Response 1 : 018

Response 2 : 019

Interviewer: I am trying to explore the perspectives of midwives to the provision of healthy eating advice to pregnant African immigrants living in the UK. By immigrants I mean black African women who have come into the UK and what is your perspective to offering healthy eating advice to this set of women. There is no particular method of talking and no right or wrong answers, so how do you offer healthy advice to pregnant women?

Response 1: For me, it is very much based on NHS guidance, so when we talk about healthy eating, we talk about things they should eat and things they should avoid and I always direct them back to the NHS website about suggestions of sugar swaps.

Response 2: I think I agree with 1 and a lot of it for me comes up at booking, the pregnancy book we give at booking discussing round about what to eat and what to avoid especially for people that have had babies before and some of it comes up again when round about the 28th week, when they are having a glucose tolerance test about limiting high levels of sugar and about portion sizes, a lot then about carbs and things like that but mostly the discussions about healthy eating is at booking around that pregnancy booklet.

Interviewer: Okay, so when they come back at the 28th week for the glucose tolerance test, that’s when the portion sizes and carbs come up?

Response 2: yeah usually or maybe when I am booking their glucose tolerance test comes up at 16 weeks, if they are high risk for diabetes, so they are having a glucose tolerance test but also about things about portion sizes particularly about carbs, low GI carbs to reduce the chances of developing gestational diabetes or if they have had glycosuria that’s when it comes up more again, and iron and stuff like that as well.

Response 1: If I am honest, I don’t really talk about healthy eating again after booking except as 2 says, they have glycosuria, or they are complaining of symptoms or if they are asking advice. It doesn’t normally come up in the pregnancy again for me and that’s not great I know but our time is so limited to discuss all of the healthy things that we need to discuss and our women who have high BMI’s go to the pregnancy plus midwives who would be the midwives that would handle it so I tend to leave a lot of those conversations to the midwives, who are speaking specifically with the time to talk about healthy eating.

Interviewer: So, there is something like pregnancy plus midwives?

Response 1: yeah in Lewisham and Greenwich trust we have pregnancy plus midwives who talk about healthy eating and healthy lifestyle to women with a BMI over 35, so at that point its not reaching those who potentially could gain weight which is those who are already overweight in their pregnancies.

African women are at an risk of gestational diabetes and hypertension at a lesser BMI.

Response 2: Although they have not been operating in that way since COVID happened. They have not been seeing them in Lewisham I believe, we have not been referring them basically since the first lockdown happened.

Response 1: I don’t know.

Response 2: there is a pathway for women of high BMI at the booking but we have not been referring them to the specific pregnancy plus midwives anymore, so there has bene talk about trying to re-establish it but I don’t know.

Interviewer: so how do the women identify as immigrants?

Response 1: So hopefully they tell us at booking. So, our questions are about country of birth, how long they have been in the UK, what their immigration status Is their entitlement to NHS care cos I think it is really important that we talk at booking about the fact because we are not the ones that report them to immigration, the immigration picks them up from the NHS number or the lack of an NHS number and talk about what they are entitled to and what they are not entitled to and how to seek support from community groups like migrant network.

Interviewer: This advice that you give probably at 28 weeks or earlier in the pregnancy, are there particularly tailored advice or is it the general advice given to everybody?

Response 1: Same standard of advice given to everybody for me.

Response 2: I would agree, the same standard apart from sometimes when I am talking about the foods that might be swapped if they are high risk of diabetes but I think that’s more, I will tailor it mostly with Asian communities and things because we talk about using substitutes, because I have worked previously in places with high Asian demographics, so I know that that’s where people are not realising that there could be problems but I cant say that it was massively tailored to other groups really and even then I don’t tailor a lot, its quite generic information.

Interviewer: Do the African women ask for specific advice or ask the advice be tailored?

Response 1: so I used to work in tens mead and we used to have a huge number of African migrant women who very very rarely would ask for dietary advice or to be fair seek advice.it would definitely seem to be that they took a lot of advice from family and friends around their health than they would from the midwives.

Response 2: I don’t think that now I get asked any dietary advice at all from the majority of the women. That’s not the question they tend to ask me about what they can eat or anything about healthy eating. I just don’t get asked often and I definitely don’t get asked by sort of African communities about how they can tailor their healthy eating really or any nutrition advice.

Interviewer: have you seen the eatwell guide and the pregnancy healthy eating guidelines?

Response 1: I’ve not seen the healthy eating guidelines, is that NHS England? Eat well yes but not the NHS pregnancy guideline.

Response 2: yes

Interviewer: Do you consider the eatwell guide appropriate to all cultures?

Response 2: No

Interviewer: Could you explain

Response 1: for me the eatwell guideline is based on a British diet, on a classic English diet, it’s a very basic meat and vegetable kind of approach to things. I think a lot of the issues is that a.) its not particularly easy to understand and I think its generally about anyone. I think it’s supposed to be much more simpler. I think that the fact that its in English, the fact that you know. I don’t think its accessible to all.

Response 2: I agree with 1, and I think that we were taught in this way from school and its been drummed into us, that’s why I have a clue about it. If it was brought in now as a new concept, I wouldn’t have a clue and it wouldn’t stick in my mind at all. And I think that my background in childcare and child development makes me understand it more than anything else that I definitely wouldn’t, it wouldn’t be anything that I think this is healthy because I know but otherwise I don’t think that it is a very accessible format for women and it is definitely not tailored to different cultures other than British people at all, even other European cultures would have a very different sort of, they would think I don’t eat any of these foods so its irrelevant to me.

Response 1: the thing is, you would want to see pictures of foods that belong to your plate normally. You don't want to see pictures of you know Things that you wouldn't normally eat you know because your brain would just skim it over. If you can't see the picture of the food you eat and not be like you know, your brain will be like oh that looks like it applies to me.

Response 2:Yeah

Response 1: You know the issue is that what you're eating surely must be healthy because It's not involved in this so you're thinking what I'm eating must really be healthy.

Interviewer so when you're giving this healthy eating advice do you think that the women understand or respond to it

Response 1: no

Response 2: no

Response 2: I think that it's become a tick box exercise really that you like ha have we discussed healthy eating I know that you are not listening to me’ but

Response 2: But why would you listen when it is not relevant, I know that we very much tell women a lot of what they cant do so our healthy eating advice is very much tailored to you cant eat this or you cant eat that rather than these are the things that we would encourage you to eat, these are the things that are gonna help your babies bones to grow, these are the things that are going to help your wellbeing, these are the things that will improve your iron levels. We just keep saying don’t, don’t, don’t , don’t. thanks very much goodbye. No I agree and I think we are very much limited to time, that usually if I am giving healthy eating advice, it is usually at the end of my appointment when we have like a minute to give this advice. So I went to a course recently about ehm, something about interviewing, about asking questions and talking about what people know before providing an information so that they take it on board but unless the people are really unwell, otherwise I don’t have time to really go into it anymore.

Response 1: No and I think we are looking at the moment whether we take out the education aspect from the booking so that it frees up time for more tailored discussions, so actually whether we can make a video for women and this is where made me think your research project Aniebiet cos we want to make a video where we talk about healthy eating in pregnancy but we can do it in a much more open way so that actually when the women then sit in front of their midwives, that conversation can be more about them personally. Because actually we have done all the “you must know this information on the video before” and now we can actually talk about how does that apply to you? What did you take away from that video you know. You tell me what was relevant to you. And I think that will be nice and … actually. Sorry to jump in on your focus group Aniebiet, but if there is a development of that, I would really appreciate it.

Response 2: that would really be good

Interviewer: yeah, that would be nice. Some of the women interviewed have indicated that they did not look at the apps and leaflets offered because they did not know any of the foods. One of the women interviewed was told her iron level was low and was asked to eat spinach, she actually doesn’t eat spinach, so she resorted to going online and looking for African foods that contained iron that was relevant to her.

Response 1: it is very impressive that she even went online and looked it up because I think if I was in the same position, I would think that this is some advice and I clearly don’t eat spinach, so what am I going to do with this. Well they might just not know what they are talking about so I just wont eat chocolate or whatever nonsense they are telling me not to eat anyway.

Interviewer: what approach do the advice take? Leaflets, booklets, apps?

Response 1: we recommend the baby buddy app, we recommend, we have got a pregnancy book that is very very very much healthy eating in England with English foods. Ermmmm and the one to one where we tick of the tick list. Don’t eat this, don’t eat that.

Interviewer: So the baby buddy app is the Lewisham app

Response 1: yeah

Response 2: I didn’t even realise we had that app, that’s new to me

Response 1: so the baby buddy app is national …I will talk to you about it afterwards

Response 2: yeah that is a new one and I am very much not up to date with that. I struggle, I think they come out quicker than I can keep up.

Interviewer: So I am going to talk about social context, which is the context of an individuals life, so environment, education, income. So do you think the eatwell guide is suitable for all social context?

Response 1: No

Response 2: no, not at all

Response 1: I think it barely meets any social context. It doesn’t meet…a lot of people have dietary needs that they are not in control of allergies and celiac that they are not eating wheat and there is a lot of variants in peoples diet, regardless of even their socioeconomic background before we go any deeper already doesn’t meet any of their needs and then you get that it doesn’t take into consideration how much it costs and how much the costs changes in the supermarkets not to talk of meeting peoples different cultural backgrounds and it doesn’t give any advice on how you might achieve having this sort of healthy diet or lifestyle if you don’t have so much money or how you can meet the…it has no adaptions to it whatsoever. It hasn’t got any advice on oh if you can have this you can swap it for this or if you don’t have finance. It doesn’t give advice on oh you can bulk buy and then it would be more cheaper and then its healthier. You can go to these places or these markets. It gives no advice to support people financially or if they are on their own, or if they plan to cook or anything at all or they don’t eat meat or haven’t come across lots of these things or cannot access it. Or they are on their own and they don’t have any support to help them. I don’t think it adapts to anything. It is very rigid.

Response 2: one of the nuance to migrant women is that their access to public funds is restricted so they rely on donated foods. So they rely on things that are donated and given to them. So its all well and good to say that you should eat all fresh fruits and vegetables but you might actually be getting all tins of potatoes. Its not like it has to be. We have to find a way to make it safe and relevant.

Response 1: and there’s nothing like that on the Eatwell plate about oh if you cant have fresh fruits and vegetables, its still good that you are having tin fruits or frozen ones. It invalidates them, so they say oh it doesn’t apply to me so I must be eating healthy or I have got my own control and so they ignore it. I think its right like even like things like the .. when it talks about things like beans and pulses, it doesn’t even speak about or give it attention. So there are people that sit there and don’t even bother to boil their lentils and things and even then its like oh well am I doing wrong because it must be healthy because I have these things and I must have cooked them and stayed at home and cooked them because they are all difficult things that they wouldn’t ordinarily be sitting and doing. So these poor women who might be living in the hostels and don’t have access to these things and they just why would you even bother to consider it.

Interviewer: Some of the things that have come up include language as being a barrier when talking to African women. Is that your view as well?

Response 1: No actually, I don’t feel that language is an issue. I mean we have got really good language line systems. We really do and I mean probably I can count on one hand the times I haven’t been able to get access to an interpreter in the last 10 years but like ive never had a problem having interpreter services there. So to me I would say no, I think time would be more of an issue than language barriers

Response 2: I suppose and I think for a lot of African women in the Lewisham area that a lot of them speak English even though they are recent migrants. A lot of them that I have been in contact with have been mostly fluent in English. There are a lot of other cultures that the language barrier becomes much of an issue but for that area that is definitely not my main barrier for African women, that they are not getting their information. Unless maybe they speak good English and they come across like they understand me but actually because it is not their first language there maybe a barrier that they are misunderstanding what I am saying but I think I don’t often find that an issue.

Response 1: I suppose the biggest issue is that none of our leaflets come in other languages. I mean there is a fantastic resource on the mammary academy website for leaflets in other languages, but they won’t include the rare African languages. They will include French, they will include some of the more common ones but if your client speaks a more specialist kind of language then you wont be able to get leaflets and the information to them in their own language and that in itself is an issue.

Response 2: Yeah, I find that a lot as well. When you are trying to explain something to someone using an interpreter and the person is not clear about the topic, it would really benefit if you are able to show them something to explain it and you cant because it is limited in what languages you’ve got. I find that is a problem for a lot of different topics. Or that other hospitals maybe have a leaflet in another language but you can’t take it because they obviously have their hospitals logo pasted all over it.

Interviewer: one of the trusts that I have interviewed from have African foods contained in the healthy eating guide.

Response 1: Really, I would want to take a look at their website.

Interviewer: Do you have an idea if women who have BMI’s higher than 30 but not reaching the 35 mark usually exceed the 35 mark at the end of their pregnancies. I know that there is a different pathway for women with BMI’s higher than 35?

Response 1: we don’t re-weight. So, unless their BMI are over 35, they are not reweighed in their pregnancy. Because calculation of BMI in pregnancy doesn’t tell us anything. Because obviously they have got a baby, they’ve got placenta, they’ve got fluids all around the baby so calculating the BMI in pregnancy is not advised really. We would talk about weight gain in pregnancy, so we might say you gained 15 kilos but we wouldn’t recalculate BMI.

Interviewer: People have talked about African women being difficult to engage especially African immigrant women being difficult to engage. Is that your opinion?

Response 1: I hate that phrase

Response 2: Laughs

Response 1: we are not accessible, they are not difficult to engage. If you are accessible they engage. I have to say, I mean like I said we have a high African immigrant population and the women came to clinic because they knew where to go. They speak to their friends and family, they speak to their church leaders and they know where the clinic was and they would present and we didn’t have any issues with women engaging, they came to all of their appointments. They did everything that you asked or them, we are just really bad at making ourselves accessible to them.

Response 2: yeah, I think with case loading it has been a little bit better actually. Because we are coming to them and it’s a lot more adaptable and I suppose that though that its quite hard because they haven’t been case loaded since COVID and people haven’t been going places so they don’t mind coming to the midwives because they are bored. I suppose it is quite a hard one to measure because they come because they wanna see someone rather than because they wanna access the midwives and I agree with …I don’t think that they are not engaging, I think that we are not just very accessible. I wouldn’t engage if I was in the same shoes, not a chance.

Response 1: I think there is also fear too around the NHS charging policy because I think it is so complicated. I mean I have been working in this environment for 12 years and I still cant wrap my head around who is entitled and what and how they are charged and how you get other payment plan and what the long term implications for that are. And I think if I cant understand that and I work in that environment, then it must be quite frightening for women trying to access the service. Ermm we still do have late presentations, we still have women who don’t present until they are 36 weeks or in labour and I think that that’s really sad when you think about that its because of the fear of charging.

Response 2: I think that is a big problem as well. I also think probably that a lot of cultures don’t have, a lot of African cultures don’t get the concept of a midwife, sort of what antenatal care consists of, they don’t engage because they just don’t really see the point in it. If you don’t have that in your country and you come to the UK, and you are gonna be charged for something you don’t understand why its there or the point of it then you don’t get the importance of it and then you have other children that you need to be dealing with. You will prioritise other things that are going on in your life because culturally this isn’t, if you did not have this at home then during your previous pregnancies , then why do I need to come in and see the midwife, what is this gonna gain for me.

Interviewer: Do you mean that African women do not see pregnancy as medicalised? This has been raised by other midwives.

Response 1: I think it is more complex than that. I think that if you don’t know the healthcare system, you don’t know what is available to you, I think that is very different from choosing not to access it because you don’t think it is important. I don’t know about.. as I said before, women knew about us and our clinic and we worked with our local communities, with our church leaders. We used to have one address in Thamesmead, and we would have a different pregnant woman in every week. But you know what we worked with them to make sure that their pregnancies were safe and they booked in early and we were able to offer them the interventions that they wanted and needed. I think it is about education. I think it is about making sure that women knew what they are entitled to and how we can keep them safe. That’s about making it relevant to them, isn’t it. Its when we factors in that, we cant just keep giving them standard advice, its got to be about what is relevant to them and their pregnancies.

Response 2: I think that these women struggle to know what midwives are for. If they have not had it before, they don’t understand that it is important.

Response 1: Most African countries do have midwives. I think its about not knowing what they are entitled to.

Interviewer: what do we think about the matriarchy system amongst African women. Do we think that they listen more to their mothers than the midwives?

Response 1: I don’t know if that’s what I think but certainly if they are asking advice from me, they have already asked their family members or their church leaders or their aunts you know if they are asking me they have already sought that advice from somewhere else. I don’t know but I think that a lot of the educated white middle class women come to me and say “I’ve looked online and I’ve found this, whereas my migrant clients are more likely to say “I spoke to my aunty or I spoke to my mother and she suggested that I try this, what do you think”?

Response 2: That’s true actually, its more Dr Google with the white women. I find it that people have spoken to other people, my neighbour said that my bump was small or a random stranger. I would much preferred that someone would ask their aunty than they would ask Dr Google to be honest.

Interviewer: Do you think that COVID has affected antenatal care services?

Response 1: I am going to pull out of this question unfortunately Aniebiet, because I have been on mat leave for the whole duration, I don’t really know how COVID affected antenatal care services. Its all on you… this one.

Response 2: yeah it has, I am trying to roll my head back to when we didn’t have COVID, we gone through a lot of changes. Our bookings are over the phone now which is good and bad. We have lost continuity for a long time for a lot of women, so maybe that has potentially caused a lot of problems, especially with the sort of accessing care and migrant women, I personally would be more comfortable with someone I know even if it’s a different place. To be like oh I am having this issue, can you advise me what to do. I found that because we were having a lot of phone calls and there was less appointments, for a while we changed the whole pathway for appointments, there were fewer appointments and first time mums and people who it wasn’t their first baby had the same amount of appointments so a lot of people would then come to you when you finally saw them face to face. It would be just like weigh the baby, you have got like 15 minutes and they just need to talk to you about all these problems so probably a lot of things weren’t addressed that they needed to talk about. Cos there is so much and so much emotional problems, a lot of the times that people would just come and tell you all these emotional problems that they had and then in the very last minute of the appointment, they will be like “oh yeah and I am having these horrendous headaches”. And it will be like oh great, because that’s not whats important to them cos theres so much going on for a while. So yeah theres been a lot of changes in antenatal services and I think it has affected people a lot and will probably affect people for a long time. I think that people don’t tell you as much or people because they don’t know anyone and because they cant recognise my facial expression because I can only show them my eyes cos of the mask and the screen, so how you can say to someone that looks like they have come out of star wars that you are having all these horrendous problems. Its just too hard to relate with someone if you are in a completely different culture, you cant even see this persons face, you have never met this person before, you have 15 minutes to try and give that talk to them or ask them any thing and think that actually this is gonna be a sort of sensible conversation that is relevant to me, I don’t think that we are relating to people at the moment with so much PPE on. But the actual provision of antenatal care changed hugely and even where we were because we used to be in GP’s and the GP’s threw us out so everything was being done from hubs, so for each area we have like 6 hubs or 5 hubs I think. So they would come for all their antenatal care at these hubs instead of it being local to them. Although for some people it was more local, yeah its changed a lot and it will affect a lot of things long term.

Interviewer: One of the themes that have come up from previous interviews is that African women are laid back in their approach. Do you think so?

Response 1: I suppose it depends on their previous experiences, I think I don’t know if I would generalize that personally. I think many women have very different experiences of pregnancy and childbirth. For some women you know it is completely non-medicalised, normal. It could happen at home with their mum, cousins, aunts all around them . actually their experiences would be relatively quite a relaxed one and other women who would have lost babies and who would have seen quite awful things happen so I don’t know that I would generalise that.

Response 2: Yeah I don’t think I would either, I,m trying to think on my most recent case load. I think on my current case load, the most of the women who are African background are quite, they sort of have a different mindset. There are African women who have sort of called me everyday anxious about things. So yeah I think that it would just depend on them and their background. I wouldn’t make that total generalisation. People who sort of call you a lot for me mostly but not always.

Response 1: My experience of the migrant women with pre-eclampsia was perhaps that they were less likely to take medication and they were definitely less trusting in medication and would often say to me “its okay because God would keep me safe”. Ermm to which I always wanted to say but God has sent me to you, I am here for you (laughs). I’m going to keep you safe, please take your medication. Ermmm but I appreciate that culturally there is a massive mistrust in the medicalisation and the treatment of particularly pregnancy but im sure medicine in general. Ermm so I don’t know whether that counts as laid back. I wouldn’t say so, I would say that that’s more distrust than laid back but yeah that was my experience.

Interviewer: We are almost at the end of the interview, just one last question. What do you think are the barriers and facilitators to offering healthy eating advice?

Response 1: Well I think education, I think our midwives need to know what our clients are eating at home before you can even start to be giving advice. I don’t know what an African plate of food versus an Asian plate of food versus a middle eastern plate of food versus a Romanian plate of food. I couldn’t tell you each and everything that would be eaten by those different cultures, so I think educating our midwives to start with. You cant have those conversations if you actually don’t know what the baseline is. Ermm and I think something simple like having access to something like a guide of what kind of things you would swap out and small changes you could make to make healthier eating and time. We don’t have time and whilst midwives are fantastically placed as the first point of contact and regular contact, actually these conversations could be with support workers. We then talk about our support workers being educated and put in place to be able to have more time and conversations with women because I don’t know that it necessarily has to be a midwife. Maybe a midwife needs to initiate an environment to be able to have these conversations. Do women want to talk about this in groups rather than on a one to one basis. So I don’t know. I would love to know what women think.

Response 2: yeah, maybe they put that to be like an antenatal class kind of

Response 1: yeah, and then how do you tailor it to the women? I don’t know.

Response 1: I would really love to hear the women’s views. I am really looking forward to the study outcome. I really am.

Interviewer: (to response 2) so what do you think are the barriers to offering healthy eating advice

Response 2: Yeah, I agree with …, a lot of it is about time. I think that is a real problem and I think that what we say to them is not accessible. Like if you came to me and said this is what I eat, how can I make it healthier, I don’t have a clue. I don’t know, I know how I can change British foods but if you came to me, I wouldn’t know how you change these foods so if you can still eat them or to make them a bit healthier. The only thing I feel like I can really say is to reduce your portion sizes. But you are growing a baby and you have been eating these portion sizes for how long, so you are just going to be really hungry so I cant help you in any way. So, I don’t think we are educated enough and I don’t think, I think the way that we are able to deliver these information is not accessible at all. You won’t listen to me even if what I am saying applies to your foods, if I am just rambling the information to you, that’s not. I mean you are not just going to pay attention.