Weight Expectations: Experiences and Needs of Overweight and Obese Pregnant Women and their Healthcare Providers

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A joint project between the Atlantic Centre of Excellence for Women's Health (ACEWH) and the Prairie Women's Health Centre of Excellence (PWHCE):

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Executive Summary

In recent years, Canada and many other countries have witnessed a rise in rates of overweight and obesity, motivating researchers, health care providers and policy makers to focus more attention on the relationships between overweight and obesity and health. This focus has included examining the impact of overweight and obesity on maternal and newborn health, resulting in a breadth of knowledge about potential negative health outcomes for both mothers and babies. There is a gap, however, in the literature relating to the psychological, emotional, and social implications of overweight and obesity in pregnancy, as well as the self-described experiences of women with overweight or obesity and those of their health care providers.

In order to address this gap, the Atlantic Centre of Excellence for Women's Health and the Prairie Women's Health Centre of Excellence interviewed both women who were overweight or obese during pregnancy and health care providers about their experiences. The objective of this qualitative study was to increase understanding of women's experiences with maternity care, including the psychological, emotional, and social implications of overweight and obesity in pregnancy. In addition, it was important to gain knowledge about practitioners' experiences with maternity care for overweight and obese women to better understand what is required for providing optimal care to this group of women. Thirty three individuals were interviewed in Nova Scotia and Saskatchewan, including 18 women who had experienced overweight and obesity during pregnancy and 15 health care providers who worked with pregnant women with overweight and obesity, including family physicians, obstetricians and gynaecologists, midwives, nurses, and registered dieticians. The semi-structured interviews consisted of conversations around all stages of pregnancy and the models of practice used to provide maternity care from both the perspectives of the women and practitioners. The findings from this study offer insights into women's experiences of overweight and obesity while receiving maternity care, the challenges and successes for practitioners in providing optimal care for this population, and recommendations on how maternity care for this group of women may be improved.

Key findings from this study include:

(1) Psychological, Emotional and Social Aspects of Obesity and Overweight during Pregnancy
In our conversations with the women involved in this study, we found that the psychological and emotional aspects of their experiences varied. Some women reported having positive experiences, others negative, while still others described their experiences as both positive and negative. The majority of the women interviewed, however, did explain that at least some portion of their care experience had been negative.

The most common causes of psychological and emotional distress experienced by the women were feelings of guilt and self-blame. The women felt responsible for their weight and diet and the potential health risks associated with overweight and obesity – both for themselves and their children. The women also feared being judged or lectured about their weight and so reported lying about or hiding information from their health care providers. Almost all the women, even those who felt their overall experience with maternity care had been positive, also described facing some form of stigma or discrimination due to their weight or size. This most commonly occurred in the form of unwelcome comments. Women also explained that poor body image during pregnancy contributed to their negative experiences.
The social aspects of overweight and obesity during pregnancy included significant life events (parents' separation, growing up in foster homes where food was controlled); changes in activity levels (from

participating in organized sports when young to a more sedentary life in college, university, or workforce and due to lack of time, feeling exhausted, or having to balance school or work and home life); gendered experiences (watching mothers struggle with weight and dieting, and feeling mothers' ideals of body image projected onto them); reproductive health (weight gain due to birth control medications, previous pregnancies, barriers to being active once mothering); and socioeconomic pressures (limited access to healthy foods and exercise).

(2) Pre-Pregnancy and Conception

We found that the majority of women who planned their pregnancies did have conversations with their health care providers about weight loss and health prior to conception, but that it was often the women who initiated these conversations. There were women who did not plan their pregnancies, so in these cases pre-conception conversations were not possible.

The suggestion of a potential link between overweight and obesity and infertility, as cited in current research, was also discussed by both women and health care providers. Women also described experiencing or witnessing weight bias in various stages of receiving infertility treatments and so some women feared asking for assistance with their fertility issues.

(3) Pregnancy

This study revealed that weight gain during pregnancy was the most commonly discussed topic between women and practitioners, but these conversations were complex. We found that some women wanted to discuss weight gain with their health care providers, others did not want to discuss it despite knowing its importance, and some women avoided the topic completely. The majority of the women we spoke with felt that recommended total weight gain during pregnancy was unrealistic and unattainable. Some health care providers also shared this opinion. Further, the women described feelings of emotional distress when facing regular weighing at appointments. A number of practitioners also questioned this practice and the negative impact it may have on the women's health and well-being.

The data showed that while conversations on diet and exercise took place between the women and their health care providers, these conversations focused more on diet than exercise. Women argued that these conversations and clinical care practices lacked the practical application of how to implement recommendations into their daily lives and did not offer any new information. Cost was also cited as a barrier to eating well and physical activity programs.

In terms of physical health risks, we found that while practitioners openly described the risks associated with overweight and obesity in pregnancy, screening women for these risks and managing care to address risks, they were not discussing the increased risks associated with overweight, obesity and pregnancy with their patients. Further, the majority of women we interviewed said that health care providers did not speak with them directly about physical health risks. Thus, many women did not realize they were high risk patients, or did not relate this status to their weight – with some feeling it was more to do with their age. This disconnect meant that women were left ill-informed and unaware of the potential physical health risks associated with overweight and obesity in pregnancy.

(3) Labour and Delivery

The majority of women reported having discussions with their health care providers about their mode of delivery options. Half the women reported having vaginal births and the other half caesarean delivery. Place of birth was not a pressing issue for most women, largely because there were no other options but to have a hospital birth. In places where more options were available, health care providers stated that

they preferred women to deliver at hospitals due to the potential health risks during labour and delivery.

We found that health care providers held diverging opinions on the clinical care guidelines and practices surrounding the potential risks of medical interventions during labour and delivery for this group of women. For instance, some practitioners supported the guidelines stating that it was best not to induce women with overweight and obesity due to the potential complications that could occur. Others reported that they were more likely to induce overweight and obese women for fear of women having larger babies and complications associated with birthing larger babies. Discussions around other medical interventions (epidurals and fetal heart monitoring) and possible complications took place for both women and practitioners.

(4) Post-pregnancy

The data revealed that while health care providers focused on the potential post-partum physical health risks (infection, prolonged hospital stays, pressure sores, blood clots, and high blood pressure) for women with overweight and obesity- the women interviewed were more focussed on the emotional aspects of the post-partum stage. This included adjusting to motherhood, dealing with post-partum depression, and worrying about losing weight after pregnancy.

Common challenges to breastfeeding were discussed by both women and heath care providers, including delayed milk production and difficulties with latching. We found that practitioners offered support and creative strategies for the challenges facing this group of women. It was also apparent that monitoring or tracking how long women breastfed or if they were receiving enough support was difficult since many practitioners, particularly obstetricians and gynaecologists as well as midwives, did not attend to women's care past six weeks post-partum.

Weight loss post-pregnancy was a significant concern for the majority of women interviewed. While some women were motivated to lose their pregnancy weight and had conversations with and support from their practitioners on how to successfully achieve this weight loss, others felt sleep deprivation, exhaustion, and need of childcare acted as barriers to engaging in weight loss activities or planning. Women described feeling emotional distress when they could not lose their pregnancy weight and continued to gain weight through subsequent pregnancies.

(5) Quality of Care

Health care providers reported that the lack of equipment (scales, beds, blood pressure cuffs, ultrasound machines, wheel chairs, ramps, and seating) designed for larger patients was a barrier to their ability to provide quality care to women with overweight and obesity. They also felt this lack could lead to injury. A lack of formal and specific training in providing maternity care to women with overweight and obesity was also identified as a barrier. Most practitioners explained they attended workshops and information sessions, but mainly had to learn "on the job."

While negative attitudes from practitioners could cause undesirable outcomes and challenge women's care experiences, we found that the majority of health care providers held positive attitudes toward providing care to overweight and obese women- stating that caring for this population was becoming more of a norm.

Approaches to maternity care used by practitioners were identified as both barriers and aids to good quality care. Participants said that the quality of maternity care was compromised when practitioners

did not discuss weight-related information, avoided questions, or gave anecdotes rather than facts. The women felt that this often occurred due to lack of time. However, health care providers also described feeling uncomfortable discussing weight-related issues as well as fearing the loss of patients if women found these discussions offensive. Health care providers who came across as being insensitive in their approach to weight-related conversations and clinical care practices also created challenges to receiving optimal quality care. For example, hurtful comments were often made, practitioners did not listen to women's needs and experiences, and practitioners frequently made wrongful assumptions about women's lifestyles. This had a negative impact on how women felt about themselves and their pregnancies.

Two approaches that ensured quality maternal health care, as described by participants, included: (1) an informative and engaging approach-where practitioners used gentle and collaborative methods to engage women, established supportive and non-judgemental environment, actively learned about women, their histories, and their specific circumstances and (2) a direct and professional approach-where women felt reassured that their health care providers would discuss concerns directly and informatively and would not withhold information.

Women and health care providers both favoured the use of multidisciplinary teams as a way to ensure optimal quality of care and the ability to address barriers.

In light of these findings we have made the following **recommendations**:

1. Some approaches to discussing weight-related issues and maternity care practices were more effective than others. To increase the level of quality maternity care overweight and obese women receive, we recommend that health care providers adopt at least one of the two valued approaches: (1) an informative and engaging approach where practitioners use gentle and collaborative methods to engage women, establish a supportive and non-judgmental environment, actively learn about women, their histories, and their specific circumstances and/or (2) a direct and professional approach where women feel reassured that their health care providers will discuss concerns directly and informatively and will not withhold information.

2. Broaching the topic of weight was often difficult and uncomfortable for both women with overweight or obesity and their health care providers. We recommend that practitioners state upfront that it is their policy to discuss weight-related and engage in particular practices, such as monitoring weight, with all patients.

3. Many of the women who shared feelings of dissatisfaction about their maternity care felt that they had been made to do certain things that made them uncomfortable, such as being weighed in a public space and having their weight disclosed aloud. We recommend that practitioners provide women with options and allow them to make choices in their care and pregnancy plans, as well as have input in decisions made throughout all stages of pregnancy.

4. Placing a large focus on BMI and total recommended weight gain, as well as routinely weighing women, was emotionally distressing for many participants. We recommend that health care providers focus their practices and discussions on elements for a "healthy pregnancy" rather than concentrating on "the numbers." By changing the focus to health and well-being in pregnancy, women with

overweight or obesity may feel less guilt and self-blame, have fewer fears of being judged or lectured about their weight, and may feel less stigmatized and discriminated against because of their weight.

5. Social factors contribute to women's struggle with overweight and obesity and play a large role in their pregnancy and maternal health care experiences. We recommend that health care providers take the social context of women's lives into consideration. By addressing social factors that may create health inequities for women, including challenges for achieving and maintaining healthy weights, practitioners can offer more appropriate strategies to increase the psychological, emotional and physical health and well-being of women with overweight or obesity during pregnancy.

6. Due to the complexity of overweight and obesity in pregnancy, which may require additional health supports and medical intervention, and the favourable attitude women had towards interprofessional maternity care teams, it is recommended that an interprofessional, collaborative approach be utilized where professionals including family physicians, obstetricians and gynaecologists, midwives, anaesthesiologists, nurses, dieticians and community agencies would work together with women to provide the best care, services and support possible prior to, during and after pregnancy.

7. Given that many health care providers may not have had much education or training with respect to working with overweight and obese pregnant women, we recommend that practitioners create or seek out opportunities to increase their knowledge about overweight and obesity throughout all stages of pregnancy.

8. A lack of appropriate equipment for larger sized bodies prevents the provision of optimal maternity care for overweight and obese women. We recommend that hospitals and community clinics assess whether their equipment and resources are adequate and in sufficient quantity to meet the needs of larger sized patients and identify needed equipment and resources.