

Contact for further information:

Maria Iyokokpolo

Tel: 01484 471428 (office hours)

Email: maria.iyokokpolo@hud.ac.uk

If you have any concerns about the research, please contact:

If you have any concerns about the research, please contact:

Dr Sharon Wray

University of Huddersfield, Queensgate,

Huddersfield HD1 3DH

Telephone: 0148447 2780

Email: s.wray@hud.ac.uk

The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Information Sheet for midwives



Maria Iyokokpolo



I am writing to request you to consider whether you might be able to help me with a research study which I am undertaking at the University of Huddersfield. I would be grateful if you could take some time to read this leaflet before deciding.

What is the purpose of the study?

This study is part of a PhD research project, which is investigating the experiences of obese pregnant women. I would like to find out how the issue of high body mass index (BMI) is raised and discussed with women and how these women respond. I will also like to identify ways in which the services these women receive might be improved.

Who is supporting the project?

The project is funded by the University of Huddersfield and is fully supported by the Midwifery Service at Calderdale and Huddersfield NHS Foundation Trust.

Who has reviewed the study?

The study has been approved by the NHS National Research Ethics Service and the School of Human and Health Sciences Research Panel of University of Huddersfield.

Why have I been invited to participate and what do I have to do?

You are being invited to participate in this research because an obese pregnant woman you will be seeing has agreed to take part in this study. She has given me permission to approach you in order to see whether you are also willing to take part.

If you agree to participate in this research, I would like to ask for your permission to allow a consultation between you and a pregnant woman with high body mass index (BMI) to be audio-recorded. The woman whom you will be caring for has already agreed to this. I would not be present in the consultation room but will be nearby during your consultation appointment. I will also be requesting the consent of the woman you will be caring for to allow you to switch on a small digital recorder to record your consultation.

I would also ask to interview you and the pregnant woman separately after the consultation. The interview with you would be carried out at a time and place that is convenient for you, and should take about 45 minutes to 1 hour to complete.

Confidentiality and anonymity

The information you provide will be kept confidential, as it would not be shared with the pregnant women or other midwives. Audio-recordings of interviews and consultations will be transcribed and names changed so that nobody will know who you or the pregnant women are. The information you provided will be kept in a secured location on campus at the University of Huddersfield, and this will be destroyed ten years after the publication of the research.

The research findings may be widely circulated through academic journal publications and conferences. Some direct quotes from your consultation and interview may be used in these documents. However, all personal details will be changed so that it will not be possible for anyone to identify you.

Appendix 8



The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Maria Iyekiokolor - Tel: 01484 471626 (office hours)

Email: maria.iyekiokolor@hud.ac.uk

My name is Maria Iyekiokolor and I am a PhD student at the University of Huddersfield. I am currently carrying out some research and would be grateful if you could take some time to read this information sheet, which will give you more information about the research, why it is being carried out and how you can help by taking part.

What is the purpose of this study?

The study is part of a PhD research project, which is investigating the experiences of obese pregnant women and midwives in antenatal settings. As part of this research, I would like to find out what women are told concerning their raised body mass index (BMI) and also to learn about your views concerning how these women respond to what you tell them. The consultation with this woman will be recorded if you consent to it.

Who can be included?

This study is specifically focusing on women with BMI $\geq 30\text{kg/m}^2$. Only pregnant women whose BMI has been taken and recorded and midwives and consultant who care for them will be eligible for inclusion.

Why have I been invited to participate?

You are being invited to participate in this research because a pregnant woman whom you will be seeing has agreed to take part in this study. She has given me permission to approach you in order to see whether you are also willing to take part.

If so, I would like to ask for your permission to allow a consultation between you and the pregnant woman to be audio-recorded. An audio recorded consultation between herself and her midwife has taken place, and they have both been interviewed. I would not be present during the consultation itself and would withdraw after switching on a small digital audio-recorder.

Participant Information Sheet for consultants, Version 3, 28/01/13

I would also ask to interview you after the consultation. The interview with you would be carried out at a time and place that is convenient to you.

What do I have to do?

Consultants who agree to take part in the study will be given a consent form to sign at the beginning of the consultation. This will document that you understand completely the aims of the research, what it involves and ensure that you understand your rights as a participant should you agree to participate. A second copy of the consent form will be given to you to keep.

How will participant's information and views be kept safe and confidential?

I will not inform anyone of your participation in this study and only the pregnant women that has been referred to you will be aware that you are participating in the study.

The conversation shared between yourself and the pregnant women will then be analysed and the analysis written up to be used as part of a PhD thesis. The result may also be circulated more widely through academic publications and conferences. It is important to make you aware that in the process of writing-up and presenting the research some direct quotes from your conversations may be used. However, all personal details will be changed and so it will not be possible for those reading the write-up to identify you.

All data collected from you and the pregnant woman, both digital and paper copies, will be kept strictly confidential. Only the researcher and her academic supervisors will have access to it. The data collected from you will be kept in a secured location on site at the University of Huddersfield and will be destroyed no more than ten years after publication of the research. Meanwhile, it may be used for other research studies.

All personal information and the records of interviews will be stored securely at the University of Huddersfield and will only be accessible by me. Any personal information will be deleted once the study is completed. The records of our conversation will be kept securely for 10 years before being deleted; however, these will not contain information that could be used to identify participants. Any quotes used in publications arising from the research will be anonymised.

Are there any benefits?

There are no obvious benefits for participants in taking part. However, your views will contribute to a better understanding of the needs of pregnant women with BMI $\geq 30\text{kg/m}^2$ and hopefully lead to improvements in the antenatal care the service provides.

What happens to the results of the study?

The study will be written up for my PhD thesis. I may also write about the research in professional journals or give presentations at conferences about the results. Participants will not be identified in any report or publication. Anyone taking part in the study will be offered a copy of the summary if they indicate interest.

Who is organising and funding the research?

The research is being carried out by Maria Iyekokolor, a PhD student from the University of Huddersfield. It is funded by the University of Huddersfield.

Who has reviewed the study?

The research has been reviewed by the NHS National Ethics Services (NRES) and the University of Huddersfield School of Human and Health Sciences Research Ethics Panel (SREP).

Contact for further information:

You can contact me by phone or email for further information to discuss the study.

Tel: 01484 471626 or Email: maria.iyekokolor@hud.ac.uk

If you have any complaints about the research, please contact:

Dr. Sharon Wray, School of Human and Health Sciences, University of Huddersfield, Queensgate Huddersfield HD1 3DH. Tel:01484 472796 or Email: s.wray@hud.ac.uk

Appendix 9



- Are you pregnant?**
Is your pregnancy 22 weeks old or above?
Have you been told by your midwife that your BMI* is 25 or over?
Do you receive antenatal care from the NHS in West Yorkshire?

* BMI stands for Body Mass Index - this tool is used to measure weight in relation to height

If your answer to all of these questions is YES, then you can contribute to a research that will help shape how antenatal care services are provided. Please consider taking part in a research study which aims to explore how services could be improved for pregnant women with a high BMI and all pregnant women in general.

If you are interested please contact:

Maria Iyakekpolor PhD student
Tel: 01484 471626 (office hours)
mobile: 07882003069

If you have any concerns about the research, please contact:

Dr Sharon Wray
Tel: 01484432286
University of Huddersfield, Queensgate
Huddersfield HD1 3DH.

*Any cost incurred as a result of your participation in this study will be reimbursed. You will also receive a £20 voucher

Appendix 10

Revision to previously approved SREP Appli... - Maria Iyemekpolor (Researcher)

Page 1 of 4

Revision to previously approved SREP Application (previously approved 20-Sep-12)- Maria Iyemekpolor (PhD Student) - APPROVED - The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues (SREP/2013/90)

Kirsty Thomson

The 28/11/2013 13:04

To: Maria Iyemekpolor U0552322 <M0552322@hudd.ac.uk>;

Cc: Sharon Wray <swray@hudd.ac.uk>; Karen Ousey <KLOusey@hudd.ac.uk>; Jane Tobbell <j.tobbell@hudd.ac.uk>

Dear Maria,

Thank you for providing further clarification with regard to IRAS and Governance approval being in place.

Dr Karen Ousey is now satisfied with the revision to your previously approved SREP application and I can confirm that your revised SREP application has received full ethical approval.

With best wishes for the success of your research project.

Regards,

Kirsty
(on behalf of Dr Karen Ousey, Chair of SREP)

Kirsty Thomson
Research Administrator

☎: 01484 471156
✉: K.Thomson@hudd.ac.uk
🌐: www.hudd.ac.uk

School of Human and Health Sciences Research Office (HHRC/01)
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

From: Maria Iyemekpolor U0552322
Sent: 28 November 2013 12:52
To: Kirsty Thomson
Cc: Sharon Wray; Karen Ousey
Subject: RE: Revision to previously approved SREP Application (previously approved 20-Sep-12)- Maria Iyemekpolor (PhD Student) - The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues (SREP/2013/90)

Dear Kirsty,

<https://outlook.office365.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMK...> 14/06/2017

Appendix 11



CONSENT FORM

The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Researcher: Maria Lysekopala

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 7/03/13 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my position as a midwife or my legal rights being affected.
 3. I agree for my consultation visit with my client (a pregnant woman who is obese) and interview to be audio-recorded.
 4. I understand that no person other than the interviewer will have access to the recording.
 5. I agree to be quoted (by use of pseudonym) in written report resulting from this research.
 6. I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.
-
7. I agree to take part in the above study

Name of Participant

Date

Signature

Consent form for midwives, Version 2, 7/03/13

Appendix 12



CONSENT FORM

The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Researcher: Maria Iyekiokpor

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 7/03/13 (Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my antenatal care or my legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study, where applicable may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to my consultation visit with my midwife and interview to be audio-recorded.

5. I understand that no person other than the interviewer will have access to the recording.

6. I agree to be quoted (by use of pseudonym) in the written report resulting from the research.

7. I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

8. I agree to take part in the above study.

Name of Participant

Date

Signature

Consent form for pregnant women, Version 3, 7/03/13

Appendix 13



CONSENT FORM

The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Researcher: Maria Iyekekpolo

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 7/03/13 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my position as a medical consultant or my legal rights being affected.
3. I agree to the consultation of my client (a pregnant woman who is obese) and interview to be audio-recorded.
4. I understand that no person other than the interviewer will have access to the recording.
5. I agree to be quoted (by use of pseudonym) in written report resulting from the research.
6. I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.
7. I agree to take part in the above study.

Name of Participant

Date

Signature

Consent form for consultants. Version 2. 7/03/13

Appendix 14

Inclusion Criteria for participants for the study

Women

- Pregnant women with BMI 30kg/m^2 and over and have been classified as pregnant women with high body mass index and in the 'high risk' antenatal care pathway.
- Have an understanding of English to be able to give consent
- Must live within the NHS Foundation Trust that ethical approval was granted for

Midwives

- Must be a midwife who provide antenatal care for pregnant women within the NHS Trust

Obstetrician

- Must work within the Trust and be part of the pregnant women with high BMI shared care and provide antenatal care for women who are referred to them

Appendix 15



The Experiences of Pregnant Women with Respect to Bodyweight Issues

Topic Guide questions for midwives

1. Tell me about your care for obese pregnant women generally.
 - a. Does this concern extend to the health of their unborn babies?
 - b. (If yes, the concerns of midwives will be explored briefly)
 - c. Do you think bodyweight impacts pregnancy and/or its outcomes?
2. More generally, what are the most important issues that you regularly encounter with pregnant women?
 - a. Are these issues common to all groups of pregnant women?
 - b. What makes you say that?
3. (If not mentioned) Would you say from your experience that the bodyweight of a woman has any significant impact on the care and outcome of pregnancies?
 - a. (If yes) What are the impact?
4. What information and advice would you recommend for a woman planning for pregnancy?
 - a. How do these women respond to the advice you give them?
 - b. Does the background (e.g. level of education and ethnicity) of women affect their response to the advice you give to them?
 - c. If you have concern following your consultation with a pregnant woman, what would you do?
 - d. How would you describe your relationship with your (obese) client?
 - e. Is there anything you will like to add to what we have discussed?
 - f. How have you found the interview?

Topic guide questions for midwives. Version 2. 28th January 2013

Appendix 16



The Experiences of Pregnant Women and Midwives with Respect to Bodyweight Issues

Topic guide questions for pregnant women

My name is Maria Iyekiokolor the researcher. The study is part of a PhD research project, which is investigating the experiences of obese pregnant women and midwives in antenatal settings. As part of this research, I am interested in audio recording the interaction between you and your midwife during antenatal booking visits. **I will also audio-record an interview with you.** All data collected from your appointment and interview, both digital and paper copies, will be kept strictly confidential. Only the researcher and her academic supervisors will have access to it. The data collected from you will be kept in a secured location on site at the University of Huddersfield and will be destroyed no more than ten years after publication of the research. Meanwhile, it may be used for other research studies.

On disclosure: If you disclose any information that raises concern about your safety and that of the unborn child, I will report it to the appropriate authority. If the concern you raise is regarding unsafe or poor care, I will encourage you to report it via the Trust complaints procedure.

1. What have you found most useful about the antenatal care you receive from your midwife?

- Has your midwife mentioned anything regarding your body mass index (BMI) to you yet?
- Have you been referred to see a specialist? E.g. a dietician?
- How do you feel about this?

2. Tell me about the antenatal visits you have received from your midwife

- What was discussed?
- What are your views about the discussion?
- Did anything make you feel uncomfortable / did anything make you feel particularly pleased or happy etc.

3. If the participant have been referred to see a specialist:

- Have you also been referred to a consultant?
- Did the midwife explain why you have been referred to see a consultant?

Topic guide questions for women. Version 2. 28/01/13

- How do you feel about going to see a consultant?

4. (If not mentioned in responses given so far) Have your midwife discussed anything relating to the fact that you are in the 'high risk' of antenatal category?

5. Do you have any suggestions on how antenatal services could be improved for women with high BMI and women in general?

6. Is there anything you would like to add to what we have discussed?

7. How have you found the interview?

Appendix 17

Topic guide questions for PW

How are you today and how's your baby doing?

I'm doing this study because obesity/fatness/body weight has become a health issue in the society today and this has influenced the kind of healthcare people are given. This too has influence the kind of ante-natal care women are getting

- What's your first impression of the ante-natal care when you first saw your midwife?

1. You have been identified as having a BMI – do you understand the term?
2. Has your midwife discussed weight issue with you?
3. Do you think your weight will affect your pregnancy?
 - If yes/no – why
4. What advice/information has your midwife given you regarding your weight?
5. Does the fact that you have been classified as 'high risk' make you worry?
6. Has your midwife discuss any health issue as a result of your weight with you?
7. How do you feel about these health issues discussed?
8. Did anything that was discussed make you feel uncomfortable/happy?
9. Has your midwife referred you to see a specialist?
 - a. Consultant

 - b. Dietitian
10. Have you gone for your scan – how was it?
 - a. Was it difficult for the sonographer to see your baby?

11. What suggestions do you have as to how the care for (big girls like you- depending on the term participants used).

12. Are you spiritual

Appendix 18



The Experiences of Pregnant Women with Respect to Bodyweight Issues

Topic Guide questions for consultants

1. Tell me about your care for obese pregnant women generally?
2. How do you address the issue of obesity in pregnant women?
 - a. Does your concern extend to the health of the unborn babies?
 - b. Do you think body weight impacts pregnancy and/or its outcome?
3. (if not mentioned) Would you say from experience that the bodyweight of a woman has any significant impact on the care and outcome of pregnancy?
 - a. (if yes) How would you describe the impact of high body weight on pregnancy?
4. There is guidelines on weight gain during pregnancy according to individual body mass index in the US designed by the Institute Of medicine, but here in the UK there are no such guidelines. What is your view on having similar guidelines for the UK?
5. If in favour of having a UK guideline, what do you think could be done to develop and implement such guidelines? If opposed to a UK guideline, what is your reason for your position?
6. Have you received any feedback from women indicating that they think they are treated differently on account of their weight?
 - a. Could you discuss these feedbacks generally?
 - b. How do you feel about these feedbacks that you have received
 - c. What would you say influences these feedbacks and the treatment obese pregnant women receive?
7. What information do you give to your obese pregnant clients?
8. How do these women respond to the advice you give to them?

Topic guide questions for consultants. Version 3. 28th January 2013.

- a. What factors do you think influence their reaction to your advice?
 - b. If you have a concern following your consultation with a pregnant woman, what do you do?
9. Is there anything you will like to add to what we have already discussed?