EXPLORING THE EXPERIENCE OF OBESE WOMEN ACCESSING MATERNITY SERVICES IN THE UK

Abstract

Obesity is a major health problem affecting a large portion of the UK population. Pregnancy increases the vulnerability of women to obesity. Therefore, the primary aim of the proposed study will be to explore the experiences of obese women accessing maternity care in the UK. In order to achieve this goal, the proposed study will adopt a primary qualitative research method, specifically a phenomenological research design. This study targets to include a total of 5 pregnant women seeking maternal care from UK hospitals. Researcher will follow-up on the participants at different stages of their pregnancy, such as week 1, week 16, week 28 and week 36. Furthermore, a follow-up will be conducted on these patients at week 1 of their post-partum period. The participants will be asked to keep journal of their experiences during their pregnancy period. They will also be interviewed to allow for collection of detailed data about their experiences. Data about their experiences will be collected using semi-structured interviews and then analysed through thematic analysis. The anticipated outcomes include a detailed understanding of the experiences and perceptions of both obese and non-obese pregnant women seeking maternal care within UK care centres.

Keywords: obesity, maternal care, obese pregnant women, normal-weight pregnant women, experiences

Table of Contents

1. Introduction

1.1 Background

Over the last couple of decades, the number of people classified as obese has increased, as revealed by data published by the World Health Organisation (2021) which shows that about 39% of adults around the world were classified as overweight. Out of this, 13% were classified as obese with a body mass index equal to or more than 30. In the UK, a report published by the House of Commons estimates that about 37% of people are overweight, while 25% are classified as obese (Baker, 2023). Studies such as Ross et al. (2016) and Lifshitz and Lifshitz (2014) attribute the obesity epidemic across the world to significant lifestyle changes that have seen people consume high-calorie foods with limited physical activity. Tiwari and Balasundaram (2021) note that because of the obesity pandemic, the World Health Organisation has declared obesity a public health concern in an effort to counter its impacts on public health around the world. Obesity is particularly dangerous for pregnant women as it can lead to complications such as gestational diabetes, increased risk of stillbirths, and high blood pressure, as revealed in the findings of Chen et al. (2018) and Snelgrove-Clarke et al. (2021). In the UK, for instance, 50% of all women accessing maternity services are classified as obese, according to a sector report published by the Royal College of Midwives (Mitchell, 2019). The report shows that increasing care complexities caused by obesity and other factors, poor midwives' retention in the UK and BREXIT policy changes have made it difficult to guarantee personal care for every woman seeking maternal care. Overweight and obese women require more specialised maternity care, which impacts the overall experience of obese pregnant women. Additionally, enhanced

training for midwives and other specialised obstetric care providers will go a long way in eliminating the barriers that make it impossible or difficult to provide effective care for pregnant women affected by obesity. By conducting this proposed study, the researcher hopes that the obesity menace can be successfully countered to improve the experience of obese women, quality of care and also guarantee successful births.

In the last two decades alone, the number of obese people in the UK has risen exponentially as a result of key changes in lifestyle. According to data published by the House of Commons, the number of people classified as overweight in the UK has increased from 52.9% to 64.3% from 1993 to 2023, while those classified as obese have doubled from 14.9% to 28.0% in the same period (Baker, 2023). The increase in the number of obese people in the UK means that the number of pregnant obese women has also increased. For instance, data published by the Royal College of Obstetricians and Gynaecologists (2018) shows that over 50% of women accessing maternal care in the UK were either overweight or obese. Being overweight and obese during the preconception period increases the risks of metabolic dysfunction, which leads to alterations in the placental function, gene expression and fatal vascular formation during pregnancy (Cha et al., 2021). Breastfeeding may also become a challenge for obese mothers due to delayed lactogenesis based on the findings of a cross-sectional observational study conducted by Ballesta-Castillejos (2020). Investigating the experience of obese women will go a long way in proposing effective measures that can be used to improve their overall experience.

1.2 Research Rationale

The proposed study focuses on the key primary research studies that have carefully looked at the experience of obese women seeking maternal services in the UK. The researcher is undertaking this proposed study as part of an initiative to explore contemporary issues in midwifery in the UK. In particular, the researcher is interested in clearly establishing how as one of the key contemporary issues in healthcare, obesity impacts maternal care. The key themes established in the proposed study will provide useful insights into how the obesity crisis can be countered to improve the overall experience and health of women and babies in maternal care. The researcher was motivated by the fact that despite several studies having explored this area, there is a widespread lack of knowledge, especially among pregnant women, on how obesity affects their overall experience during pregnancy. The risks of obesity for pregnant women are clearly illustrated by several studies such as Davies et al. (2010) and Marchi et al. (2015). Other than the heightened risk caused by obesity, obese women require complex care, which most midwives in the UK lack. In investigating this area, it is also important to look at the attitude of midwives towards obese women, which, by all means, defines their experience.

1.3 Aim of the Study

The aim of this proposed study is to explore the experiences of obese women accessing maternity care in the UK.

1.4 Research Question

What are the experiences of obese pregnant women accessing maternal care?

2. Literature Review

2.1 Literature Search

The primary objective of this chapter is to provide a critical review of existing literature about the experiences of obese pregnant women when accessing care services in the UK healthcare system. The papers reviewed in this chapter were retrieved from different medical databases such as MEDLINE, PsychInfo, PubMed, and Science Direct. The keywords and search terms are used to narrow down the scope of the search on electronic databases. Keywords and terms are also used to increase the overall quality of the search results as they focus the search on key areas that are relevant to the research problem under investigation. For this review, several keywords, which included obesity, maternal, pregnancy, care, birth, outcome, women, and complications, were used. These keywords were combined using Boolean operators (AND, OR, NOT or AND NOT) to form search terms and phrases in order to narrow down the scope of the search further. Search phrases such as maternal and care, obesity and maternal care, obesity and birth outcome, obesity and pregnancy complications, maternal care or complications and obesity not overweight were formulated. Asterisks were also used to ensure that all related areas were factored into the search. For instance, inserting an asterisk at the end of words such as obes* ensured that the search returned results with obese and obesity. The keywords used during the literature search include Obesity OR overweight AND Maternal experience OR Maternal care.

The search conducted across the four databases outlined returned a total of 250 published research studies that have focused on how obesity impacts maternal care

and birth outcomes. Analysing over 250 research studies manually is not feasible, and therefore, this number was narrowed down to 8 articles that met all the conditions stipulated in the inclusion and exclusion criteria (Appendix 3). The inclusion and exclusion criteria were formulated in line with the research objectives and questions. Only those studies which met all the inclusion criteria would be considered for review. The first inclusion criterion was based on the publication characteristics of the research paper. Specifically, only those studies which were published in the English language and before 2015 were selected for review. This inclusion criterion was applied to ensure the identification of studies with the most recent evidence about the research problem. Furthermore, the literature search process was limited to primary studies as an approach to ensuring the authenticity and quality of the collected evidence for review. All eight studies were primary studies in the sense that participants were recruited and interviewed in relation to the impacts of obesity on maternal care and birth outcome. To guarantee the quality of the eight articles, the CASP checklist (Appendix 4) was used to perform the appraisal. Each of the three themes is supported by extensive findings published in corresponding studies, as will be discussed. The eight studies sampled include McGiveron et al. (2015), Heslehurst et al. (2015), Catalano and Shankar (2017), Goisis et al. (2016), Dearden et al. (2020), Saucedo et al. (2021), Holton et al. (2017), and Summers et al. (2015). The themes are discussed in detail below. Overall, the findings of these studies show that obese women accessing maternal care, as well as the foetus they carry, are exposed to several short-term and long-term risks which may affect their quality of life.

2.2 Causes of Obesity in Pregnant Women

Four studies documented evidence about the causes of obesity among pregnant women. Goisis et al. (2016) conducted a study to investigate how various inequalities in the UK contribute to obesity in pregnant women and how this subsequently affects the fetal development and postpartum development of these children. The study adopted a quantitative primary approach, drawing on data from over 10,000 children belonging to the Millennium Cohort Study group in the UK. Drawing on data published by various health agencies in the UK comprising 45000 records, Catalano and Shankar (2017) established that due to hormonal changes, pregnant women are more likely to develop high levels of insulin resistance, which can lead to significant weight gain. Family income inequalities and related risk factors were used as the indication of the maternal prepartum lifestyle as it illustrates how healthy a woman is likely to be during pregnancy and their postpartum lifestyle. On the other hand, the study by Goisis et al. (2016) acknowledges that while the findings provide a clear insight into how the socio-inequalities can contribute to obesity in pregnant women, the results are limited by overreliance on the study on BMI of women while ignoring the fact that high BMI may also result from genetics instead of poor diet. Nonetheless, the findings show a significant pattern between high BMI and poor income background which validates the conclusion taken. Evidence reported in these studies shows that socio-economic background of obese women often contribute to the nature of experiences they would encounter when accessing maternal care.

Catalano and Shankar (2017) replicated the findings above in their own study that also focused partially on some of the factors that contribute to obesity among

pregnant women. Catalano and Shankar (2017) replicated the findings above in their own study that also focused partially on some of the factors that contribute to obesity among pregnant women. The findings of the analysis conducted revealed that income inequalities play a significant role in maternal health. With a significance level of p-0.00 which indicates a strong correlation, the study revealed that women from low-income backgrounds were likely to be obese due to poor diet, poor mental condition and other related factors that are caused by lack of specialised care during pregnancy that can be accessed by women from high-income background. Consistent findings are reported in the study by McGiveron et al. (2015). Generally, these studies have established that obese women are likely to be discriminated against when seeking maternal care services compared to the normal weight pregnant women.

Unlike women from high financial backgrounds, women from poorer backgrounds may not have access to specialised care which incorporates dietary control, behaviour modification and exercise, which makes them highly susceptible to weight gain in their prepartum period. The contribution of income inequality to obesity can also be seen in the findings of McGiveron et al. (2015), which revealed that obese pregnant women exposed to weight intervention measures gained less weight compared to those without intervention. Holton et al. (2017) also conducted a study to investigate the various factors that contribute to uncontrolled weight gain during pregnancies and the subsequent impacts that obesity has on the health of women. The study adopted a qualitative approach and collected data through semi-structured interviews. A total of 17 pregnant women classified as obese with a BMI of 30 and 2 professional midwives were recruited randomly from different maternity care centres to participate in the study.

Including the midwives in this study was particularly important because it would enhance the understanding of the role they play in providing specialised care for pregnant women affected by obesity. This implies that access to specialised care and intervention measures during pregnancy impacts the overall experience of women seeking maternal care. While McGiveron et al. (2015) did not focus exclusively on income inequalities, their findings showed that access to professional intervention measures had an impact on weight gain and overall maternal and foetal health - but the access to professional intervention depends on income.

Qualitative thematic analysis was used to analyse the data collected to identify dominant themes in relation to obesity in pregnant women (Holton et al., 2017). The findings of this study revealed that among other factors, the key contributors to weight gain in pregnant women were misconceptions regarding the cause of weight gain, barriers to professional midwifery care such as income and shortage of professional midwives, and reluctance to discuss weight and what causes weight gain due to self-esteem issues. Even though the reported results were based on small sample size, evidence from this study can still be generalised to the wider population of women. This also shows how social and economic inequalities contribute to health inequalities like obesity. One of the themes identified as a major contributor to obesity in pregnant women is the barrier to professional care, which include financial constraints for women from poor financial backgrounds, which is relevant to the NHS care users (Holton et al., 2017; Catalano Shankar, 2017). On the other hand, women from high financial backgrounds may be affected by shortages of professional midwives, which has actually been flagged as a major concern in the UK. The studies discussed in this section have

revealed various factors that contribute to obesity in pregnant women, which connect back to the various income-related barriers that prevent them from accessing professional care (McGiveron et al., 2015; Goisis et al., 2016). With obesity on the rise, the impact on pregnant women is rapidly becoming a major health concern that needs immediate attention. Specifically, poor access to care increases the vulnerability of women to obesity as they are not able to acquire the required information about their health, including diets and the types of physical activities to engage in.

2.3 Impacts of Obesity on Maternal Experience

As pointed out, one of the outstanding themes in the studies sampled was how obesity impacts maternal health and the overall experience of pregnant women affected by obesity. McGiveron et al. (2015) aimed to establish a clear understanding of how obesity impacts maternal health. To test the relationship between the two variables, the researchers adopted a quantitative approach which provided a suitable platform on which the correlation between obesity and maternal health could be tested. The researchers invited all pregnant women in the facility of choice who had a BMI of 35 to participate in the study (McGiveron et al., 2015; Goisis et al., 2016). The intervention approach enabled the researchers to test the positive impacts of weight loss intervention in pregnant women relative to obese pregnant women not exposed to any intervention measures (Holton et al., 2017; Catalano and Shankar, 2017). This is important in showing the experience of obese pregnant women relative to pregnant women with normal weight. In total, 89 pregnant women with a BMI of 35 and above agreed to participate in the programme consisting of 7 sessions spread out across several weeks and supervised by healthy lifestyle midwives and advisors. The findings

of this study revealed that obese pregnant women exposed to weight intervention measures gained less weight (4kg) compared to those not exposed to any intervention measures (10kg) (Holton et al., 2017). As a result, women who participated in the program were less exposed to pregnancy risks and complications that stem from obesity, such as gestational hypertension and postpartum haemorrhage, at a statistical significance level of 0.02. Evidence presented in these studies shows that quality of care provided to obese pregnant women may vary from that provided to the normal weight women. Hence an indication that pregnant obese women are highly vulnerable to different forms of discriminations within the maternal care setting.

McGiveron et al. (2015) acknowledge that while the findings of this study provide useful insights into how the negative impacts of obesity on maternal health can be managed, the study is limited by the lack of a randomised selection. To address this limitation, Heslehurst et al. (2015) adopted a randomised approach in recruiting 19 women to participate in a similar study that aimed to evaluate the experience of obese pregnant women in the UK. Despite the small sample size, researchers in these studies achieved data saturation which was key for ensuring enhanced transferability of the reported findings to the general population of women who might be at high risk of obesity. The target population of this study were women attending dietetic clinics in the UK (Holton et al., 2017). The recruitment strategy involved emailing women booked as having a BMI greater than 30 and requesting them to participate in the study. The data collected through direct interviews were analysed using thematic analysis. The findings revealed that while most of the women had struggled to manage their weight throughout their lives, weight-related complications only became apparent during their pregnancy.

For instance, most of the participants experienced hypertension and other pregnancy-related complications arising from their being obese. Like McGiveron et al. (2015), Heslehurst et al. (2015) find a strong link between obesity and gestational hypertension. The manifestation of this condition is particularly strong in comparison to the prepregnancy period, where the symptoms were mild or non-existent based on the experience described by the women interviewed. The findings of McGiveron et al. (2015) and Heslehurst et al. (2015) are replicated further by Catalano and Shankar (2017) in their own study that focused on the impacts of obesity on maternal health. Catalano and Shankar (2017) conducted a thorough review of data published by various health agencies in the UK regarding obesity and maternal health. The findings of this study revealed that since most women gain weight during their pregnancy due to factors like increased insulin resistance, postpartum weight gain can lead to postpartum weight retention with an overall negative effect on maternal health. Even though these studies have reported that women often gain weight during pregnancy, making them obese, they have not provided detailed explanations about the possible impacts of weight gain or obesity on the quality of care and experiences of the involved pregnant women. Therefore, this is an important area which the proposed study will be focusing on addressing.

The quality of all the studies included in this review was assessed using the CASP tool, and all of them met the criteria for their inclusion. The study revealed that obesity stemming from prepartum weight gain is associated with risks such as blood clots, gestational hypertension, and difficulties breastfeeding, and postpartum weight retention is associated with cardiometabolic risks and increased complications in

subsequent pregnancies (Holton et al., 2017). Overall, the results of these studies attribute the several risks identified to maternal obesity due to their notable effects on pregnant obese women. For instance, the studies discussed show that weight intervention measures are important for pregnant women in order for the women to maintain a healthy weight (McGiveron et al., 2015). It is important to point out that despite the highlighted limitations associated with each study, their findings resoundingly agree that obesity has several negative impacts on maternal health.

2.4 Obese Women's Experience and Childbirth Outcomes

The previous section focused on the impacts of obesity on maternal health. This section focuses on the impact of obesity on women's experience with regard to childbirth outcomes. The study conducted by Catalano and Shankar (2017) provides useful insights into how obesity in pregnant women affects not only maternal health but also foetal health and birth outcomes. Saucedo et al. (2021) focused on the relationship between obesity and maternal and infant deaths. The researchers hypothesised that there is a higher maternal death rate in obese women compared to women with a normal BMI. The researchers adopted a quantitative approach, drawing on maternal death data. The duo noted that when women gain weight beyond the recommended limit during pregnancy (BMI<30), the weight and size of the baby may also be affected, which can lead to pregnancy-related complications such as caesarean delivery and childhood obesity of the newborn. However, it is important to note that these studies largely focused on the negative consequences of pregnancy on the body image of involved women with little evidence about the experiences they encounter as well as the

quality of care they receive after becoming obese. This is an important area which the proposed study will be focusing on addressing.

Using the multivariable logistic regression, which refers to the measure of the extent of the relationship between dependent and independent variables, the researchers were able to measure the relationship between body mass index and maternal death to accurately determine whether obesity leads to higher maternal death rates (Heslehurst et al., 2015). As hypothesised, the findings of the study revealed that a high BMI, which indicates obesity leads to higher maternal death risk. In particular, the risk of maternal death was 1.6 times higher in pregnant obese women compared to pregnant women with normal BMI (Catalano and Shankar, 2017). On the other hand, the risk was three times higher in women with severe obesity compared to women with normal BMI (Saucedo et al., 2021). Maternal deaths are caused by underlying conditions stemming from obesity which can impact the overall health of the foetus.

In an earlier study, Summers et al. (2015) investigated how obesity impacts the health of pregnant women negatively and how it can lead to pregnancy-related complications and eventual maternal and foetal death. The study was a population-based cohort study that focused on 226,958 singleton pregnancies in Britain between 2004 and 2012. The relationship between pregnancy and BMI was examined using the logistic regression model approach. The findings of the analysis conducted revealed that a 10% increase in body weight beyond the recommended limit resulted in a 10% increase in the risk of preeclampsia, stillbirths, gestational diabetes, and fetal macrosomia at a significance level of 0.01 (Goisis et al., 2016). The highlighted risks become severe as pregnant women cross from group one obesity to group three

obesity. This indicates that obesity has a significant impact on birth outcomes due to a number of health complications that stem from a higher BMI (Dearden et al., 2020). In particular, an increase in the number of stillbirths with an increase in BMI shows that maternal obesity poses significant risks to the unborn baby, which is an indication of poor birth outcomes (Summers et al., 2015). Collectively, the findings of the studies analysed in this section reveal a direct link between obesity and poor birth outcomes such as maternal and foetal deaths.

2.5 Summary and Gaps in Literature

The aim of this chapter was to review evidence about the impact of obesity on maternal health, birth outcomes and experiences. The conducted review established that there is still limited evidence regarding the experiences of pregnant obese women in accessing and using maternal care in the UK healthcare system. Therefore, the proposed study focuses on addressing this gap in the literature by conducting RCT research involving both obese and normal-weight pregnant women with the intention of comparing and contrasting their experiences. The conducted review has shown that obesity has a significant impact on the experience of pregnant women through three key themes, and as a result, it may be indicative of the potential findings of the pilot study. Another important gap identified from the conducted review is that there is still no extensive research which has been conducted to establish the primary consequences of obesity on quality of life and experiences among pregnant women seeking maternal care in the UK health care centres. The first theme indicates that obesity in pregnant women is directly linked to risks such as preeclampsia, stillbirths, gestational diabetes, and macrosomia which affect maternal and foetal health and, thus, impacts the

experience that obese women have during pregnancy. The second theme has revealed that, like maternal health, maternal obesity affects birth outcomes in several ways, which include significant and permanent alteration in the hypothalamic structure and function, early childhood obesity and increased risk of caesarean delivery. The third theme identified confirms that social and economic inequalities may be behind increased cases of maternal obesity that are concentrated among lower- and middle-income women, which further defines the experience of obese women across social classes.

3. Research Methodology

3.1 Research Design

The proposed study will adopt a qualitative research methodology with the aim of accessing different lived experiences, perceptions and thoughts of pregnant women about the impacts of obesity on the quality of care provided to them in the UK. Therefore, the proposed study will be guided by interpretivist research philosophy. With reference to the explanations by Tamminen and Poucher (2020), interpretivist philosophy believes in the existence of multiple realities about a single research phenomenon. Therefore, the adoption of this philosophical approach was appropriate for the proposed study as it will allow for the inclusion of both positive and negative experiences encountered by pregnant obese women within the UK maternity care settings, contrary to when a positivist philosophy is adopted where only a specific type of experience could be reported. Furthermore, the proposed study will adopt a phenomenological research design. Specifically, the study by Dibley et al. (2020) reports that phenomenological research design emphasises examining the human experiences of individuals within the defined research population. Therefore, the adoption of this research design will be appropriate for the proposed study as it will allow for the collection and analysis of primary qualitative data based on lived experiences and perceptions of pregnant obese and normal-weight women about the problems they encounter when seeking maternal care services within the UK care centres.

3.2 Study Population and Sampling Approach

The proposed study targets to include a total of 5 pregnant obese women seeking maternal care within the UK healthcare settings. The primary data will be collected from 5 participants about their experiences when seeking maternal care. The researcher will follow-up on these 5 women through their pregnancy experience and interview them at different stages of their booking appointments, such as at their first booking, at week 16, at week 28 and at week 36. Furthermore, a follow-up interview will be conducted on these participants at week 1 of post-partum. The researcher will ask the patients to keep journal of their experiences. This approach will be appropriate as it will allow for the collection of detailed data about the experiences of pregnant obese women during and immediately after their pregnancy. Therefore, the sample size should be large enough to retrieve a variety of information but not so large that the remaining participants do not offer useful information (Rees, 2011). This sample size is considered suitable based on the recommendation of Creswell (2007), which states that 20-30 interviews are adequate to achieve data saturation. It also considers the recommendation of Ritchie et al. (2003), which suggests no more than 50 interviews depending on the complexity of the research problem. Dearnley (2005) states that semi-structured interviews are highly suitable in qualitative studies because they provide the participants with an opportunity to narrate their experiences in relation to the research issue under investigation.

On conducting the booking appointment, in some parts of the UK, community midwives will ask women if they would be interested in being contacted for research purposes and have it documented on the electronic notes system. The NHS trusts

utilising this system will be ideal for forming the sample as women who have already agreed to be contacted for research intentions are more likely to accept to be part of the study. These women will then be recruited through purposive sampling and then contacted for informed consent via telephone so that they can make an informed choice on whether they would like to participate in the study and if they consent to audio-recorded interviews.

3.3 Data Collection Method

Data collection will be conducted through semi-structured interviews. The interviews will aim to last 45 minutes, and the researcher will follow an interview guide (Appendix 2) to ensure optimum use of interview time (DiCicco-Bloom and Crabtree, 2006). The interviews will take place in local children's centres so that privacy and confidentiality can be honoured whilst also being convenient and familiar to women - which may facilitate holistic discussion and influence a positive rapport (Gubrium et al., 2012). A formal request will be sent to the children's centres to grant permission for the women to participate in this study.

3.4 Data Analysis Method

The collected data will then be analysed using the thematic analysis technique. Specifically, the process of data analysis will begin with the transcription of the recorded interviews. The audio recordings will be transcribed verbatim and analysed using the thematic analysis approach. In conducting thematic analysis. A 6-step thematic analysis process described by Maguire and Delahunt (2017) will be adopted in this study. The first step involves familiarisation with the collected and transcribed data, where the researcher will read thoroughly the transcriptions to understand their contexts. The

second step involves the generation of the initial codes from the transcribed data, which will then be used for identifying the dominant patterns. Thereafter, the codes will be used for developing themes in the third step; then, the themes will be reviewed to ensure their relevancy in the fourth step. The fifth step involves the definition of the themes describing their key contexts. The last step involves the presentation of the generated themes and their relationship with the research phenomenon under investigation. The collected data through interviews and journals to be kept by the participants about their experiences will be analysed using thematic analysis process. Themes to be generated from the proposed study through thematic analysis will specifically be about the experiences of pregnant obese women when seeking maternal care. Therefore, the expected results will include both positive and negative experiences of the included obese women. The themes will be about the factors that limit successful provision of quality care to obese pregnant women, strategies for ensuring and promoting inclusive care with specific focus on the obese pregnant women, and the role of maternal care practitioners in enhancing quality of care provided to the obese pregnant women.

3.5 Ethical Considerations

The ethical considerations include participants' informed consent, confidentiality, and privacy, as well as seeking approval from the University ethics board. How these ethical measures were put in place will be discussed in the main study. This includes participants' informed consent, confidentiality, privacy and seeking approval from the Research Ethics Committee. The research purpose, procedure, benefits, and risks will be outlined by the investigator to the participants, privacy and confidentiality will be

discussed, and the right to withdraw without consequences will also be presented to gain informed consent. Debriefing will also be offered following the completion of the research to remove any anxieties or misconceptions the participants may have developed during the research to preserve participant dignity (Harris, 1988). To protect the participants from distress, counselling will be arranged upon the completion of the research. Any offence, embarrassment, or mental harm in the participant's experience will be discussed with qualified psychologists so that the participants may exit the research situation in a similar frame of mind to when they entered it. No participant will be coerced to take part in this study. Furthermore, the privacy of the participants will be achieved by assigning them pseudonyms rather than using their actual names when presenting the data.

3.6 Timeline

The proposed study will take a period of 3 months to complete. The timeline for each task to be executed during the research process is visualised in the Gantt chart presented in Appendix 8. Ethical approval for this study will be sought within two weeks after the research proposal is approved. The actual study will only be started if the proposal passes the ethical approval stage. The developed Gantt chart provides a detailed description of each task and the proposed timeline for them to be undertaken.

3.8 Funding

The researcher acknowledges that accumulating a large sample size and conducting the pilot study will not only be time-consuming but will also require extra manpower and funding – all resources that are under high pressure and in high demand during this post-pandemic era. The Health Research Authority (2022) has accumulated

various sources for research funding, including the National Institute for Health Research (NIHR), which addresses a variety of health priorities based on the relevance and quality of the research to public health and the NHS. The conditions for applying to NIHR are met by the proposed pilot study as obesity is a national public health concern in the UK, with an estimated 25.9% of adults in England being classed as obese (The Health Survey for England, 2021), and therefore the application for funding may be granted through this scheme.

4. Conclusions

4.1 Limitations

There are key limitations which are likely to be experienced in the proposed study. The first limitation is associated with the inclusion of a small sample size which is likely to limit the generalisability of the generated findings to the general study population. However, the researcher will increase the comprehensiveness of the collected by achieving data saturation during the interview sessions. Furthermore, the proposed study intends to use a purposive sampling approach which may be associated with potential bias as the researcher will have the ultimate authority to select participants to be included in the study. However, effective selection of the participants in this study will be achieved by applying defined eligibility criteria which each participant should meet in order to be included in the study. Furthermore, the quality of the collected data for analysis is likely to be compromised by the recall bias as the participants will be required to recall their experiences when seeking maternal care services, an approach which may interfere with the overall quality of the collected data for analysis.

4.2 Critical Reflections on Personal Learning

Reflective practice is critical to midwifery practice as it increases self-awareness, self-directed learning and both professional development and clinical performance (Gillett, Hammond and Martala, 2009). Throughout my midwifery project, I have continuously self-reflected on my skills by utilising self-assessment exercises (Appendix 5, 6 and 7) along with my interactions with my peers and supervisor, and on how the overall research processes have impacted and contributed towards my personal and

professional development. By reflecting on my weaknesses, I was able to identify my struggle in appropriately managing my time between my academic, clinical, and personal commitments. I was falling into a pattern known as 'reactionary workflow' that was severely inhibiting my progress in the execution of my primary goal (this project) due to poor management of other circumstances (Belsky, 2021). Therefore, I created a SMART target to ensure I could monitor my progress in achieving my goal before the deadline. I have had an opportunity to interact with my supervisor on several occasions in which I have received valuable feedback on improving my research design. My supervisor provided guidance on my progress, and I found the feedback (Appendix 9) helped me to improve the quality of my research knowledge and develop my skill set. My interactions with my peers (Appendix 10) whilst conducting this pilot study have also been useful in helping me improve my research knowledge by providing a fresh perspective. My interpersonal skills, such as active listening, effective communication, ability to develop from constructive criticism and critical analysis skills, have also improved significantly because of the positive interactions I have had with my peers and supervisor. These skills will be advantageous when conducting future research opportunities as well as within my professional practice as a midwife.

4.3 Recommendations

The findings of the eight research articles analysed have revealed several areas of improvement that can be addressed to improve the overall experience of obese women seeking maternal care in the UK. It has been established that potential causes of obesity in pregnant women include a lack of professional care and knowledge, which is significant behind pregnant women gaining excessive weight. Lack of health

awareness among women regarding the most appropriate health practices to follow increases their vulnerability to obesity and overall poor health. The implication for midwives as a strategy for improving the overall experience of obese women seeking maternal care is to encourage responsible behaviour at every contact to encourage women to maintain a healthy weight. These behaviours should be evidence-based and include increased promotion of safe physical activity and the continuous reminder of the benefits of adopting a healthy diet on maternal and foetal wellbeing (Dunkley-Bent, 2004). Midwives should also be aware of maternal health disparities along racial and income groups that exist in the UK, as revealed by the analysis conducted. Thus, practical measures should be put in place to ensure pregnant obese women are not discriminated against, overlooked, or discouraged from engaging in the available care services through healthcare professionals' attitudes and behaviours (Furness et al., 2011). Along with public health information, midwives should maintain regular training on recognising the early warning signs of potential complications that may develop as a result of being obese so that timely interventions can be put in place to improve the overall experience of obese women accessing maternal health care.

Gaining a deeper understanding of the factors affecting obesity in pregnant women may aid midwives in building an empathetic midwife-woman bond which facilitates open, trusting communication and improves maternal engagement and satisfaction, as promoted by the Code (NMC, 2018). The BMI scale is among the most important strategies that are used for determining whether an individual is underweight, normal weight, overweight or obese (Catalano and Shankar, 2017). Nonetheless, concerns have been raised that this approach fails to account for a person’s body mass

versus muscle (lean tissue) content (Goisis et al., 2016). The BMI is measured by dividing a person's weight (in kilograms) by their height (in metres squared) (Goisis et al., 2016). This approach fails to distinguish between excess muscle, fat or bone mass (McGiveron et al., 2015). Furthermore, Goisis et al. (2016) and Catalano and Shankar (2017) reported that the use of BMI to determine if an individual is obese is outdated because it fails to account for good muscles and good fat contents which may also contribute to high BMI among individuals with normal weight. Therefore, there is need to develop new scale that can be used for determining an individual is obese or not while accounting for their excess muscle, fat or bone mass. Obese women should be encouraged to participate in health management programmes such as slimming world and weightwatchers. Even though maternal care providers should encourage obese women to be part of these referral care plans, their participation should be in a voluntary basis as they should not be coerced to take part in such programmes. Women should be part of their referral care plan and be able to make informed choices on accepting or declining presented opportunities. Therefore, it is recommendable for the care providers to ensure that pregnant women are provided with adequate information about the care plan which would guide them to make their informed decision of whether to participate in such plans or not.

References

Baker, C., 2023. *Obesity statistics*. [Online] Available at: https://commonslibrary.parliament.uk/research-briefings/sn03336/#:~:text=The%20Health%20Survey%20for%20England,is%20classified%20as%20'overweight'. [Accessed: April 4, 2023].

Ballesta-Castillejos, A., 2020. *Relationship between maternal body mass index with the onset of breastfeeding and its associated problems: An online survey - International Breastfeeding Journal*, *BioMed Central*. [Online] Available at: https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/s13006-020-00298-5#:~:text=Several%20studies%20have%20found%20that,of%20breastfeeding%20and%20delayed%20lactogenesis. [Accessed: 20 May 2023].

Belsky, S., 2021. *How to make your ideas actually happen*, *InnovationManagement*. [Online] Available at: https://innovationmanagement.se/2011/05/09/how-to-make-your-ideas-actually-happen/ [Accessed: 25 May 2023].

Catalano, P.M. and Shankar, K., 2017. Obesity and pregnancy: mechanisms of short term and long term adverse consequences for mother and child. *Bmj*, *356*.

Cha, E., Smart, M.J., Baxter, B.J. and Faulkner, M.S., 2021. Preconception care to reduce the risks of overweight and obesity in women of reproductive age: an integrative review. *International Journal of Environmental Research and Public Health*, **18**(9), pp.4582-4587.

Chen, C., Xu, X. and Yan, Y., 2018. Estimated global overweight and obesity burden in pregnant women based on panel data model. *PloS One*, **13**(8), p.e0202183.

Creswell, J. W., 2007. Qualitative inquiry and research design: choosing among five approaches. 2nd ed. London: Sage.

Davies, G.A., Maxwell, C., McLeod, L., Gagnon, R., Basso, M., Bos, H., Delisle, M.F., Farine, D., Hudon, L., Menticoglou, S. and Mundle, W., 2010. Obesity in pregnancy. *Journal of Obstetrics and Gynaecology Canada*, **32**(2), pp.165-173.

Dearden, L., Buller, S., Furigo, I.C., Fernandez-Twinn, D.S. and Ozanne, S.E., 2020. Maternal obesity causes fetal hypothalamic insulin resistance and disrupts the development of hypothalamic feeding pathways. *Molecular Metabolism*, **42**, p.101079.

Dearnley, C., 2005. A reflection on the use of semi-structured interviews. *Nurse Researcher*, 13(1).

Dibley, L., Dickerson, S., Duffy, M. and Vandermause, R., 2020. *Doing hermeneutic phenomenological research: a practical guide*. New York: Sage.

DiCicco-Bloom, B. and Crabtree, B.F., 2006. The qualitative research interview, *Medical Education*, **40**(4), pp. 314–321.

Dunkley-Bent, J., 2004. 15th ed. In: Henderson C, Macdonald S (eds). Edinburgh: Bailliere Tindall.

Eriksen, M.B. and Frandsen, T.F., 2018. The impact of patient, intervention, comparison, outcome (PICO) as a search strategy tool on literature search quality: a systematic review. *Journal of the Medical Library Association: JMLA*, **106**(4), p.420

Furness, P.J., McSeveny, K., Arden MA, Garland C, Dearden AM, Soltani H, 2011. Maternal obesity support services: a qualitative study of the perspectives of women and midwives. *BMC Pregnancy and Childbirth*; **11**.

Gillett, A., Hammond, A. and Martala, M., 2009. *Successful academic writing*. Harlow: Pearson Education Limited.

Goisis, A., Sacker, A. and Kelly, Y., 2016. Why are poorer children at higher risk of obesity and overweight? A UK cohort study. *The European Journal of Public Health*, **26**(1), pp.7-13.

Gubrium, J.F., Holstein, J.A., Marvasti, A.B. and McKinney, K.D. eds., 2012. *The SAGE handbook of interview research: the complexity of the craft*. New York: Sage Publications.

Harris, B., 1988. Keywords: a history of debriefing in social psychology. In J. Morawski (Ed.), *The rise of experimentation in American psychology* (pp. 188-212). New York: Oxford University Press.

Health Research Authority, 2022. *Funding*, *NHS choices*. [Online] Available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/funding/ [Accessed: 24 May 2023].

Heslehurst, N., Russell, S., Brandon, H., Johnston, C., Summerbell, C. and Rankin, J., 2015. Women's perspectives are required to inform the development of maternal obesity services: a qualitative study of obese pregnant women's experiences. *Health Expectations*, **18**(5), pp.969-981.

Holton, S., East, C. and Fisher, J., 2017. Weight management during pregnancy: a qualitative study of women's and care providers' experiences and perspectives. *BMC Pregnancy and Childbirth*, **17**, pp.1-10.

Lifshitz, F. and Lifshitz, J.Z., 2014. Globesity: the root causes of the obesity epidemic in the USA and now worldwide. *Pediatric Endocrinology Reviews: PER*, **12**(1), pp.17-34.

Maguire, M. and Delahunt, B., 2017. Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, **9**(3).

Marchi, J., Berg, M., Dencker, A., Olander, E.K. and Begley, C.J.O.R., 2015. Risks associated with obesity in pregnancy, for the mother and baby: a systematic review of reviews. *Obesity Reviews*, **16**(8), pp.621-638.

McGiveron, A., Foster, S., Pearce, J., Taylor, M.A., McMullen, S. and Langley-Evans, S.C., 2015. Limiting antenatal weight gain improves maternal health outcomes in severely obese pregnant women: findings of a pragmatic evaluation of a midwife-led intervention. *Journal of Human Nutrition and Dietetics*, **28**, pp.29-37.

Mitchell, G. (2019) *RCM reveals the state of midwifery services in England and Scotland*. [Online] Available at: https://www.nursingtimes.net/news/reviews-and-reports/rcm-reveals-state-of-midwifery-services-in-england-and-scotland-12-09-2018/.

Nursing and Midwifery Council, 2018. The Code. [Online] Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [Accessed 20 May 2023].

Rees, C., 2011. *An introduction to research for midwives*. Edinburgh: Churchill Livingstone/Elsevier.

Research Ethics Committee, 2020. *Research Ethics Committees Overview*, *NHS choices*. [Online] Available at: https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-committees-overview/ [Accessed: 26 May 2023].

Ritchie J, Lewis J, Elam G, 2003. Designing and selecting samples. In: Ritchie J, Lewis J, editors. *Qualitative research practice: a guide for social science students and researchers*. London: Sage. p. 77–108.

Ross, S.E., Flynn, J.I. and Pate, R.R., 2016. What is really causing the obesity epidemic? A review of reviews in children and adults. *Journal of Sports Sciences*, **34**(12), pp.1148-1153.

Royal College of Midwifery, 2022. *Midwives Magazine 2022*. [Online] Available at: https://www.rcm.org.uk/publications [Accessed: 26 May 2023].

Royal College of Obstetricians and Gynaecologists, 2018. *Care of women with obesity in pregnancy (Green-top Guideline No. 72)*. [Online] Available at: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/care-of-women-with-obesity-in-pregnancy-green-top-guideline-no-72/#:~:text=Obesity%20is%20becoming%20increasingly%20prevalent,BMI)%20within%20the%20normal%20range. [Accessed: April 4, 2023].

Saucedo, M., Esteves-Pereira, A.P., Pencolé, L., Rigouzzo, A., Proust, A., Bouvier-Colle, M.H. and Deneux-Tharaux, C., 2021. Understanding maternal mortality in

women with obesity and the role of care, they receive a national case-control study. *International Journal of Obesity*, **45**(1), pp.258-265.

Schiavenato, M. and Chu, F., 2021. PICO: what it is and what it is not. *Nurse Education in Practice*, **56**, p.103194.

Snelgrove-Clarke, E., Macdonald, D., Helwig, M. and Alsius, A., 2021. Women's experiences of living with obesity during pregnancy, birthing, and postpartum: a qualitative systematic review protocol. *JBI Evidence Synthesis*, **19**(11), pp.3183-3189.

Summers, L., Hutcheon, J.A., Bodnar, L.M., Lieberman, E. and Himes, K.P., 2015. Risk of adverse pregnancy outcomes by prepregnancy body mass index: a population-based study to inform prepregnancy weight loss counselling. *Obstetrics and Gynaecology*, **125**(1), p.133.

Tamminen, K.A. and Poucher, Z.A., 2020. Research philosophies. *The Routledge International Encyclopedia of Sport and Exercise Psychology*, **2**(7), pp. 535-549.

The Health Survey for England, 2021. *Health survey for England, 2021: data tables*, *NHS choices*. [Online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/health-survey-for-england-2021-data-tables [Accessed: 26 May 2023].

Tiwari, A. and Balasundaram, P., 2021. *Public health considerations regarding obesity*. Florida: StatPearls Publishing.

World Health Organization: WHO, 2021. *Obesity and overweight*. [Online] Available at: https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.

Appendices

Appendix 1: Eligibility Criteria for Participants in the Proposed Study

Obese Pregnant Women	
Inclusion • Women with a BMI of 30 and above. • Women who have given birth in the last year at a hospital that uses Badgernet electronic notes system. • Women who have had an NVD, Instrumental or CS. • Primiparous or Multiparous women.	Justification • To ensure women meet the criteria of obesity. • To make it easier to recruit participants willing to be part of research studies. • Ensures inclusion of all maternal birthing experiences of obese women despite mode of delivery.
Exclusion • Intrauterine death or stillbirth. • Non-English speaking. • Suffering from postnatal depression, PTSD or from any mental health impact. • Women with existing medical/obstetric conditions not associated with obesity	Justification • Bereavement experience will negatively impact maternal experience, and to make the woman relive it is unethical. • Limited funding and resources may impact the availability of translation services.

	• Unethical to include participants as the study may enhance their symptoms by enquiring about their pregnancy experience. • To ensure other factors not associated with obesity that have negatively influenced pregnancy experience don't alter the validity of the data collected.
Healthy Weight Pregnant Women	
Inclusion • Women with a BMI of between 18.5-24.9 • Women who have given birth in the last year at a hospital that uses Badgernet electronic notes system. • Women who have had an NVD, Instrumental or CS. • Primiparous or Multiparous women.	Justification • To ensure women meet the criteria of healthy weight. • To make it easier to recruit participants willing to be part of research studies. • Ensures inclusion of all maternal birthing experiences of obese women despite mode of delivery.
Exclusion • Intrauterine death or stillbirth.	Justification

• Non-English speaking. • Suffering from postnatal depression, PTSD or from any mental health impact. • Women with existing medical/obstetric conditions not associated with obesity	• Bereavement experience will negatively impact maternal experience, and to make the woman relive it is unethical. • Limited funding and resources may impact the availability of translation services. • Unethical to include participants as the study may enhance their symptoms by enquiring about their pregnancy experience. • To ensure other factors not associated with weight management that have negatively influenced pregnancy experience don't alter the validity of the data collected.

Appendix 2: Interview Guide

Interview Guide	
• What is your weight? • What is your BMI? • What is your household income? • What is your ethnicity? • Can you talk about your overall experience regarding your weight? • Can you rate your pregnancy experience from 1-10 with 1 being very unhappy to 10 being very happy – and why? • Did your weight affect your pregnancy experience, and how? • How do you maintain your weight? • Were you satisfied with the care you received, and why/why not? • Did you develop any conditions in pregnancy, or did the mode of delivery change? if yes, then which conditions, which delivery method, and were the complications weight related?	• Can you remember when you were first given advice about your weight? What happened? How did it make you feel? • How did you feel about the constant healthy eating and exercise promotion from the midwives at every contact? • Have you felt discriminated against or judged unfairly because of your weight? What happened? • What is the most helpful thing maternity health services can offer to help someone like yourself in terms of weight management? • Describe what was positive about your maternal experience

	• Describe what you would change about your maternal experience • Describe your level of physical activity • Do you have any previous medical condition that has affected your weight – physical or mental?

Appendix 3: Research Inclusion and Exclusion Criteria

Inclusion	**Exclusion**
Articles published after 2015	Articles published earlier than 2015
Primary studies	Published in any other language other than English
Articles with at least two keywords in their abstracts.	Does not make specific reference to obesity in pregnant women.
Articles that have focused on and published in the UK.	Articles with participants outside the UK

Appendix 4: CASP Checklist for Qualitative Studies

Studies under Appraisal: McGiveron et al. (2015), Catalano and Shankar (2017), Dearden et al. (2020), and Summers et al. (2015).			
Section A: Are the results valid?			
	Yes	Can't tell	No
1. Was there a clear statement of the aims ofthe research?	Yes		
2. Is a qualitative methodology appropriate?	Yes		
3. Was the research design appropriate to address the aims of the research? 4. Was the recruitment strategy	Yes		

appropriate to the aims of the research?			
5. Was the data collected in a way that addressed the research issue?	Yes		
6. Has the relationship between the researcher and participants been adequately considered?	Yes		
Comments: The results of all the studies appraised are valid because they have met all the conditions set out under this section.			
Section B: What are the results?			

7. Have ethical issues been taken into consideration?	Yes		
8. Was the data analysis sufficiently rigorous?	Yes		
9. Is there a clear statement of findings?	Yes		
Comments: They adhere to all the requirements			
Section C: Will the results help locally?			
10. How valuable is the research?	Yes		

Appendix 5: CASP Checklist for Quantitative Studies

Studies under Appraisal: Heslehurst et al. (2015), Goisis et al. (2016), Saucedo et al. (2021), and Holton et al. (2021).			
Section A: Is the basic study design valid for a randomised controlled trial?			
	Yes	Can't tell	No
1. Did the study address a clearly focused research question?	Yes		
2. Was the assignment of participants to interventions randomised?	Yes		
3. Were all participants who entered the study accounted for at its conclusion?	Yes		
Comments: The results of all the studies appraised are valid because they have met all the conditions set out under this section.			

Section B: Was the study methodologically sound?			
4. Were the participants 'blind' to intervention they were given?	Yes		
5. Were the study groups similar at the start of the randomised controlled trial?	Yes		
6. Apart from the experimental intervention, did each study group receive the same level of care (that is, were they treated equally)?	Yes		
Comments: They adhere to all the requirements			
Section C: What are the results?			
7. Were the effects of intervention	Yes		

reported comprehensively?			
8. Was the precision of the estimate of the intervention or treatment effect reported?	Yes		
9. Do the benefits of the experimental intervention outweigh the harms and costs?	Yes		
10. Can the results be applied to your local population/in your context?	Yes		
11. Would the experimental intervention provide greater value to the people in your care than any of	Yes		

the existing interventions?			

Appendix 6: Personal SWOT Analysis

Strengths	**Weaknesses**
• Strong communication skills • Listening skills • Strong interpersonal skills • Strong analytical skills • Ability to ask questions seeking clarifications to understand better.	• I have a strong compulsive need to finish things on a tight deadline; however, I am finding it too difficult to balance it with other educational, clinical and personal commitments. • This causes me stress as it has led to loss of focus and resulted in being off-task
Opportunities	**Threats**
• I have an opportunity to improve my interpersonal skills through current and future interactions. • I have an opportunity to improve my research skills. • An opportunity to develop skills for academic and professional development.	• I am still getting to learn how to conduct research, and this may threaten the quality of the final study.

Appendix 7: Personal Skills Audit

Fundamental skills	**Thinking skills**	**People and Social skills**	**Personal Development skill**
Oral/Written Communication I can communicate verbally, none verbally, written and orally. My project is written; however, I have done a lot of oral communication when discussing it for feedback.	**Reflection** I can reflect upon experiences and develop myself by analysing significant situations to support my learning. This is displayed in my critical reflection on my learning journey in my project.	**Team working** I can work in a team and co-operate with other members to work towards a set objective whilst ensuring all the team members feel valued. I have worked with my peers, receiving constructive criticism whilst also providing them constructive criticism so that we could all excel in our project.	**Integrity and honesty** My moral compass allows me to differentiate between right and wrong and allows me to promote fairness, dignity, and reliability in the bonds that I form. This is evident in the respectful but professional relationship that I have formed with my women, my peers, and my supervisor.
Numeracy I can interpret numerical data along with	**Creativity and Innovation**	**Self Belief** I am confident in my own capabilities and	**Self-Awareness** I am aware of my own knowledge base, skill

analysing it, and both present it and view it in the appropriate context. I have reviewed both quantitative data and qualitative data when finding my articles for my scoping review.	When faced with a problem, I can think of solutions that are innovative so that I can continue to progress towards my goal. I was struggling to focus on completing my project as I kept getting distracted by my phone, so I downloaded an app that restricted my access to my phone for a set time limit.	acting on my strengths. Therefore, I have pushed myself to complete this project despite all the setbacks.	set and proficiencies. I am aware of my limits and my scope of practice. I can assess my strengths and weaknesses. This has proved useful when utilising reflective practice.
ICT Skills My ICT skills allow me to present and communicate information. I can use search engines and document softwares with ease. This has allowed me to research my	**Analysis and Decision Making** I can critically analyse options and reach a conclusion where I can decide my next step. I have displayed this throughout the planning of my project, where I	**Influence and Negotiating** I identified my desired outcome, which was to complete this project by the deadline. I ensured I was flexible enough to meet my supervisor's schedule	**Career Management** Throughout writing this project, I have also attended placement and implemented appropriate time management techniques. I have

papers and compose my projects.	have decided how my pilot study would be performed.	and discussed feedback with her till we made a mutually agreeable development plan.	spoken to specialist research midwives regarding a future in research in midwifery and got their advice on progressing in my career.
<u>Explanation and student guidance notes</u> **Go through the skills outlined here and put evidence against as many of them as you can.** **Remember, these are all 'generic' skills that will help you be more successful now and in the future.**	**Problem Solving** I struggled to prioritise my tasks and balance placement, university submissions, personal life and the completion of this project. I discovered I was in a 'reactionary workflow', which was prohibiting my progress, so I put restrictions in place on my secondary situations to focus on my primary goal.	**Leadership** I have shown my leadership skills during placement when I worked alongside the Band 7 to achieve my management competencies. I reviewed the workload and delegated tasks to the staff that were suitable to their skills,	**Adaptability and Flexibility** As a multilingual person, I have translated for many South Asian women during my clinical placement. I have adapted my terminology and approach to a level that is welcoming to the women and not patronising to enhance maternal experience

It is important that you have evidence of experience with each skill. **Once you have tried to fill in all the gaps, select three skills that you feel you could improve upon and make an action plan for how you will develop yourself in these areas.**	**Ability to put theory into practice.** I have been incorporating the knowledge I have learnt in university modules into clinical practice, thus displaying my ability to put theory into practice,	**Networking** By working with numerous healthcare professionals throughout the course of my degree, I have created many professional friendships and have established my own professional identity and role within the clinical setting.	**Commitment** I have shown commitment to my midwifery degree and to this project by ensuring I persevere despite the pressure from personal circumstances and by working through a pandemic.
	Action Planning and Organisational skills I have planned this midwifery project and developed it based on an idea I had of an interesting health dilemma pregnant women in the UK are facing. I have ensured I	**Interpersonal skills** My interpersonal skills have developed greatly since beginning this midwifery degree. I have formed relationships and rapport with people from all walks of life, which has significantly	

	finish the project in time to meet the deadline to promote professionalism.	improved my communication, social and active listening skills.	
	Cultural and Client Awareness I can identify women from different cultures and communities and respectfully enquire about their needs to ensure I can offer holistic woman-centred care.	**Independent Working** I have worked independently on forming my project prior to gaining feedback on it. I have taken accountability and responsibility for my academic and clinical practice as instructed by the NMC standards.	

Appendix 8: Action Plan – SMARTER Goals

	Skill One: Action Planning and Organisational Skills	**Skill Two: Creativity and Innovation**	**Skill Three: Independent Working**
Specific – what exactly are you trying to achieve?	I am trying to improve my action planning and organisational skills by developing my focus on completing my midwifery project	I am trying to develop my creative and innovative problem-solving skills.	I am trying to develop my independence so that I can work confidently with minimal supervision
Measurable – give details of targets, outcomes, results you are seeking to achieve	I will know I am successful when I complete my midwifery project before the deadline	I will know I am successful when I successfully think of 3 out of the box solutions for any problems that I come across.	I will know I am successful when I feel confident in my work and skills to the point that I can practice without checking for validation, as my self-belief in my knowledge base

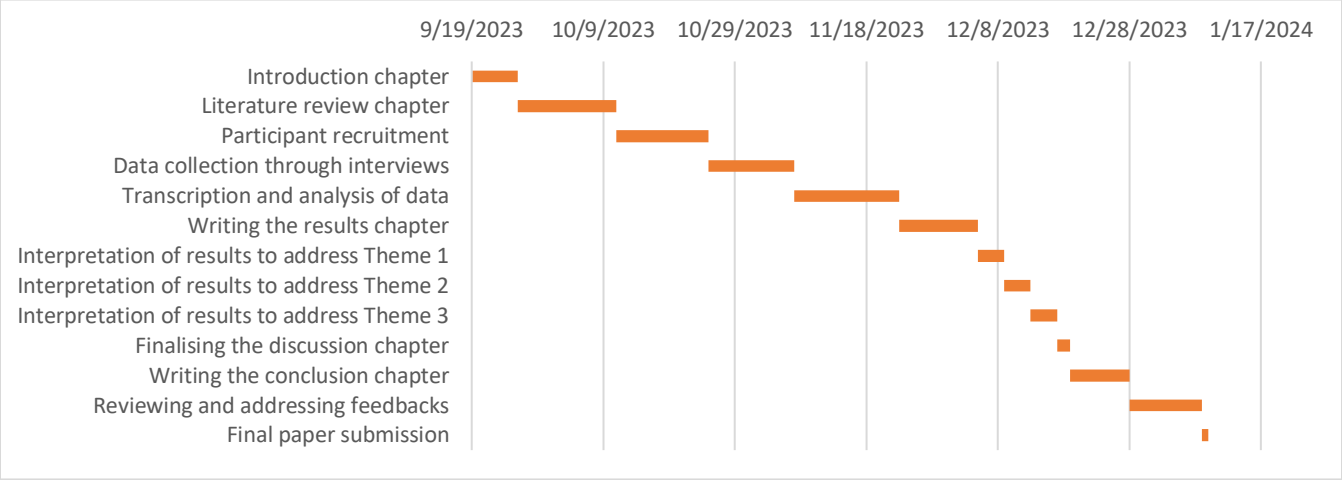
			and skill set is enough.
Achievable – Are your targets realistic and easy enough to achieve in the time you are giving yourself	My target is realistic to achieve in the time frame I have given myself. However, the difficulty is dependent on my organisational skills.	My target is realistic to achieve in the time frame I have given myself. However, the difficulty is dependent on my problem-solving skills,	My target is realistic to achieve in the time frame I have given myself. However, the difficulty is dependent on my independent working skills.
Resources – do you know who and what can help you to achieve your targets?	I have my supervisor and peer's support along with all the available resources on Moodle, on the internet and in the library.	I have access to search engines like ,Google where I can find techniques to improve my problem-solving skills.	By continuously reviewing my modules and my e-learning and by ensuring I am competent and up to date on my proficiencies, I can use the university's SPACE to practice my skills outside of

			placement to maintain my confidence.
Time – set times/dates for starting and completing your targets	To be completed by 26/05/23 12:00	To be completed by 26/05/23	To be completed before the end of the third year
Evaluation – have you included continuously checking your plan / your targets?	Yes I continuously reviewed my progress and made my supervisor aware of it, also	Yes With every problem I have faced, I have tried to think of creative solutions to train myself so that I can develop my skillset.	Yes I will continue to monitor my progress by checking in with my practice assessor and assessing the level of supervision I require in different areas and scenarios. I will also be using critical reflective practice to develop myself and improve my

			independent working
Review – has it worked, did it make a difference, and do you want to make further changes?	I was successful in achieving my target. The organisational skills and discipline that I have developed will be very useful when applied to my daily life.	I was successful in achieving my target. I displayed innovative problem-solving for problems that I encountered not only with my midwifery project but also in placement and in my real life.	Since making the goal, I have worked with minimal supervision, which has been emphasised by my placement assessors' feedback and my final grade for the placement. However, I do believe there is still further need for improvement, and I plan to apply the same plan to different areas of maternity care till I am confident in my ability to work

			autonomously without feeling nervous.

Appendix 8: Gantt Chart



Appendix 9: Supervisor Feedback

Dear Rukshar
As discussed the writing style is fine but the sections are in the wrong part of the work-please see comments beside texts.
There is some consideration of your literature review methodology which is good-apply to the literature you the ready
Please look at some fo the studies in more depth and use a CASP tool or similar to help you.-I believe you have done this form discussions
Please access a book on research proposals and how to write them
I think Trish Greenhalgh and Helen Aveyard but there are lots in the library.
Keep writing and then move things around
Get someone form ADD or CAS to help review the sections in more detail once you have written them.
It is making sense but with being out of context it is hard to judge exactly how things fit together.

Appendices
Can include my email and my feedback-just delete my name
Has done a SWOT analysis and personal skills table-relate them back to the project.
Limitations has a sections
Ethics needs padding developing
Consider your client group and their vulnerabilities
They may have been "got at" for year for their weight, they may feel guilt, they may have eating disorders, medical conditions etc.
They get upset-so what will you put in place to support them-counselling services.
Abstract
Appendices.

Appendix 10: Peer Feedback

Peer Review Midwifery Project

On reviewing your work I can see you have put much thought and effort into planning your pilot study. You have used a scoping review and previous studies and data to support your pilot study and rationalise your decision. You have explained your methodology well and have critically analysed the literature you have chosen well with reference to the CASP in the appendix. You have a lot of information and a lot of resources in your literature review which is taking up word count you could dedicate to your pilot study - although I see you are forming your pilot study on the scoping review.

You have clearly outline your aim of the plan and have explained how you would gather the sample, collect the data and also analyse it along with potential findings and an loosely estimated timeline supported by a GANTT chart. You have anticipated outcomes and made recommendations for future midwifery practice whilst also assessing your own reflective practice.

I would recommend to review the amount of papers in your scoping review to free up word count and allow a better flow for your work.