Mexican midwives’ experiences of caring for pregnant women suffering from obesity

Mexikanska barnmorskors upplevelser av att vårda gravida kvinnor med fetma

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ABSTRACT

Obesity is increasing, in 2011, ca 11 percent of all Swedish women were classified as obese, many of them in fertile age. A pregnancy with obesity runs greater risks for complications. A country which has faced the obesity problem is Mexico, with one of the highest obesity rates among women in the world. The obesity trend among fertile women imposes new demands on the healthcare system; especially on the midwives. This study aimed to describe Mexican midwives’ experiences of caring for pregnant women suffering from obesity. Nine midwives in Mexico were chosen through network sampling, the method was semi-structured interviews. The interviews were analyzed with content-analysis. Five main categories emerged: Midwives’ experience of health promotion care for pregnant women suffering from obesity, Midwives experience of interprofessional work regarding pregnant women suffering from obesity, Midwives’ experience of advice when caring for pregnant women suffering from obesity, Midwives’ general thoughts about nursing for pregnant women suffering from obesity and Midwives’ feelings regarding pregnant women suffering from obesity. To be able to reduce the problems with obesity among pregnant women, nurses need to involve the family, raise the discussion about socioeconomic resources, explore deeper reasons behind the obesity, work with empowerment and strengthen the teamwork with other health care professions. The findings could apply to countries where obesity has increased, where obesity among pregnant women is not given the importance needed. A highlighted significance to this problem is not only economically beneficial for society, but could also save lives.

Keywords: Health Promotion Care, Mexican Midwives, Obesity, Pregnancy
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1. BACKGROUND

1.1 Obesity

Over the past decades obesity has become a global health crisis, which has led to the concept globesity (Avena, Gold, Kroll, & Gold, 2012). Globesity causes health issues as well as affects the national economy and diminishes life quality (Adolfsson, Finnerup Andresen, & Brattstrom Edgren, 2013; Lobstein, 2010). In 2011, 10.7 percent of all Swedish women, 15 or older, were classified as obese, many of these in fertile age (OECD, 2013). The main explanation for overweight and obesity is a greater intake than output of energy, intake being food and beverages (Martinez, 2014). Obesity is mainly related to lifestyle; however there is also a genetic factor (Auld, 1989). Ultimately, the interaction between genes and behavior is what causes overweight and obesity (Sullivan, 2014).

World Health Organization (WHO, 2013a) defines obesity as a person with a body mass index (BMI) greater than or equal to 30 kg/m². BMI is a weight-for-height index used to classify overweight and obesity. Obesity is a state where the body has gained a significant amount of fat which causes stress for the body, and leads to a greater risk of non-communicable diseases (NCDs) (Rtveladze et al., 2013). The main risk factor for mortality in NCDs is overweight, obesity and an unhealthy diet. NCDs are diseases which are not passed from person to person, and they are often chronical with a slow progress. The most common NCDs are cardiovascular diseases, diabetes, cancer and chronic lung diseases. The first two being highly associated with overweight and obesity (WHO, 2013b). The probability of an early death caused by NCDs, increases by 30 percent for every extra 15 kilograms overweight (Rtveladze et al., 2013).

From a historic perspective humanity has fought against a lack of aliment, hence obesity has historically been associated with wealth and success (Bloomgarden, 2003). In industrial countries where the shortage of food is no longer a vast problem, there has been a switch in the healthy weight ideal during the last centuries. Obesity has gone from being an admirable state among the upper classes to a problem for the more vulnerable population such as those living in poverty. The obesity epidemic is now extending to low- and middle-income countries, where there has been an increase in per capita income (Cecchini et al., 2010; Barquera, Campos & Rivera, 2013). This economical change has been seen in countries.
where the middle class is evolving such as Russia, India, China, and most notably in Mexico (Cecchini et al., 2010). There are now more people dying from obesity related complications than from starvation (Dobbs et al., 2014). The growing obesity rate is partly explained by a change in diet and a more sedentary lifestyle. Socially vulnerable groups are described as more at risk for an unhealthy lifestyle (Pellmer, Wramner & Wramner, 2012). This is due to an easier access to “fast food” and sugary beverages, as well as generally low food literacy, meaning a lack of knowledge in food preparation, appropriate food sizing and proper diet (Barquera et al., 2013).

### 1.2 Obesity in Mexico

Mexico is a country with one of the highest obesity rates in the world, and the highest obesity rate among women. About 35 percent of the Mexican women of 15 years and older are obese (OECD, 2013). Obesity in Mexico is widespread throughout the country, and exists in all age groups among both genders. The rapid raise in obesity rates is more prevalent in the most vulnerable parts of the population. The complexity in the situation lies in the findings that obesity coexists with undernutrition in the most vulnerable communities, and even within the same families (Barquera et al., 2013).

In 2010, approximately 75 percent of all deaths in Mexico were estimated to be caused by NCDs. The main risk factors for mortality in NCDs were overweight, obesity and unhealthy diet (Rtveladze et al., 2013). In 2013, the healthcare costs of obesity-related diseases in Mexico were estimated at US $880 million per year. If the obesity trend continues to grow, the healthcare cost will raise above US$1 billion per year within seven years (Barquera et al., 2013).

To understand the increase of obesity in Mexico, El Instituto Nacional de Salud Publica, Mexico’s National Institute of Public Health, analyzed the national income databases and other databases in 2002. Their studies showed there are seven changes in the nutrition transition:

1. A decrease in time available for food preparation.
2. An increase in the availability of low-cost processed foods with high quantities of sugar, fat and sodium.
3. An increase in fast food consumption and food consumption outside the home.
4. An increase in per capita income.
5. An increase in the availability and supply of ready-to-eat foods and processed foods.
in general.

6. An increase in exposure to food and beverage marketing.
7. An increase in technology that decreases physical activity.

Another result from the same study was the dramatically increased intake of sugary beverages in Mexico; between 1999 and 2006 there was an increase with 252 percent among adults. In fact, Mexico has one of the highest intake of caloric beverages in the world; 20 percent of the total energy intake in the population is from sugary beverages. Intake of sugary drinks is associated with obesity. In the original Mexican diet there are already many caloric beverages such as sugar sweetened flavored drinks called aguas frescas and fruit juices. Furthermore, the study found existing guidelines and labeling schemes are confusing and misleading and nutrition literacy among the population is low (Barquera et al., 2013).

The same study also reported a decrease in important food groups such as fruits and vegetables, dairy products and meat. These food groups are necessary providers of vitamins and minerals that are important for good health, and to prevent diseases. Additionally, the level of physical activity in Mexico has decreased since 2006, which can be seen as a contributor to the increasing obesity rate (Barquera et al., 2013).

In 2005, Mexico started an attempt to tackle the obesity problem in response to the healthcare burden and high mortality in obesity-related diseases. The Mexican Ministry of Health formed a National Agreement for Healthy Nutrition (ANSA) with ten goals. Among them: promote physical health, increase intake of fruit and vegetables, reduce fat and sugar in beverages, easy to understand labeling of food, promote breast feeding and educate the public about portion sizes. Despite the attempts to tackle obesity with the ANSA there has, so far, not been any significant change in the obesity rates in Mexico. The challenge of the ANSA is to balance between the Mexican industry’s economic interests and the public health goal. Another challenge is government limitations, including the absence of transparency and deficient budgeting (Barquera et al., 2013).

If Mexico does not gain control over this alarming obesity trend, it is estimated to lead to further economical and healthcare burdens. An analysis by Rtveladze et al. (2013) stated that by 2050 only nine percent of the females in Mexico will be normal weight. Furthermore, they also found a reduction by one percent in the mean BMI could save $US 85 million per year in healthcare costs. These higher healthcare costs can be avoided with health promotion efforts (Rtveladze et al., 2013).
1.3 Obesity, pregnancy and parenthood

A pregnant woman who is obese in the beginning of her pregnancy faces more risks not only for herself, but also for the unborn child, ante- and postnatal. In 2011, a study made in the UK showed of all pregnancy-related deaths, 27 percent were caused by obesity (Stadtlander, 2014). For the mother, obesity is related to a greater risk for preeclampsia, gestational diabetes, venous thromboembolism, hypertension and even miscarriage (Sabounchi, Hovmand, Osgood, Dyck, & Jungeheim, 2014; Foster & Hirst, 2014, Stadtlander 2014).

Obese women are also more likely to give birth to a baby with spina bifida, omphalocele, heart defects and multiple other abnormalities (Ramsay, Greer & Sattar, 2007; Stadtlander 2014; Sullivan, 2014). Defects such as spina bifida, pre-term delivery and low birth weight can be prevented with a diet containing recommended levels of folic acid, iron and protein (Squibb, 2014). These vital nutrients are rarely found in an unhealthy diet, since these nutrients mainly exist in fruit, vegetables, dairy products and meat. Ultrasounds and other clinical examinations in relation to pregnancy are difficult to carry out in women with high BMI, thus making it harder to detect defects i.e. heart problems and abnormal fetal size (Foster & Hirst, 2014; Stadtlander, 2014). Obesity could also be an inhibiting factor for pregnancy, due to a higher risk for polycystic ovary syndrome (Sabounchi et al., 2014).

Furthermore, the children of obese mothers run a greater risk for developing child obesity, and most of them are expected to stay obese when reaching adulthood. A child with one or two obese parents runs a 40 and 80 percent risk of becoming obese. As obese parents have an unhealthy lifestyle it is more likely the child will follow their behavior. However, there could also be a genetic factor which contributes to the child’s susceptibility for obesity (Stadtlander, 2014).

1.4 Midwifery in Mexico

For centuries in Mexico, pregnancy and childbirth, with and without complications were attended by midwives. In the 1960’s, when the medical specialty obstetrics grew more common, it was decided midwives could only attend normal pregnancies and deliveries. The medical profession began to restrict the role of the midwives, which eventually lead to a change in limits between what the medical professions considered a normal or an abnormal pregnancy. Finally, it was argued physicians should attend all births; hence the role of midwives was occupied by gynecologists. This coincided with major advances in gynecology,
which made the pregnancy much safer and decreased childbirth complications. Hence, the
community stopped accepting graduates in nursing and midwifery (Carillo, 1999).

Nowadays, professional midwives and nurse midwives are rare in the public healthcare
system. In Mexico there are three different types of midwives: “parteras tradicionales”
(traditional midwives), “parteras profesionales” (professional midwives) and “enfermeras
parteras” (nurse midwives) (personal communication, Guadalupe Landerreche, midwife,
November 27, 2014). The differences are:

1) Traditional midwives.
The majority of the traditional midwives have no traditional education, they have learnt the
profession from their mothers, grandmothers and other midwives in their community. Their
clients are aware that the midwives have learned and gained their experience only from their
teachers and their own work, and they attend the client in the client’s home. The midwives
work according to their culture and customs. In general they give prenatal, delivery and
postpartum care (personal communication, Guadalupe Landerreche, midwife, November 27,
2014). Traditional midwives are more common in rural areas and lower-income families
(personal communication, Laura Cao Romero, midwife, November 15, 2014).

2) Professional midwives.
In Mexico there is only one school for midwifery which is recognized by “la Secretaría de
Salud”, the Mexican Secretary of Health, and the only school which has a certificate to teach
midwifery. The studies are four years. There are other midwifery schools, but they are not
recognized by the Mexican Secretary of Health (personal communication, Guadalupe
Landerreche, midwife, November 27, 2014).

3) Nurse midwives.
The nurse midwives study nursing and obstetrics at the university during four years and after
completing the studies they receive a registered nurse license. Then they specialize another
year in perinatal nursing. Nurse midwives are recognized by the Mexican Secretary of Health.
(personal communication, Guadalupe Landerreche, midwife, November 27, 2014).

1.5 Midwifery in Sweden
In Sweden, midwifery is a one and a half year post-graduate education after completing a
nursing bachelor of three years and one year of work experience. Therefore, all midwives in
Sweden are registered nurses specialized in midwifery. Midwives have their own ethical code,
International Code of Ethics for Midwives, but since Swedish midwives are registered nurses, they are also working according to the International Code of Nursing (ICN) and the guidelines set by Svensk Sjuksköterskeförening (Swenurse), the Swedish Society of Nursing. The main focus of this study is on health promotion and nursing, not the midwives’ special competence. Nurse/midwife and nursing/midwifery are therefore used as synonyms in this study.

1.6 The role of the midwives’ maternal care
The obesity trend among fertile women imposes new demands on the healthcare system; especially on the midwives who have to meet the needs, such as specific controls, of this growing patient group. Obesity is a preventable disease (WHO, 2013a) and within the maternal care the midwives’ promotional healthcare benefits both mother and child.

A study by Smith, Taylor & Lavender (2014) described motivational group meetings, based on pregnant women’s BMI to be successful for a long-lasting change in lifestyle. Furthermore, a study made in the UK conclude midwives seldom raised the issue of overweight (Foster & Hirst, 2014). Even though, both from an economical perspective and public health perspective, it is vital to initiate a discussion about overweight and an unhealthy lifestyle, as this is an expanding problem (Dobbs et. al, 2014).

1.7 Definitions
Health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). Another definition is that health does also include dimensions of disease, where health and illness are not to be seen as opposites, but should be understood as a coherent unit. The focus should not be on the absence of disease, as health is a state of balance between different dimensions, such as a physical, mental, emotional, social and spiritual wellbeing (Kostenius & Lindqvist, 2006).

Nursing is “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (American Nurse Association, 2015).

Health promotion is “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions” (WHO, 2015). Health promotion aims to develop health as a resource in the everyday life. The nurse can work in a health promotion manner by
promoting, supporting and prioritizing health, both on an individual and societal level (Kostenius & Lindqvist, 2006).

A holistic view is to understand the human being as a unity of body, soul and spirit, and health as a whole of the person’s experiences, and values. It is also to let the person define health. Holistic care is when the registered nurse sees the whole person, beyond the medical condition (Swenurse, 2012a, b; Hedelin, Jormfeldt & Svedberg, 2009).

Person-centered care is to make the patient a co-creator and accessory in his or her care, and treatment. Every person is unique, and should be treated individually, and after the person’s own condition (Swenurse, 2012a). Person-centered care aims to fulfill the patient’s wishes, needs and expectations. The patient should be considered as an information seeker, cooperation partner, and decision maker in their own care (Carlsson & Wennman-Larsen, 2009).

Empowerment is an approach where the patients is given an active role in their own care. Empowerment means self-reinforcement and to give back the power to the patient through strengthening the individual’s knowledge, competence and self-esteem. This liberates the patient from passivity, and thereby give the patient an active role (Swenurse, 2012b; Kostenius & Lindqvist, 2006).

1.8 Motive

Obesity is a disease that can be prevented (WHO, 2013a), and in the future it is important that prevention of obesity becomes a greater part of the nursing responsibility. In 2011, ca 11 percent of all women, 15 or older, in Sweden were classified as obese, many of these in fertile ages (OECD, 2013). The obesity trend among fertile women imposes new demands on the Swedish healthcare system.

As Mexico is already tackling this problem, the Swedish healthcare system could benefit from the experience Mexican midwives might have. Nursing is a global profession, and obesity is a global problem, thus nurses worldwide could benefit from this study. To explore how the Mexican midwives experience this problem could give a different cultural perspective of this aspect, which could also increase the knowledge and awareness about cultural differences, and give a further multicultural understanding, much needed in Sweden’s growing multicultural society.
The International Council of Nurses (ICN, 2012) states that nurses have four fundamental responsibilities: promote health, prevent illness, restore health and alleviate suffering. The findings of this study could support Swedish nurses to be more prepared when meeting an obese patient, regardless of the patient’s culture, as well as fulfilling the responsibilities stated by the ICN.

One of the most important role of a nurse is to inspire beneficial lifestyle changes, educate and give information about the risk with an unhealthy lifestyle, and to reduce unhealthy lifestyles that could risk the public health (Swenurse, 2012a). The aim with nursing is to give the patient the possibility to make well-based decision through dialog, participation, individual planning, and adequate information and knowledge (Swenurse, 2010). With this study and the knowledge gained from its results Swedish nurses can obtain tools to help patients with obesity problems.

Swenurse (2012b) has made several suggestions on how to improve health promotion in nursing. Swenurse states that research has to be more focused on subjective experiences of health and wellbeing to individualize the healthcare. This study gives a deeper understanding for the subjective experiences of the Mexican midwives, hence, promoting this proposal.

2. AIM

The aim of this study was to describe Mexican midwives’ experiences of caring for pregnant women suffering from obesity.

3. METHOD

The study was an empirical qualitative research study with a descriptive design. The study was carried out by conducting interviews with midwives chosen through network sampling.

3.1 Sampling Strategy

The study included nine midwives working in hospitals, clinics and private practice in Mexico City and Cuernavaca. The midwives were chosen by network sampling; meaning they were chosen through referrals from earlier participants in the sample (Polit & Beck, 2012). The first midwives were found on websites from midwives associations in Mexico City, and Facebook pages found by a Facebook search on “partera” (midwife in Mexican Spanish). These midwives were asked if they wanted to participate in the study, and if they knew other midwives eligible for the study. Their referrals were contacted via e-mail, and asked to
participate. To ensure all three types of midwives were included, the authors recruited participants through different channels. Eleven midwives were asked to participate before arriving to Mexico, and all accepted. When arriving in Mexico, the midwives were contacted again, at that time, nine midwives were interested in participating in the study. Two midwives did not answer the authors’ e-mails, and were thereby excluded. The midwives that chose to participate in the study received an informative letter (see attachment one).

3.2 Data Collection
Semi-structured interviews were conducted in Mexico City and Cuernavaca during January and February 2015. The interviews were conducted at a time and place chosen by the participant, and ranged between their work places, homes and public places. Before the interviews, the midwives read and signed an ethical consent form (see attachment two). The questions were about their experience of caring for obese pregnant women (see attachment three). There was one leading interviewer and one observer. The observer took notes of the participants’ body language and expression of the participant, to ensure all non-verbal communication was noted. This was important for the latent analysis (Polit & Beck, 2012). The observer had the possibility to complement with questions. Complementary questions were asked to clarify the answer, and to re-direct back to the subject of the study. Six of the interviews were carried out in English, the three remaining were done in Spanish, with one of the authors of this study, fluent in Spanish, translating.

The interviews varied in time between 19 and 52 minutes. Some midwives were economical with words, while others were generous in sharing their experiences. The quality of the interviews did not depend on the length of the interviews, but on the content, therefore the time did not determine the quality. The midwives had between one and twenty-seven years of experience, and their education varied. Three were professional midwives, four were nurse midwives and two were traditional midwives. Their working environment was different, and included private clinics, private practice, and hospitals. Five midwives worked with in private practice, two worked at private clinics, one midwife worked at a hospital, and one midwife worked both at a hospital and at a private clinic.

3.3 Data processing and analysis
The interviews were recorded with a Dictaphone. After each interview, one author listened to the interview and transcribed it verbatim. After transcribing the interview, the whole interview was listened through by the other author while reading the transcript to ensure the
correctness of the transcript. Non-verbal data such as laughter, sights etc. were also transcribed. The recorded interviews were analyzed with a latent and manifest qualitative content analysis (Graneheim & Lundeman, 2004). After transcribing the interviews, meaning units corresponding with the aim of the study were identified and condensed into shorter sentences. The first interview was analyzed together, to ensure similar method of working. The remaining interviews were divided, and meaning units and condensation was done separately by authors. When in doubt, the authors consulted each other. The condensed sentences were then organized in subcategories after discussing each sentences’ content. This process is called triangulation. The subcategories were structured to a similar content and given a suitable name describing the content. Among the sub-categories, patterns were found. The sub-categories with corresponding patterns were then sorted into categories, see table 1, this served as the result of the study.

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Condensation</th>
<th>Sub-category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>They realize how good their mother’s food was, their grandmother’s food was, and they they’ll come back to cooking at home</em></td>
<td>Information about diet makes the women realize how unhealthy their current diet is</td>
<td>Midwives’ feelings how the pregnant women suffering from obesity respond to their advice</td>
<td>Midwives’ experience of advice when caring for pregnant women suffering from obesity</td>
</tr>
<tr>
<td><em>Children are very smart, so if you tell them you have to eat well, and you don’t have to eat so many candies or bread or whatever, but you do it. Your children won’t understand because well, you’re telling something but you’re not doing something, right?</em></td>
<td>Midwife tells the women the children will do what you do, not what you say</td>
<td>Family focus</td>
<td>Midwives’ experience of health promotion care for pregnant women suffering from obesity</td>
</tr>
<tr>
<td><em>They’re like other pregnant women for me, it’s not like “oh, she’s tall! She’s thin! She’s pretty! She’s fat!”’, no, like all women, is not different</em></td>
<td>Caring for obese pregnant women should be the same as for other pregnant women</td>
<td>No difference in caring for obese pregnant women and non-obese women</td>
<td>Midwives’ general thoughts about nursing for pregnant women suffering from obesity</td>
</tr>
</tbody>
</table>

Table 1.

3.4 Ethical considerations

All research should be characterized by an ethical approach. An ethical approach means taking responsibility for the participants included in the study, and to ensure the information is collected and handled respectfully (Kristensson, 2014). To work in accordance with the four
fundamental responsibilities of the ICN’s ethical code, it is important the purpose of the study is aimed towards promoting health, and the patient’s wellbeing. During the process of this study, the four basic moral principles: respect for autonomy, beneficence, non-maleficence and justice, were always present.

During the planning of the interviews, and writing of the questions the authors took in consideration that obesity can be a sensitive issue. Hence, the questions were phrased respectfully, this assured that the non-maleficence principle was respected. It was important that the participant did not feel obligated to take part in the interview. To protect the participants’ autonomy and integrity they were informed that the study was voluntary and confidential. It was of great importance that the participants understood that the authors were students, not conducting the study to judge, patronize or make the midwives feel insufficient. All data were treated confidentially. The participant received an informative letter before the interview and signed an informed consent form to assure they were aware of their rights. Both documents were translated to Spanish by a professional interpreter, to ensure the participants understood their rights fully. The documents were written in consideration to the Declaration of Helsinki, an international declaration created to protect participants in research studies, and ensure that the four ethical principles are followed (World Medical Association, 2014). Since the study was conducted to promote health, the beneficial principle was secured.

The Universidad Nacional Autónoma de México, the largest university in Latin America, was contacted about the need of an ethical permit to conduct this study. In consideration to their “Aspectos Éticos”, Ethcial Aspects, there was no need for an ethical permit.

4. RESULTS

The results showed the Mexican midwives’ experiences of caring for pregnant women suffering from obesity could be summarized into five main categories, with 19 sub-categories which served as the headings of this study, see below.

**Midwives’ experience of health promotion care for pregnant women suffering from obesity**

- Holistic care
- Explores diet and evaluates diet changes
- Family focus
- Empowerment
- Adjust care to women’s own resources
- Identifying and preventing risks
Midwives experience of interprofessional work regarding pregnant women suffering from obesity
- Teamwork with nutritionist
- Teamwork with physician
- Teamwork with other healthcare professionals

Midwives’ experience of advice when caring for pregnant women suffering from obesity
- Midwives’ views on how to give advice
- Midwives’ feelings towards giving advice
- Midwives’ feelings how the women respond to their advice

Midwives’ general thoughts about nursing for pregnant women suffering from obesity
- Equality in caring for pregnant women suffering from obesity and non-obese women
- Challenges when caring for pregnant women suffering from obesity
- Limited experience of challenges when caring for pregnant women suffering from obesity
- Midwives’ experience of obesity as a growing health problem

Midwives’ feelings regarding pregnant women suffering from obesity
- The worries of the midwives
- The frustrations of the midwives

4.1 Midwives’ experience of health promotion care for pregnant women suffering from obesity
This category describes how the midwives worked with health promotion when caring for pregnant women suffering from obesity. The midwives’ experiences of giving health promotion care was sorted into seven different sub-categories: holistic care, explores diet and evaluates diet changes, family focus, empowerment, adjust care to women’s own resources, identifying and preventing risks and informing and educating the women.

To give the best possible care to the pregnant women suffering from obesity, the midwives found it important to explore deeper emotional reasons behind the obesity, and not only focus on the unhealthy diet. They stressed a midwife need to know the person behind the obesity, and investigate if there are other emotional problems causing the overeating such as previous traumas, a damaged relationship to food, and a damaged relationship to taking care of oneself. The midwives believed a midwife has to be attentive enough to see what the women is not telling you, as it is more important than what they do tell you. They also mentioned creating a trust for the women to help the midwife explore the deeper reasons behind the overweight. The midwives stated they need to know the women’s clinical history, background, family situation and surroundings. They described the women’s need for the midwife to ask...
questions, listen, and understand the women’s situation. For the midwives it was urgent to be able to catch where the women need help. The midwives expressed how to improve the women’s self-esteem. The majority expressed a midwife should help the women go through the emotional aspects of the obesity, and thereby prepare her for motherhood.

“...going a lot deeper than weight gain” (Professional midwife)

“If they need to talk about food, then we’ll do that, and if they don’t, we won’t”. (Professional midwife)

The midwives also described how they explored the diet of the pregnant women suffering from obesity, and evaluated their diet changes. During the meetings with the women, the midwives wrote down everything the women ate to learn about their eating habits, and explores diet reasons for the weight gain. The midwives identified strengths and weaknesses in the women’s diet, and suggested diet changes on the basis of their findings. One midwife mentioned having group discussions about diet to increase the awareness of unhealthy foods.

The midwives expressed they include the family in the care for pregnant women suffering from obesity. The midwives explained the whole family has to be included, as the diet of one parent affects the rest of the family. The family can help and support the mother’s new diet, and it is important to teach both parents about a healthy lifestyle, which makes the whole family involved in the pregnancy. One midwife had done home consults, and experienced it to give good results because of the insight in the family situation.

“... that makes the whole family involved in the pregnancy, we say ‘they’ are pregnant” (Nurse midwife)

The midwives’ care did not only see to the mother, but also to the unborn child, as good health in the mother affects the baby positively. The midwives expressed the importance of teaching the mother how to be a good role model, since the baby will follow the mother’s example. They educated the women about the importance of a healthy diet after the birth to prevent child obesity.

“If they’re not taking care of themselves now, they will not take care of themselves later on, and the consequences for the baby, basically is that they will be educated by their example” (Nurse midwife)
The midwives explained they cannot solve the obesity problem for the women, but they can give them the information and suggest the women to seek help, so the women can make their own decisions about a healthy lifestyle.

“She has all the information, and then she can make the decision” (Professional midwife)

The midwives believed it important to acknowledge that the women had the power to change her own lifestyle, hence the midwife is only a guide who helps the women help themselves. The midwives also taught the women to take responsibility for their condition. It was found that the midwives empowered and supported the women to make good choices and made the women realize that they can change, no matter their background.

“She’s intelligent, and she chooses. It’s her life, it’s her baby, and it’s her body” (Professional midwife)

The midwives talked about creating a trusting and respectful relationship to support the women, and making them realize that obesity will not solve itself, they have to do their part. Midwives stressed giving information is only useful together with support, hence, making it essential to work as a team to accomplish good results. Love and support from the midwife gives the women strength and confidence, and together, they worked towards happiness, not focusing too much on the worries. The midwives believed working with the women as a team is what caregivers are supposed to do, one expressed it as:

“...we share the caring” (Professional midwife)

The midwives described working one step at the time, and encouraging the women to experiment with new diet changes and see the benefits of those changes. The midwives thought to avoid complications, and change the behavior of the women, they have to work together. Furthermore, the midwives felt that if the women came to their care, the midwives have to talk about obesity. One midwife compared it to a mother’s care, the difference being that the women listen more to the midwife. An opposite finding was a midwife specifically saying she was not the women’s mother, hence the women have to take more responsibility for their condition.

Several midwives explained they have to know the family’s economic situation, to be able to give affordable advice. They emphasized working with the women’s resources, since if the women cannot afford nor have the resources, such as a specific food, in the area where they live, the advice is useless.
The midwives explained to the women, based on their economical possibilities, how to afford a healthy diet. One midwife expressed she even showed the women there was no difference in price between healthy and unhealthy food by comparing receipts of different types of food.

The midwives expressed the need to work with women before they become pregnant. They found it important to identify “risky pregnancies” and prevent possible complications. Not to mention, the importance of not neglecting nutrition with the aim of avoiding obesity related risks. The majority of the midwives mentioned awareness as a part of the midwives work. They found it important to be aware of weight gain, complications, and risks. One midwife considered merely being aware of possible complications as the only action midwives have to take when caring for these women.

During the meetings with obese pregnant women, the midwives initiated the discussion about lifestyle, obesity and the related risks. All midwives considered having a discussion about nutrition and overweight as part of their role.

“[as a midwife] it’s what we dedicate most of the time to – nutrition, always”
(Nurse midwife)

The midwives asked the women about their diet, gave individual suggestions about diet changes, and made diet plans. The midwives talked about the importance of making lifelong changes, and learning how and what to eat. The focus tended to be on the benefits of eating healthy, both for the mother and for the baby. One midwife emphasized the importance of the women to not stop eating, and that it is better to eat badly, than not at all. A small number of midwives mentioned they encouraged the women to start walking more, and informed about the importance of exercise. The midwives informed the women about the possible reasons for gaining weight, the recommended weight gain during pregnancy, and what obesity is. The majority of the midwives informed the women about the risk for diseases. The midwives also informed about the risks for the baby.

4.2 Midwives’ experience of interprofessional work regarding pregnant women suffering from obesity
The midwives described the importance of involving other professions of the healthcare team, when caring for pregnant women suffering from obesity. The findings were summarized in
three sub-categories: teamwork with nutritionist, teamwork with physician and teamwork with other healthcare professionals.

The midwives mentioned they would refer a pregnant woman suffering from obesity to a nutritionist, and ask them to discuss the woman’s diet. Working with a nutritionist helps the midwives in their work to avoid complications; one midwife even had a nutritionist on staff in her clinic. The midwives informed the women about the importance of seeing a nutritionist.

Several midwives would consult a physician when feeling unsure if the woman was within the midwife’s competence. If the physician clears the woman from medical help, they saw no problem in continuing caring for them without the physician. Some midwives would refer the women to a physician, but not until the development of complications and the pregnancy turning high-risk. A small number of midwives would refer to other healthcare professionals, such as the diabetes association and acupuncturists. One midwife expressed how she felt a shared responsibility with all members of the healthcare team when caring for pregnant women suffering from obesity.

4.3 Midwives’ experience of advice when caring for pregnant women suffering from obesity

This category explores the feelings of the midwives when they gave lifestyle advice, how the midwives thought advice should be given, and how the midwives experience the women’s response to their advice.

The midwives had thoughts about how, and when, to give advice to the pregnant women suffering from obesity. Most midwives expressed pregnancy is a good opportunity to give advice, and a good opportunity for the women to change lifestyle.

“I feel that it’s a big opportunity for them to become conscious of their eating habits”
(Traditional midwife)

However, one midwife believed changes in the lifestyle should not be made during pregnancy. The midwives said if the women seeks the midwife’s care, they were open for receiving advice. The midwives experienced the women became more conscious and felt more responsible, because of the pregnancy.

“...they are opening a door for you, for everything, you can do almost everything”. (Nurse midwife)
Almost all midwives emphasized the midwife should not terrorize nor scare the women when giving advice, since this behavior could make them leave the care and destroy the trust. They thought scaring a woman made her stressed, and she would stop enjoying the pregnancy.

“To educate and inform without discouraging and terrorize them about the terrible things that can happen, I think it has better results” (Nurse midwife)

Most midwives also stressed one should not scold the women if they gained weight, nor should they forbid any type of food. If the midwives do not scold the women, they will create a trusting relationship with the women. One midwife stressed you should not put the women on diet. Instead of forbidding, the midwives suggested saying “you can eat it, but less”. It was not enough to only tell the women to “eat well”, the advice needed to be more specific.

“Since I don’t tell her off, or forbid her, she has the confidence to tell me”
(Professional midwife)

The midwives believed having a discussion about the obesity was not a matter of pushing or making the women feel bad, and the midwife’s role is not to demand the women to act a certain way. However, one midwife said when giving advice, a midwife has to be a little strict.

Most midwives believed there was a need to educate the women about lifestyle. To achieve good results the midwives needed to know when the women were ready to listen, otherwise the advice will be useless. Most midwives felt they could make a difference by giving information, creating the right dynamics, and have empathy for the women. The majority also thought the midwife should dedicate time and give the women importance in order to solve the obesity problem.

“If they feel uncomfortable, I’ll mention it, but I’ll not go deeper into it, because she won’t need it” (Professional midwife)

One midwife said having a discussion alone with the women gave better results, as she found it uncomfortable to discuss weight. However, although the discussion can be uncomfortable, another midwife thought talking about food is only about nurturing the body, as nurturing the body is caring for the women, thus, making it a midwife’s responsibility. All midwives felt they have to take the discussion, and when giving advice, the focus has to be on the benefits of weight loss. One midwife said she informed the women to be careful due to the overweight’s effect on the self-esteem together with the hormonal changes during pregnancy.
Most midwives believed changing the diet little by little to achieve good results, and to see how the women respond to the suggested changes.

The majority of the midwives considered giving advice about lifestyle was their responsibility, but that it was complicated, complex and problematic. One of the midwives experienced it as difficult as she felt she did not have the special knowledge a nutritionist has, while another mentioned her own BMI as an obstacle when having the conversation.

“Well, I don’t feel so well [when discussing overweight], because I’ve always been very skinny, very thin”. (Nurse midwife)

It was also said it was hard because the woman knew more about nutrition than the midwife did. Another midwife felt uncomfortable about bringing up a woman’s weight, since she believed nobody likes to be told they are overweight, and therefore the woman will feel bad. One experienced it as hard to give advice about diet due to the women’s lack of compliance.

Midwives sensed if they did not raise the discussion, nobody would, it was difficult to help the women due to the lack of time and follow-ups. However one midwife felt in only one meeting, she could start to change someone’s lifestyle and make a difference.

A few midwives found it easy to give lifestyle advice to the women, one even liked it. Some midwives felt a midwife can give the women a good opportunity to help them change their unhealthy lifestyle. However, one midwife would only give advice if obesity was the single present problem.

Most midwives experienced, most of the time, the women wanted to listen to and follow their advice, because they experienced that the women were interested in speaking about overweight and nutrition. They also felt most of the women were glad to change, understood the advice, and were committed to the changes.

“She understood what she had to eat. How fat would hurt her, how soda would hurt her. [It was the first time she heard it] and she was 22 years old.” (Professional midwife)

Some midwives felt there was a lot of resistance to talk about nutrition among the women, and not all of the women could be intercepted. They also sensed that the women did not like to hear their diet is hurting them, and it is hard for the women to understand the importance of a healthy diet and to change their lifestyle.
Some midwives experienced that the women wanted to see quick results, which made the women lose spirit if they did not. There was also an experience of an obese pregnant woman who, due to her complications, was inspired to change. The majority of the midwives thought education made the women more conscious about food, and the women liked to receive the advice. One midwife felt she was not taken seriously during a meeting with a woman, and she did not think the woman would follow her advice.

4.4 Midwives’ general thoughts about nursing for pregnant women suffering from obesity

This category illustrates the midwives’ general thoughts about nursing for pregnant women suffering from obesity. Most of the midwives considered obesity among pregnant women as a serious problem, while one midwife, although seeing it as a problem in general, had not experienced any difficulties when caring for these women. The different views about caring for the women were categorized into four sub-categories: equality between caring for pregnant women suffering from obesity and non-obese women, challenges when caring for pregnant women suffering from obesity, limited experience of challenges when caring for pregnant women suffering from obesity, and midwives’ experience of obesity as a growing health problem.

The midwives stated they made no difference in the care they gave when nursing for pregnant women suffering from obesity, and pregnant non-obese women. They highlighted all women are unique, regardless of their appearance. The midwives said they had the same role when caring for obese women as in any other pregnancy: informing and orientating.

“We have to give the same care we give to other women” (Professional midwife)

The midwives would not reject caring for obese women because of their condition. A few midwives had the experience a birth with an obese woman was as easy as a birth with a non-obese woman.

As most of the midwives mentioned they worked with homebirths, the challenges obesity could bring would make obese pregnant women too high-risk for a homebirth. The midwives thought it would be too complicated to attend an obese woman at her home, and stated they could not do a homebirth with obesity related complications. However, it was also mentioned obese women were not excluded of having a homebirth, but they would have to work harder because of the obesity.
“We can’t do a [home]birth with preeclamptic gestational diabetes. It’s just too complicated.” (Professional midwife)

One midwife had an experience where an unwanted pregnancy did not show until the fourth month because of the obesity. Another challenge mentioned, was how the women’s size affected the receiving of the baby, and how the midwife needed assistance during the delivery. One midwife described a unique experience of not having any difficulties when caring for pregnant women suffering from obesity. She experienced that all pregnant women suffering from obesity she had cared for, had been young, which were in favor of their health, thus, making the obesity harmless. She emphasized the women she had cared for, had been obese since childhood, and therefore, their bodies were used to the obesity.

“She had been suffering from obesity her whole life, so she was really fine being that way” (Professional midwife)

The midwife recognized that obesity could be dangerous for some obese women, but she had never experienced any complications when caring for these women herself. As long as the women follow the advice, and take care of themselves during pregnancy, the midwife experienced obesity would not cause any problems. She considered many of the obese women to be healthy, and their deliveries easy. Moreover, the midwife explained the women might not lose weight during the pregnancy, but gain the recommended amount of weight. The midwife shared her experience of a delivery she considered funny because of the couple’s different sizes.

The majority of the midwives considered obesity among pregnant women as an, unfortunate, growing health problem. They explained the obesity among pregnant women is more common in public system compared to within private practice. One midwife, working at a public hospital, said:

“The majority of the women we attend are overweight.” (Nurse midwife)

Although not shocked by the high numbers, the midwives considered obesity to be a serious public health problem. The midwives experienced that obesity among pregnant women can be a problem from before the pregnancy, but also a condition appearing during the pregnancy. Several midwives emphasized how dealing with obesity among pregnant women is their responsibility.

“I feel it’s my worry and my job” (Nurse midwife)
4.5 Midwives’ feelings regarding pregnant women suffering from obesity

The midwives expressed different feelings while caring for the pregnant women suffering from obesity. The two most prominent feelings summarized in this category, is organized in two sub-categories: the worries of the midwives, and the frustrations of the midwives.

The midwives voiced their concerns and worries about the mother, the baby and the healthcare system in Mexico. The concerns regarding the mother included missing specific tests, possible complications during pregnancy and obesity related diseases. The worries concerning the baby were possible child obesity, and possible complications related to the mother’s obesity. Other worries expressed were about unhealthy nutrition, the safety for the mother and the baby such as not referring to a physician in time, the mother being a bad role model, and the possibility of future problems related to obesity. One midwife expressed concern about the size of the mother making it hard for the baby to come out, and the mother to move during labor. Some midwives expressed a concern about the women’s tendency to choose unhealthy food.

A returning concern was the approach the Mexican healthcare system has to obesity among pregnant women, and about obesity being a general health problem.

“*What I worry most about, is the public healthcare system, because there are a few other opportunities to do that type of work [prevent obesity]*” (Nurse midwife)

The findings were dominated by frustrations about the public healthcare system. These frustrations were concerning the lack of obesity prevention, women not using prenatal care, insufficient prenatal control, and insufficient advice and support from the physicians and nutritionists. Other frustrations included the public healthcare does not give importance to obesity, scolds and judges the obese women, and society’s dislike against obesity. The midwives were frustrated because of economic differences affecting the woman’s care such as not having access to nutritionists, the public healthcare not educating women and a lack of continuous care. Furthermore, they were frustrated about the perception among other healthcare professionals that obese women cannot give birth naturally. The midwives also felt frustrated about not being included in the public health system, and thought that if they were to be included, the problem of obesity would decrease.
“Public institutions don’t give importance to it, even though it’s a serious problem in our country. It’s not given importance to this problem”

(Nurse midwife)

The midwives were frustrated about the incapability to give a woman the birth she wanted because of the complications related to obesity. Other frustrations mentioned were the women’s lack of compliance and thus developing complications, women’s unhealthy lifestyle choices and the overall misconceptions about diet such as healthy food is more expensive.

5. DISCUSSION

5. 1 Methodological considerations

In this study, semi-structured interviews were used, this allowed an exploration of the attitudes, feelings and values among the midwives. Furthermore, it enabled a deeper understanding of the midwives’ experiences. This method served the purpose of the study.

5.2 Trustworthiness

Trustworthiness is a way to describe and value the sustainability of a qualitative study. Trustworthiness is described in four dimensions: credibility, transferability, conformability and dependability (Kristensson, 2014). To ensure the trustworthiness of this study, these four dimensions were considered closely during data collection and analysis.

5.3 Credibility

In this study, network sampling was used since it was considered a suitable strategy for this study. Network sampling is considered, by some, as a weak sampling method, since there is a high risk the sample becomes too homogenous. The participants can have similar views since by knowing each other there is a possibility of influencing one another (Polit & Beck, 2012). To gain a more heterogeneous sample, Mexican midwives of all three types were included, and recruited from different channels, both in and around Mexico City. None of the midwives in the sample worked at the same place. Most of the interviewed midwives were first source, they were not referees from earlier participants, since they were found on different midwives association websites and Facebook. This guaranteed diversity in the sample with different perspectives, which ensured a higher credibility. The midwives had different types of education, and length of work experience. The different length of experience among the midwives was considered an advantage, as this gave a wider perspective.
The questions used in the study were responsive to the aim of the study, and open-ended for the midwives’ own interpretation. The questions were therefore interpreted differently depending on the midwife, which gave the study different insights and angles. The different interpretations gave a greater variation to the study. In some cases, the questions had to be asked again in an alternative way, or a follow up question had to be asked to re-direct to the subject of the study. This limited misunderstandings and ensured the focus of the study.

The analysis method chosen for this study was content analysis. Content analysis was chosen since it is a suitable method to explore subjective experiences and feelings. Content analysis is at risk for bias. Bias can result from a number of factors, such as the authors unintentionally influencing and threatening the credibility of the results (Polit & Beck, 2012). To limit this bias, triangulation was used. Triangulation means that two or more authors analyze and interpret the material, in this way the results is not at risk for a single view interpretation (Kristensson, 2014). To make the analysis process visible for the reader, thus increase the credibility, table 1 shows an example of the analyzing process.

The authors discussed the possibility of using the first interview as a pilot study. However, when the first interview was conducted, the authors did not yet know if there was a sufficient amount of participants in the study, since not all participants had answered the e-mail. The authors considered that the answers given in the first interview were corresponding towards the aim of the study, and therefore the questions were believed to be relevant and used in the remaining interviews.

5.4 Transferability
Transferability describes how well the results can be transferred to other groups (Polit & Beck, 2012). Since the sample is small, this study cannot give a representative view of the experiences of all Mexican midwives. However, the aim was not to generalize, but to give a deeper understanding of what was encountered. The results could be transferrable to other midwives working with pregnant women suffering from obesity, both in Mexico and other countries.

5.5 Confirmability
Confirmability describes the level of objectivity and neutrality of the data and the analysis, and how well the results are represented in the data (Kristensson, 2014; Polit & Beck, 2012). The results are strengthened with quotes from the interviews, thus, the readers can make their own judgment, hence, increasing the confirmability of the study.
To ensure the participants did not feel affected by the authors, the participants were encouraged and given time to speak freely without being interrupted. The body language of the authors can always influence the participants during the interviews, but to different extent. Even though the authors were aware of this, it was inevitable to eliminate the authors’ influence, such as unintentionally smiling when the participants’ answers corresponded to the aim of the study. The authors aimed to be neutral, while at the same time giving the participants full attention and using active listening.

During the interviews, the body language, and non-verbal communication was noted by the not-interviewing author. This was added to the transcribed interviews. When noticing non-verbal communication, the author interprets the feelings and attitudes of the participants, based on the author’s own values and experiences. The authors were aware of this, and considered it a strength in the analysis process, and used for the latent analysis.

5.6 Dependability
Dependability is used to evaluate the stability of the data over time (Polit & Beck, 2012). To show the validity of the results, the time and place of our data collection is described. Furthermore, the questionnaire is attached, see attachment three, which can be used for others who want to conduct a similar study.

5.7 Limitations
The participants were given the choice to undertake the interview in either English or Spanish. Six of the interviews were conducted in English which posed a possible language barrier, as this was not the mother tongue of neither the participants nor the interviewers. However, the participants were given the possibility to partly express themselves in Spanish, their mother tongue, since one of the interviewers was fluent in Spanish. Three of the interviews were conducted in Spanish, with the Spanish speaking interviewer translating. This was, again, a possible language barrier, since it was not the mother tongue of the interviewers. The translating interviewer did not have a formal education in interpreting, however, the level of the interviewer’s Spanish was advanced enough, and therefore the language barrier was not great. The reason for not excluding non-English speaking midwives in the study was to gain a more representative selection to protect the trustworthiness of the study.

5.8 Result Discussion
The results in this study revealed the midwives emphasized working with the family and their resources. They found it important to explore the deeper reasons behind obesity, and empower
the women. Furthermore, the results showed a strong teamwork between the nutritionist and the midwives, and that all midwives thought nutrition was a part of nursing.

The midwives described working with the whole family, in what in Sweden is defined as family focused care (Benzein, Hagberg & Saveman, 2009). As the diet of one family member affects the rest of the family, the midwives stressed it was important to include the family. Family focused care benefits the whole family, as described in both this study, and other studies (Sullivan, 2014; Stadtlander, 2014). Studies have also shown the BMI of the parents, and unhealthy lifestyle contributes to child obesity (Sullivan, 2014; Stadtlander, 2014). The results demonstrated educating and informing the whole family gives motivation for long-lasting changes for the family. The midwives in this study experienced the parents are role models for their children, hence, the parents’ diet affects the children’s future health and wellbeing. This suggests that nursing has to involve the whole family to combat the problem with obesity.

In Sweden, family focused care has received special attention during the last twenty years. The role of the caregiver has shifted, from the families, to the public health institutions, and is now gradually shifting back to the families again (Benzein, Hagman, Saveman & Syrén, 2010). In a report by Benezein et al. (2010) family focused care is presented as a new phenomenon. Our study showed this “new” concept does not exist as a separate type of care in Mexico, but it is rather the standard care. Therefore, there is a cultural aspect on what “care” is. Our findings suggest that if the whole family is not included, the problem with obesity among pregnant women cannot be solved, due to it being a family problem, and not only a problem for the mother, as long as her integrity and autonomy is not compromised.

Although family focused care is a hot topic within Swedish nursing and is given much space in the nursing studies, it has not yet entered the clinical practice as a set way to give care. It has been seen that the family has to adjust to the convenience of the healthcare, not the other way around. An example of not including the family is when conducting motivational interviewing (MI). MI is a therapy method where the registered nurse helps the patient help themselves by increasing their own motivation to change a certain behavior (Miller & Rollnick, 2013). In a MI-meeting with the patient, for example about obesity, the conversation is only with the person in question, not the whole family. One of the reasons found for not including the family is that the registered nurses might view the family as a burden (Benzein, Johansson, Årestedt & Saveman, 2008). However, this study comes to a different result, as the
midwives were glad to work with the whole family. To solve the obesity problem among pregnant women, a suggestion is that MI has to change from focusing on the individual towards helping the families help themselves.

A report stated if the family takes too much responsibility in the care of a family member, this can lead to increased illness for the family (Benzein, Johansson & Saveman, 2004). This implies that the healthcare system is in charge of the care, and the family is merely an observer, and by giving the responsibility back to the family, the healthcare system does not take its responsibility and “bothers” the family. In contrary to Benzein et al. (2004), the findings of our study showed giving the family members a greater role, when caring for a pregnant woman suffering from obesity, will not cause illness for the other family members as they are a unit that can affect each other’s lifestyles in a positive way. Furthermore, it was also found in this study that including the whole family gives better results, since the whole family works as a support system which increases the women’s compliance.

Traditionally, pregnancy has been a matter for the women only. In a country, as Sweden, where gender shared responsibility during pregnancy is promoted, a study by Maroto-Navarro et al. (2013) still showed a lower involvement of men than women. The same study has identified the health benefits and the increased wellbeing that comes with the father being more involved during the pregnancy. Since this and other studies confirms that including the partner is beneficial for the whole family to fight and prevent obesity during pregnancy (Stadtlander, 2014; Sullivan, 2014), it is important that the healthcare system sees beyond the gender roles when caring for pregnant women suffering from obesity.

A registered nurse’s responsibility is to promote health and prevent illness (ICN, 2012; Swenurse, 2012b). For registered nurses to be able to work in a health promoting manner, regarding obesity in pregnant women, the Swedish healthcare system has to see beyond the gender roles, and give back nursing responsibilities to the families themselves. Since family focused care has a cultural aspect, it is beneficial for Sweden’s growing multicultural society. The Swedish healthcare system need to change focus from obesity among pregnant women being a matter for the individual, to include the whole family when possible.

This study also described the midwives thought it was important to consider the family’s economy and resources in the area where they lived. This was an interesting insight, since in Sweden, economical differences are rarely discussed, especially within the context of healthcare. Sweden is the number one country in the Western world where the socioeconomic
differences have increased the most since 1995 (Cingano, 2014). Burström (2012) described a study that showed high-income patients received more expensive care than low-income patients. Despite this alarming facts, economic inequalities are not given much space when discussing healthcare issue within nursing, such as obesity among pregnant women.

Socialstyrelsen, the Swedish National Board of Health and Welfare, (2005a) stated a low socioeconomic status is the strongest risk factor for illness and death. Therefore, socioeconomic differences should be given a bigger part within nursing. In the findings of this study, the midwives experienced the obesity problem was more present in the public health sector, where the patient group was dominated by low-income families, which supports that vulnerable socioeconomic groups are more at risk. The midwives in this study found it important to explore the family’s economic situation to give good person centered care. In their experience, when giving care to obese pregnant women they always considered the family’s economic situation, as well as their resources in the area where they lived. Furthermore, they stressed advice which are not adjusted to the family’s private economy is useless, which was found both an interesting and important finding.

Mexico is a country with big income inequalities (Cingano, 2014), despite that the topic of private economy did not seem as a sensitive or vulnerable subject among the midwives. On the contrary, they saw it as an obligation when giving care to obese pregnant women. According to the Swedish National Competency Standards for the Registered Nurse (NCRN), one of the registered nurse’s qualifications is to identify and actively try to prevent health risks, and if needed, give motivation to a changed lifestyle (Socialstyrelsen, 2005b). This can only be done if the patient has the possibility to comply with the advice given. If the registered nurse does not take the socioeconomic situation into consideration, the advice will be of no use, as this study showed.

Raising the discussion about private economy in Sweden can be considered offensive and impolite, and has never been considered to be a part of nursing. However, if the Swedish healthcare system does not overcome this taboo, and starts giving lifestyle advice based on the person’s resources, health promotion care will, no matter how good the advice, not give any results. Furthermore, a suggestion is that taking the socioeconomic situation into consideration when giving care to obese pregnant women should be a natural part of nursing. The authors believe one way of doing this is to educate the Swedish nurses and create awareness about socioeconomic differences. Burström (2012) reached the same conclusion,
and stated to decrease social economic differences within health care, the health care professional, first and foremost, needs to be aware of the social economic differences that do exist in society today.

ICN (2012) states registered nurses have a responsibility to influence societal development, and share their knowledge with society of how a person’s social and economic situation affects the health. Therefore, Swedish registered nurses need to create more awareness about the influence of socioeconomic status, as giving good health promotion and person-centered care is impossible without raising the discussion about the socioeconomic situation. The Swedish healthcare system needs take into account the growing socioeconomic dissimilarities in Sweden to actually help the individual. Only then can the qualifications of person-centered care be reached.

Another finding in this study was that the midwives found it important to explore deeper emotional reasons behind the pregnant women’s obesity. The midwives in this study stressed the importance of knowing the women behind the obesity, and to make no difference in giving care to obese pregnant women and non-obese pregnant women. A Swedish study by Adolfsson et al. (2013) found obese women feel they are not being seen as the person behind their condition. By not seeing the person behind the obesity, the registered nurse does not have the capability to give person-centered care.

Furthermore, the results showed the midwives believed it was necessary to ask questions about the women’s personal life, listen, observe and understand. If the midwives does not ask questions, they will never discover the deeper reasons behind obesity. This is important, as the focus in Sweden tends to be on giving information, and working towards a solution, not exploring the deeper reasons behind the problem. The authors question this, since they believe it is difficult to solve a problem without knowing the cause. Registered nurses in Sweden should base nursing on a holistic view and person-centered care (Socialstyrelsen, 2005b).

However, a question could be if it is possible to give a holistic person-centered care without knowing the women behind the obesity and the possible emotional reasons causing their condition. Moreover, the midwives expressed how being attentive, and creating a trusting relationship facilitates their work when exploring deeper reasons behind the obesity. These findings are in line with “Värdegrund för omvårdnad” the Swedish Basic Values for Nursing, explaining this trusting relationship balances the power in the relationship, and is described as a condition for knowing the patient (Swenurse, 2012a). The relationship between patient and
nurse is always imprinted by power, vulnerability and dependability (Öresland & Lützén, 2009). Therefore, the authors find it important to be aware of this fact, to prevent the victimizing of the patient and give back the power to the patient, by making her an accessory in her own care.

A smaller finding in this study was that some midwives were not comfortable having the discussion about weight. Similar results were found in a study made in the United Kingdom, by Foster and Hirst (2014) where midwives thought it was uncomfortable to discuss overweight. An obstacle mentioned, both in this study and by Foster and Hirst (2014), was that the midwives’ own BMI affected whether or not they were comfortable to give advice. As similar findings were found on two different continents, this suggest that there is a global similarity in attitudes towards giving weight-related advice in correlation to self-image. Therefore this study strengthens the results found by Foster and Hirst (2014). However, all midwives in this study considered it their role to have a discussion about nutrition and the underlying reasons for obesity, which is different to the findings of Foster and Hirst (2014).

In similarity with Foster and Hirst (2014) there is a notion that weight may be considered a sensitive subject, and that it is an insult to call somebody obese. However, as most of the midwives in this study saw the weight discussion as an evident subject, it is essential to change these attitudes when it comes to weight-related advice. The attitudes of midwives are vital to be able to prevent obesity among pregnant women. As the ICN’s ethical code (2012) clearly states, two of the responsibilities of the registered nurse is to promote health and prevent illness, the discussion about obesity cannot be ignored. To avoid the discussion about obesity among pregnant women would be equal to not discussing how smoking affects the health of the mother and the unborn child.

As mentioned in previous studies, the experience of most of the midwives in this study confirm that pregnancy is considered a good opportunity to change women’s unhealthy lifestyle (Sullivan, 2014; Smith et al, 2014; Foster & Hirst, 2014). However, there was also a small finding that changes in lifestyle should not be pushed during pregnancy. A similar finding by Foster and Hirst (2014) demonstrated the midwives in their study did not consider pregnancy a good time to change lifestyle. Nevertheless, a study made by Smith et al. (2014) showed most obese women do not want their midwives to ignore the problem. The authors suggest that health care professional use pregnancy as a possibility to do health promotional
care. In Sweden, midwives have a great opportunity as they have a unique chance to create a trusting relationship with the pregnant women because of the continuity of pre-natal care.

The midwives in this study described their work with empowerment. Within nursing, the patient is viewed as a free individual, with the ability to make their own choices and take responsibility (Lidén, 2009). The midwives believed it were their role to support and guide the pregnant women. They gave the women the tools to make a change, as she had the power to do so. It was mentioned several times it is the women’s choice to make lifestyle changes, and she is intelligent enough to decide for themselves. This is important, since in Sweden, empowerment is sometimes seen as a special manner to give care. For the midwives in this study, nursing for pregnant woman suffering from obesity includes giving back the power to the women as part of the standard care and not a separate type of care.

Most midwives in this study considered it important to work as a team together with the mother to give good care. One midwife explained it as “we share the caring”, a quote found illustrative in how to work with pregnant women suffering from obesity. With increased participation in their care and knowledge about their condition, the patient could better adapt their health promotional resources and take more responsibility for and control over their lifestyle, which will lead to increased wellbeing (Fransson Sellgren, 2009). By sharing the caring, the midwives take advantage of the women’s own resources and support them, to increase their wellbeing, and together, they work towards a healthier lifestyle. Although this is not a new perspective, this has often been forgotten in the Swedish healthcare system. Thus, to give adequate personal-centered care, registered nurses need to re-adapt this view of nursing.

The findings of this study showed to accomplish positive results, the lifestyles changes have to be made step-by-step with a combination of information and support, only then can advise be useful. This is also known as The Scaffolding model; as the midwives strengthen the women to make a change, while at the same time they are prepared to step in if the women need help and support. The model states the teacher, in this case the midwives should provide the pregnant women suffering from obesity, with multiple opportunities for success (De León, 2012). The midwives did this by educating the women little by little, and support and empower the women.

The midwives in this study often used ‘love’ when they described how to work with the women. Love and support was found to be fundamental when they cared for pregnant women
suffering from obesity. This is a great difference from how nursing would be described in Sweden, since love is considered to be a strong personal feeling. To express your love for your patients would be to not withhold the professional relationship. The warmth expressed by the midwives when they talked about their patients was touching, as the midwives were truly committed to their patients’ wellbeing. There is of course an important distinction between a personal and professional relationship, but when it concerns the change of somebody’s lifestyle, the authors believe the Swedish healthcare system can learn from the warmth of the Mexican midwives’ care.

According to WHO (1984), the fundamental elements of health promotion are empowerment, equality, collaboration, autonomy and shared responsibility. These elements of health promotional work are still applicable in nursing. The findings in this study showed the Mexican midwives, without clearly mentioning health promotion, stressed all these elements when they gave care to pregnant women suffering from obesity. Although health promotion is one of the largest working areas in nursing, it is not given enough space in the nursing education in Sweden. At Örebro University, health promotional studies only comprise 7.5 credits out of 180 credits, 4 percent of the educational program, which is still more than most other universities in Sweden. This is surprising, as promoting health and preventing illness is two out of four of the nursing responsibilities, according to ICN (2012) and the Swedish National Board of Health and Welfare (2005b). Hence, there is a disproportion in how the education is organized. To reduce the increasing obesity rates, the nursing education in Sweden needs to give more importance to health promotion, and in particular obesity and nutrition.

Another interesting finding in this study was the midwives’ close working-relationship with the nutritionists. This is an interesting discovery, since the authors have limited experience of working with nutritionist. The NCRN states a registered nurse should work with a team of healthcare professionals and use their knowledge and through teamwork contribute to a holistic view of the patient (Socialstyrelsen, 2005b). To be able to give pregnant women suffering from obesity good care, more education about what knowledge the different healthcare professionals can contribute with is needed.

The Mexican midwives considered nutrition as an important part of nursing, since caring for the body is caring for person. In Sweden, the guidelines are vague on what the registered nurse’s role regarding nutrition should be. Furthermore, nutrition is not given much space in
the Swedish nursing program. A suggestion is that the knowledge about the other healthcare professionals’ unique competences is expanded, and more importance is given to nutrition as a part of nursing since, as one midwife expressed, nurturing the body is caring.

6. CLINICAL SIGNIFICANCE

This study can give Swedish registered nurses a deeper understanding, and an increased knowledge about nursing for pregnant women suffering from obesity. By partake of knowledge that the Mexican midwives have, Swedish registered nurses also could obtain a deeper cultural understanding of this complex global health problem. When meeting pregnant women suffering from obesity, Swedish registered nurses can use the result of this study to improve their person-centered care and health promotion care. This study strengthens the results of other studies made, thus increasing evidence based nursing regarding pregnant women suffering from obesity. The results of this study can be implemented in nursing, and improve the care given to this patient group with the aim to decrease obesity among pregnant women.

7. SUGGESTIONS FOR FURTHER RESEARCH

It would be of interest to do further research about the experiences of midwives worldwide in relation to nursing for obese pregnant women. Further research could strengthen the results of this study, and could thereby provide a tool to design the nursing education with more focus on health promotional, especially regarding obesity. Further research is required to improve the nursing education, and decrease obesity among pregnant women. A suggestion is to conduct a study which explores the Swedish midwives’ experience of discussing socioeconomic differences. This could be useful in the aim to decrease obesity, since there is socioeconomic contributor.

8. CONCLUSION

It is expected that globesity is not to decrease in the near future. Attempts have been made to reduce obesity in Mexico, these have not yet made a significant difference. From a societal perspective, the costs and the illness caused by obesity are already too high, and if the healthcare services do not give importance to this problem, the cost and suffering will continue to increase.
This study showed that the Mexican midwives involved the family, considered socioeconomic resources, explored deeper reasons behind the obesity, empowered the women more and had a strong teamwork with other health care professionals. These experiences can help give Swedish registered nurses tools to work with the obesity problem among pregnant women. Furthermore, there is a need for more education with further focus on health promotion, as this would not only increase the health of the population, but also decrease the healthcare costs and ultimately save lives.

There is an imbalance within the Swedish nursing education, where restore health and alleviate suffering carries greater weight than promote health and prevent illness. The midwives have a great responsibility to help decrease obesity among pregnant women, which is beneficial for both the mother and the child. To reduce obesity is vital since obesity does not only create big costs for the society, but also causes illness and death.
9. REFERENCES


Smith, D., Taylor, W., & Lavender, T. (2014). The role of antenatal and postnatal social support for pregnant women with a body mass index \( \geq 30 \text{ kg/m}^2 \). *British Journal of Midwifery*, 22(8), 564.


Dear Participants,

Our names are Emma Kardell and Pauline Hammarskiöld Madero, and we are studying to become registered nurses at Örebro University in Sweden. During our last semester, we are writing our thesis with focus on the science of nursing. The aim of the study is to describe Mexican midwives’ experiences of caring for pregnant women suffering from obesity, and get a deeper understanding for their maternity work. We are both interested in carrying out this study as we both want to become midwives, and meet the needs of Sweden’s growing multicultural society.

Taking part in the study is voluntarily, and the participant can withdraw without consequences at any time without giving a reason for your withdrawal. Being a participant means being interviewed about your experiences of caring for pregnant women suffering from obesity. The interview is estimated to take approximately 30 to 60 minutes, and will take a place where and when you wish to meet us. The interviews are recorded, and anonymous, which means that no one will be able to identify what you have told us. The recordings will be used for our study only. Please feel free to contact us with questions about the study.

Best regards,

Pauline Hammarskiöld Madero (Pauline.hammarskiold@gmail.com)

Emma Kardell (Emmaa-k@hotmail.com)

Supervisor: Sigrid Odencrants (sigrid.odencrants.oru.se)
Attachment 2.

Informed Consent Form

I understand that I am being asked to participate in a research study from Örebro University. This research study will describe Mexican midwives’ experiences of caring for pregnant women suffering from obesity. If I agree to participate in this study, I will be interviewed for approximately 30-60 minutes about my experiences. The interview will be recorded, and take place where I choose to meet. No identifying information will be included when the interview is transcribed. There are no risks associated with this study.

I realize that the interviewers are student and are carrying out this study to learn and benefit from my experiences, not to in anyway judge or evaluate my work.

I realize that my participation in this study is entirely voluntarily, and I may withdraw from the study at any time I wish, without any consequences.

I understand that the study data will be kept confidential. However, the results are going to be published in a thesis at Örebro University.

If I need to, I can contact Emma Kardell and Pauline Hammarskiöld Madero, at any time during the study.

The study has to be explained to me. I have read and understand this consent form, all of my questions have been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

__________________________________ _____________
Signature of participant   Date

___________________________________ ______________
Signature of the interviewers  Date
Attachment 3.

Questionnaire
We are Emma Kardell and Pauline Hammarskiöld Madero. Thank you for meeting us! The aim of our study is to describe Mexican midwives’ experiences of caring for pregnant women suffering from obesity. Therefore, we want to hear what you feel, and your experiences. We would like you to speak freely, and keep in mind we are students, and nothing you say can be tracked back to you. We are only here to learn, and would really appreciate it if you share your feelings and experiences with us.

Demographic data
What type of education do you have?
For how long have you been working as midwife?
What experiences do you have from working with pregnant women suffering from obesity?

Further questions
Do you have any particular feelings when meeting these women?
   What feelings, can you give an example?
How do you feel when you discuss a women’s overweight?
Do you inform the women about the potential risks that their condition might cause for them and their babies?
In your opinion, what is the midwives’ role in caring for pregnant women suffering from obesity?
What are your thoughts about obesity among pregnant women?
Do you find it easy or hard to give advice to these women?
   In what way?
Thank you for your participating and showing your interest! Can we contact you if we have any questions about your answers?