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Original Article

'Get alongside us', women's experiences of being overweight and pregnant in Sydney, Australia

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Abstract

Studies of women's experiences of being overweight and pregnant are limited in the literature. Given the increasing rates of obesity in pregnant women, and the impact of being overweight on the health of the mother and the child, this qualitative descriptive study aimed to explore the perceptions and experiences of overweight pregnant women attending two maternity units in Sydney, Australia. Fourteen women aged between 25 and 42 years with a body mass index greater than 30 kg/m^2 participated in a face-to-face interview in their third trimester of pregnancy or in the early post-natal period. All interviews were recorded and transcribed. Field notes were also recorded following each interview. Data were analysed using thematic analysis. Four themes were identified in the data: 'being overweight and pregnant', 'being on a continuum of change', 'get alongside us' and finally 'wanting the same treatment as everyone else'. Most women recognised their weight as an issue both for their own health and well-being and for its impact on the baby. Women believed health professionals should address the issue of obesity with them but do so in a supportive and positive way that recognised their individual needs and expectations. Health professionals need to consider new approaches or models of care for overweight women that give them support and enable individual needs and expectations to be met. Culturally specific programs may also need to be developed.

Keywords: obesity, overweight, pregnancy, women's experiences, communication, midwifery.

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Background

Rates of overweight and obesity are increasing both nationally and internationally (Sassi *et al*. 2009). According to the World Health Organisation (WHO), over 1.6 billion adults are overweight, and of these, around 400 million are obese (World Health Organisation 2006). Obesity rates in Australia are among the highest in the world, with 61% of Australian adults estimated to be overweight or obese [Australian Institute of Health and Welfare (AIHW) 2008]. Based on data from over 14 000 women attending one Australian hospital, Callaway *et al*. (2006) found 34% of pregnant women fitted the WHO definitions of being overweight, obese or morbidly obese. There are very real differences in health outcomes for each of these different categorisations of overweight; however, in light of the growing body of literature on the preferred language when discussing excess weight (Thomas *et al*. 2008; Dutton *et al*. 2010; Vartanian 2010; Gray *et al*. 2011; Volger *et al*. 2011), the authors have chosen, where possible to adopt the term

overweight as a global term for all categories of overweight.

In addition to the increased health risks associated with being overweight in the general population, such as coronary heart disease, type 2 diabetes, stroke, osteoarthritis and depression [Australian Institute of Health and Welfare (AIHW) 2008], pregnant women who are overweight are at increased risk of hypertensive disorders, gestational diabetes, miscarriage and recurrent miscarriage, caesarean section and longer hospital stays (Lashen *et al*. 2004; Hall & Neubert 2005; Callaway *et al*. 2006; Sarwer *et al*. 2006; Siega-Riz & Laraia 2006; Villamor & Cnattingius 2006; Ramachenderan *et al*. 2008; Dodd *et al*. 2011). The Confidential Enquiries in Maternal Deaths in the United Kingdom reported that 27% of maternal deaths between 2003 and 2005 were in women who were overweight (Lewis 2007); a notable increase from 16% in 1993 (Lewis 2004). This increase reflects the increase in rates of obesity in the general population; nevertheless, any increase in maternal mortality is a cause for concern. Infants of these women also have an increased risk of birth defects, hypoglycaemia, premature delivery, fetal/neonatal macrosomia and admission to intensive care (Callaway *et al*. 2006; Heiskanen *et al*. 2006; Ramachenderan *et al*. 2008).

Literature describing the potential maternal and perinatal risks associated with being overweight and pregnant is considerable (see for example Siega-Riz & Laraia 2006; Heslehurst *et al*. 2008; Ramachenderan *et al*. 2008; Dodd *et al*. 2011). There are also a growing number of publications exploring perceptions of health care providers caring for overweight patients (Brown *et al*. 2007; Heslehurst *et al*. 2007; Schmied *et al*. 2011). In phase one of the current study, we undertook a qualitative exploration of the perceptions and experiences of health care providers caring for overweight pregnant women (Schmied *et al*. 2011). The findings of this and other recent studies highlighted a number of contradictions experienced by health professionals when caring for childbearing women who are overweight; these include, on the one hand, an increasing acceptance of excess weight ('a creeping normality'), and on the other, the continuing stigma associated with being overweight (Puhl & Heuer 2009; Schmied *et al*. 2011); the challenges of how to communicate effectively with patients about their weight (Dutton *et al*. 2010; Gray *et al*. 2011; Schmied *et al*. 2011) and the lack of resources, equipment and facilities ('feeling in the dark') to adequately care for overweight childbearing women (Heslehurst *et al*. 2007; Schmied *et al*. 2011).

In contrast to the extensive literature on risks to maternal and infant health as a consequence of being overweight and pregnant, there is limited literature reporting studies of women's experiences of being overweight and pregnant. A recent meta-synthesis by Smith & Lavender (2011) found only six papers that fit with their question on the maternity experiences of women with a body mass index (BMI) $\geq$30 m/kg^2. Only two of these papers (Nyman *et al*. 2010; Furber & McGowan 2011) focused on the maternity experiences of overweight pregnant women as their primary aim; in each of the other studies, data on women's experiences were a small component of a larger study of body image changes in pregnancy in primigravidas (Fox & Yamaguchi 1997), 'transitions to motherhood and early family formation through the empirical lens of food' (Keenan & Stapleton 2010, p. 370), attitudes to physical activity in pregnancy among overweight pregnant women (Weir *et al*. 2010) and Wiles (1998) who explored the beliefs of women of above average weight in relation to weight gain during pregnancy. Furber & McGowan (2011) and Nyman *et al*. (2010)

Key messages

- Women wanted health professionals to avoid hiding behind terms such as body mass index and to 'say it like it is' when talking about their weight, but this must be done in a sensitive and caring manner.
- Women are at different stages on a 'continuum of change', and midwives need to be cognisant of opportunities for motivating women in relation to exercise and diet even though pregnant.
- Health services need to consider flexible models of care where overweight women with no other 'risk factors' might have access to predominantly midwifery-led models of care.

identified a number of similar issues for these women. Women in both studies expressed awareness of, and responsibility for, being overweight. Both papers report how women felt being overweight meant they were classified as 'high risk' locating them within a medicalised model of care. Negative feelings such as humiliation, shame, stigma and discomfort associated with being overweight and pregnant were evident in both papers. On a positive note, Nyman *et al*. (2010) also talked about some women's 'affirming encounters' with health professionals where the women were 'seen behind the fat' (p. 427). These studies were conducted in England (Furber & McGowan 2011) and Sweden (Nyman *et al*. 2010); the current study provides the first published results on women's experience of being overweight and pregnant within the Australian context.

Given the increasing rates of being overweight in pregnant women, and the impact of being overweight on the health of the mother and the child, the aim of this study was to explore the perceptions and experiences of overweight pregnant women attending two maternity units in Sydney, Australia.

Method

This study was carried out using a qualitative descriptive method (Sandelowski 2000, 2010). This method is useful when seeking to explore individual experiences and perceptions of a phenomenon (Neergaard *et al*. 2009); the phenomenon here was being overweight and pregnant. Participants were drawn from two hospitals within two Sydney Area Health Services in New South Wales, Australia. Participants were women in their third trimester of pregnancy or who had recently given birth, and who had had a BMI ≥ 30 kg/m^2 at their first visit to the antenatal clinic. The WHO definition of obesity was used in this study.[1] Ethics approval for the study was obtained from the relevant Area Health Service and University Human Research Ethics Committees. All participants were provided with an information sheet about the study and had an opportunity to have any questions or concerns answered by a member of the research team. Consent forms were signed prior to the start of each interview.

[1]Obesity may be measured and defined in a variety of ways; the WHO defines obesity as an excess of body fat that impacts on the health of individuals and as having a BMI equal or >30 kg/m^2 (World Health Organization 2000).

Table 1. Women recruited at each site including place or method of recruitment

	Site 1	Site 2
Antenatal clinic	14	3*
Post-natal ward†	2	–
Word of mouth†	2	–
Total number recruited	18	3
Withdrawn/unable to contact	6	1
Total number of participants	12	2

*One woman gave birth between recruitment and interview. †One antenatal woman and one post-natal woman.

The majority of participants were recruited and interviewed by the first author through the antenatal clinics at each of the sites. All women saw a midwife prior to their appointment with the obstetrician or endocrinologist; the midwife invited women who fit the criteria of a BMI ≥ 30 kg/m^2 to talk with the interviewer. Women who indicated they were happy to talk with the interviewer were then approached to formally discuss the project and invited to participate in the research. If the woman agreed, arrangements were made to have an interview at a convenient time/place. Recruitment details are outlined in Table 1. Two women withdrew for personal reasons, and five were unable to be contacted to arrange an interview. Recruitment was less successful at the second site, and this was attributed in part to the physical layout of the antenatal clinic affording less opportunity for privacy to discuss the study with potential participants.

Data collection

Data were collected through face-to-face interviews, with one exception when a woman's 18-year-old daughter also participated. With women's permission, all interviews were recorded on a digital audio recorder. Three interviews took place in the woman's home, two in the post-natal ward and the remainder in a private room at the hospital. The interviews were

Table 2. Interview schedule used to facilitate interview with women

- You have identified yourself or have been identified as having a high BMI. What do you understand by this term?
- How would you like health professionals to address this issue (of your weight) with you?
- Do you ever feel the midwives/health professionals judge you unfairly because of your weight?
- Could you tell me about your experience of encounters with and treatment by caregivers during your pregnancy (labour and since).
- Describe how your weight has affected your pregnancy – the way you feel about yourself, any concerns about your health or baby's health, labour or birth or care during your post-natal period.
- Please describe anything that may have occurred during your pregnancy that caused a problem that you think might be due to your weight
- Did anything occur during labour or birth that caused a problem due to your weight?
- After your baby was born were there any situations that caused you a problem due to your weight?
- What has been most helpful about the care you have received from the midwives/doctors/hospital staff?
- What could have been improved about the care you received?
- What is the most helpful thing health services can do to help someone like yourself who is overweight?

between 15- and 60-min duration. Following each interview, field notes were recorded with additional details relating to the interview, setting or circumstances of the interview. Interview questions were developed by the authors and informed by discussions with health professionals working with overweight pregnant women as part of the first phase of this study (Schmied *et al*. 2011) and the relevant literature (see Table 2). Basic demographic data were collected to enable us to describe participants in the study; one woman declined to answer these questions.

Data analysis

Audio data were transcribed; eight interviews were transcribed by the researcher undertaking the interviews; and the remainder were professionally transcribed and subsequently checked. Data were analysed using thematic analysis (Braun & Clarke 2006). The first stage involved the researchers familiarising themselves with the data while at the same time looking to identify the key issues or concerns within the text (themes). The identification of themes was an inductive process. The researchers then coded the transcripts to reflect these themes, which were reviewed and refined to form sub-themes/categories reflecting women's experience of being overweight and pregnant. Transcripts were coded individually by each author and reviewed to ensure the rigour of analysis. Extracts or quotes from the data are presented in the findings to reflect women's voices, to ensure participants' confidentiality and anonymity pseudonyms have been used throughout.

Results

Fourteen women aged 25–42 years participated in the study. The women interviewed antenatally were between 32–38 weeks gestation, and those interviewed post-natally were between 3 days to 6 weeks post-natal. In addition, the daughter of one of the women interviewed post-natally (Sophie) also participated in an interview. Women's pseudonyms, BMI, parity and time of interview (antenatal or post-natal) are shown in Table 3.

Following the analysis, four themes were identified in the interview data: 'being overweight and pregnant', 'being on a continuum of change', 'get along side us' and 'wanting the same treatment as everyone else'. The following sections discuss each of these themes.

Being overweight and pregnant

This first theme relates to how women felt about being overweight, and about being overweight and pregnant. It reflects how they saw themselves first as an overweight woman and second as an overweight pregnant woman. For the majority of these women, being overweight was not related to being pregnant because most had been overweight for many years, 'I've been bigger since I was like 13 . . . it didn't just suddenly creep up on me' (Alison); however, for a few

Table 3. Pseudonyms, BMI, parity and time of the interview (antenatal or post-natal)

Pseudonym	BMI/weight*	Parity	Antenatal/post-natal
Alison	58.8	Multiparous	Antenatal
Chloe	122 kg*	Multiparous	Antenatal
Rachel	41	Primiparous	Post-natal
Denise	111 kg*	Multiparous	Antenatal
Anita	54.7	Multiparous	Antenatal
Jane	35.7	Multiparous	Antenatal
Therese	39.3	Multiparous	Antenatal
Bianca	46	Multiparous	Antenatal
Sue	42	Primiparous	Antenatal
Leah	40.6	Multiparous	Antenatal
Gwen	42	Multiparous	Antenatal
Emma	Declined to answer demographic questions		Post-natal
Mary	39.7	Primiparous	Antenatal
Sophie†	37.1	Multiparous	Post-natal

*Two women provided their weight only. †Sophie's 18-year-old daughter, Diane, also participated in this interview.

it was more recent, 'I think it was just letting myself go' (Therese).

Most women expressed some degree of discomfort with their excess weight and were openly critical of themselves in this regard. Alison for example had reconciled herself to being overweight but at the same time stated, 'I don't like being fat', while Rachel stated, 'I think I was probably harder on myself . . . so I didn't feel pressured by anybody except for myself'.

Frustration with public perceptions and stereotypes about overweight people were reflected in the words of some of these women. Anita, for example challenged the 'perception that we're all lazy and sit down and eat all day', or as Alison said 'everyone just assumes that you mustn't do anything'. These two, like many of the other women, were busy working and, or caring for other family members, while some also participated in regular sporting activities.

Women's response to questions around how they felt their weight had affected their pregnancy provided insight into how they felt about their overweight pregnant bodies. In the context of talking about finding clothes that might fit her, Gwen commented that she did not feel she looked pregnant, that in fact she felt 'frumpy, I don't feel pregnant because I don't have the round, I don't have that stick with the ball'. Her subsequent comments indicate she was pleased when someone commented on her 'condition' as she stated 'then well you must be able to see a tummy now'. Gwen's comments indicate she missed not looking the way she perceived, a 'classic' pregnant woman might look, with her weight concealing her pregnant 'tummy'.

The physical symptoms of pregnancy women talked about were the same as those experienced by many pregnant women: sore backs, swollen feet, varicose veins, tiredness, breathlessness and being less mobile. Women recognised this; Jane, however, compared her experience to that of her sister who was not overweight and was pregnant at the same time when she noted 'the bigger you are it's got to be harder'. Anita agreed, 'I think all the practical stuff is even more cumbersome than it would be if I was a small person'. Describing this same issue from another perspective, Rachel explained how losing weight during her pregnancy had helped her 'feel better in myself and I found my mobility and even the tiredness . . . it was making things easier in a lot of ways'.

Women also talked quite openly about their overweight and pregnant bodies. Anita for example describes her feelings about her weight and how this might affect those caring for her during her pregnancy and in labour.

> Apart from me being uncomfortable about my weight and about my appearance, when you're first in labour, and they're wanting to look and poke and prod and I'm thinking, oh my goodness the poor person has to go down there and

deal with that . . . and see me without my underpants on and you know, um that's my body issues but they've never actually gone, oh I don't want to do that. So that's, that's all been fine.

Being on a continuum of change

The continuum of change was a key aspect of women's talk. At one end of the continuum were women who were not concerned about being overweight; at the other end was one woman who was actively doing something about her weight. Women were not necessarily consciously engaged in the process of change nor were they necessarily wanting to change; their comments, nevertheless, appear to position them at particular stages along a continuum. The first point on the continuum was for women who did not have an interest in changing, or were comfortable with, their weight; there were at least two women at this point. Bianca, in particular, associated her lack of concern about her weight with her cultural background; 'I'm fine with it (weight) 'cos I come from a background where they're pretty overweight, I'm a Pacific Islander I'm from Tonga'.

At the next step along the continuum, women understood there was a problem with their weight, were possibly thinking about doing something about it but felt during pregnancy was not the right time. Comments from Sue and Anita support this position, 'there's nothing I can do now' (Sue) and 'you can only do so much while you're pregnant, you can't go and run every day when you're not used to running' (Anita).

Towards the end of the continuum were women who felt they had no choice; they had to do something about losing weight, and this was expressed as they talked about their plans and strategies to achieve this. Gwen for example planned to change her diet '. . . as soon as the baby's born'. While Denise had learnt from experience, that weight 'starts to sneak on' after the baby is born, so her plans included setting 'a routine early this time . . . I've already started- . . . really trying to focus on what my plans are going to be post [birth]'.

At the other end of the continuum moved women beyond planning to actually do something about managing their weight. One woman had reached this stage; she had made changes immediately prior to her pregnancy to aid conception, and through her pregnancy to help manage pre-diabetic insulin resistance. For Rachel, her baby's health was her primary motivation, and she was determined she 'wasn't going to put on anything excessive'; she went on to note that after the birth, 'it's much harder to stay focused now that it's just about me and not so much about her'.

As Rachel's comments illustrate women's motivation to change and try and lose weight came from concern for the baby and concern for self. Some women prioritised one concern over the other. Bianca said she did not have any difficulty losing weight with a previous pregnancy after the 'Doctor said you need to lose weight else you get complications in the delivery . . . if I want to have complications during the delivery then keep doing what I was doing (putting on weight)'. Whereas Therese's motivation was 'just for me I want to lose weight for my own self esteem to make myself feel good'. For some women, losing weight was based around increasing activity while others saw it as both increasing physical activity and improving their diet 'my two main goals is to eat right . . . and then just start off slowly with the fitness' (Mary).

Get alongside us

The third theme was around the way health professionals addressed the issue of their weight with these women. Women found health professionals had varying ways of dealing with the subject of their weight, which included ignoring it all together, being critical or having an open conversation. As one woman explained, these conversations can go 'either way, it's either avoidance . . . or quite attentive, it's one or the other, there's no sort of middle ground' (Anita).

One of the key inclusion criteria for this study was that all women had a BMI greater than 30 kg/m^2, so, by the WHO definition all could be classified as obese. It was therefore a surprise to some that their weight was not discussed or was even, some felt, avoided. Denise remarked 'you always know yourself that you are [overweight] . . . from the doctor's perspective, he

never addressed it'; while Jane observed that although her height and weight had been measured, they were not discussed.

When doctors or midwives did talk to women about their weight, some women found them unhelpful and judgemental. Anita had found some to be 'what I could consider "preachy" '. Jane noted her GPs comment ' "you do know for your height that you are very obese" I'm like "OK I just had a kid" "you're still obese" ', while another woman talked about the unhelpful attitude of a health professional 'it was just more or less that you're too big, lose weight . . . no suggestions of how to lose weight . . . she had no bedside manner, and was very rude' (Gwen).

Some women felt they received mixed messages or contradictory advice. In an ironic twist, at least three women were told they were not putting on enough weight during their pregnancy; for example Jane commented how the midwives had expressed concern when she had 'only gained six kilos'.

In contrast, most women had experiences with health professionals, midwives in particular, who were open, supportive, non-judgemental and who did not make them feel uncomfortable about being overweight. For example Denise reported, 'I don't think I ever felt judged as being you know like "oh, you're really fat" or anything like that'. While Anita had found them open to talking about her weight and 'they'll make suggestions . . . but they're not overly, you know at me about it constantly'. Some women felt supported and encouraged by particular individuals, for example Rachel commented the dietician was 'probably one of the most helpful people . . . she'd be like no that's fine what you're doing and I never felt actually pressured'. The qualities identified by Denise, Anita and Rachel are all important components of a helping relationship.

Anita felt health professionals' personal feelings about weight might impact on the care they provide: 'you can tell when some people have an issue they don't say anything but they don't like to touch you'. She also noted that what health professionals did not say or do was also important: 'just the fact that they don't pull faces when I show them my stomach, and that they don't tend to go "oh my goodness look how big this woman is" '.

Finally, women talked about ways health professionals might approach discussions about weight. On the subject of what words to use and how to talk about being overweight, Rachel noted, 'It's really hard to say to somebody well sorry you're too fat. How do you say that nicely?' While specifics of the language to be used were not so clear, there was a sense that staff should be open and not hide behind euphemisms or technical terms; Alison felt they should 'just say it the way it is rather than trying to hide it'. Euphemisms are often used to avoid embarrassment or discomfort when talking about sensitive subjects, such as an individuals' weight. Alison's reflections on the way health professionals use BMI provided a good illustration of this, she felt health professionals 'don't really think about it'. She goes on to explain

> BMI doesn't word it, I hate that, it's like 'oh you have a high BMI' well that's great, that's pretty obvious . . . they don't say it's like 'cos you are bigger . . . that's nothing wrong with just saying that, I mean people that are bigger know they're bigger.

While recognising 'you don't like to be told these things' (Denise) and some women might be offended by an open approach, Bianca noted when it came to talking about her weight 'as long as they tell me the truth that's fine'. This comment was supported by others who remarked it was important that the topic be raised but not to be judgemental and to be supportive to help women deal with their weight 'rather than coming from a point of being very intimidating towards somebody I guess try and get alongside somebody and encourage them' (Rachel).

Wanting the same treatment as everyone else

This final theme arises from comments that address women's concerns about the organisation and facilities within the hospital. Women identified problems around access to clinical services and equipment that arose as a direct result of their being overweight.

'It's just the criteria' treats me differently

Women in this study were aware decisions about who could attend midwifery-led clinics and the birth

centre were guided by hospital policy. Their comments, however, reflected concerns about how reliance on guidelines for such decisions led to a loss of individuality and lack of capacity by professionals to assess health concerns or risks on an individual basis. Alison likened this to being put in a 'bucket', 'you're overweight "beepbom" you're in this bucket. It's sort of like they have a bucket for different people and you don't feel like you're in a bucket you just feel like you're a person'. At the same time Alison stressed she did not feel staff chose to treat her differently to other women; she felt hospital protocols or policies determined the differences in care, she remarked 'the people I see don't [choose to treat me differently], it's just the protocol that they've got to follow'.

Underpinning these hospital policies and subsequent decisions is a concern by health professionals that overweight women are at greater risk of complications during pregnancy and childbirth. The impact of these decisions resulted in frustration and/or fear. Therese, who was having her eighth child, was frustrated she had to attend the doctor's clinic rather than the midwives clinic:

> they can see that through all my pregnancies so far there's been no complications . . . I guess it's just the criteria that they have down there . . . you had to be under 100 kilos, and they accepted me at 99, where they wouldn't accept me this time 'cos I was 102.

At the same time, women, those with complications related to their weight and pregnancy such as Gestational Diabetes Mellitus (GDM), as well as those without any complications, understood their weight was a potential risk factor that could impact on either or both themselves or their baby. They identified potential risks such as GDM, high blood pressure and cholesterol, and problems during delivery. Anita described these as 'those obese, overweight um symptoms'. Women acknowledged if or when problems were present care would need to be modified, by treating all overweight women it was, as Alison stated, 'like they pre-empt problems'.

Women wanted the option of seeing the midwives for a number of reasons 'because I'm after a more natural sort of birth' (Alison) and continuity in knowing your midwife 'to come here and be seen by so many different people every time, I just, I don't like it. I like the more individual connection kind of thing' (Therese). Convenience was another key factor, the midwives clinics had flexible hours 'my partner can't make these appointments . . . you only get certain days you can come because you're overweight' (Alison); similarly Therese was unable to get care for her other children during the day, and in school holidays had to bring seven children to the antenatal clinic while she attended the doctors clinic, which often involved waiting for long periods in a busy environment.

For Sophie and her daughter Diane, hearing Sophie described as 'high risk', by the receptionist in the antenatal clinic, made them anxious and frightened.

> I went there (reception) and the lady said to me 'oh, she's on high risk' and I was shocked . . . because they (doctor) didn't mention anything . . . he said he's concerned about my age . . . I asked the lady and she said 'oh because you're overweight'.

Diane describes the family's reaction to this 'we were thinking "oh no, something's going to be wrong with the baby" . . . we weren't really comfortable or confident anymore'.

I know there's a baby but it's still me

The final aspect concerns issues with equipment and facilities for overweight women. Women reflected on their experiences in previous pregnancies as well as their current pregnancy. The main areas where women had any concerns were ultrasound and cardiotocography (CTG).

Ultrasounds were problematic with the main area of concern 'with them being able to feel where the baby is' (Anita); this was particularly notable earlier in the pregnancy when the baby was smaller. Women commented about the amount of pressure applied through the transducer and the pain and discomfort this caused, 'she was digging into my ribs, and I went, yeah I know there's a baby there too, but still – it's still me' (Leah). Leah expressed concern about feeling she had been forgotten in the process of focusing on the procedure.

Obtaining a clear reading on CTG monitoring was also problematic for some women. Both Denise and Rachel said they felt their 'belly fat' or the 'extra apron' affected the positioning of the CTG and they had 'to hold the CTG in certain places because it wouldn't pick up' (Rachel) or had to 'manipulate it a little bit, to sort of, keep the trace' (Denise). In contrast, Sophie noted she had not experienced any problems 'they find it easily'.

Anita expressed concern that because of difficulties encountered in undertaking routine procedures or tests, overweight women may not receive the same care as that provided to women of normal weight. She comments:

> For them to say well, we won't worry about that bit then- . . . like for them to at least try and do what they need to do, and not sort of leave it, which happened a couple of times in my other pregnancies . . . I want the same sort of treatment as everyone else.

Discussion

The findings of this study of the experiences of overweight pregnant women add to a sparse literature around this subject. Four broad themes: 'being overweight and pregnant', 'being on a continuum of change', 'get along side us' and finally 'wanting the same treatment as everyone else' emerged from the analysis.

We acknowledge several limitations to this study. This was an exploratory qualitative study undertaken in only two sites and was not intended to be representative of the broader population, but to help understand women's experiences of being pregnant and overweight. Nevertheless, the findings show a number of consistencies with previously published studies in the same area, which suggests, that, in these areas at least, these women's experiences are not unique. There were challenges in recruiting participants; firstly, this may have been due to the sensitive nature of the topic, raising questions about the language we use when we talk about issues of weight within both the research and clinical context. Secondly the environments within which women were recruited posed challenges, in particular, in relation to privacy when introducing the study. As noted the majority of interviews were scheduled to coincide with women's appointment at the antenatal clinic, this meant women were conscious of the time they had available and may have lead to some important issues not being discussed in detail.

Consistent with the findings of Furber & McGowan (2011) and Nyman *et al*. (2010), being overweight for these women was self-evident. With only a couple of exceptions, most women recognised their weight as an issue both for their own health and well-being and for its impact on the baby. These exceptions related to cultural norms. We interviewed three women of Pacific Island background, none of whom expressed the same level of concern or dissatisfaction with their weight as other women in this study. Cultural differences in body image ideals have been well documented (McCabe *et al*. 2009; Sundborn *et al*. 2010), with reports Pacific Islanders 'value large and robust body sizes' (McCabe *et al*. 2009, p. 299). While there is evidence of a growing preference for 'a healthy body size', there is reportedly less stigma associated with large body size within Pacific Islander than Australian communities (McCabe *et al*. 2009; Sundborn *et al*. 2010).

The theme describing the 'continuum of change' arising from women's discussion about their desire to change their weight reflects the first stages of Prochaska & DiClemente's (1983) stages of change model. As noted above, there were women who did not see their weight as a problem, placing them at the 'I'm fine with it' (pre-contemplation) stage; others who were aware their weight was a problem, were thinking about changing their behaviour but not yet doing anything, at the 'there's nothing I can do now' (contemplation) stage, and a group who talked about their plans to start exercising and monitoring their diet in the near future, at the 'as soon as the baby's born' (preparation) stage. It is not possible to comment on, or assess if, or how, these women might move on through the continuum. The one woman who had reached the 'action' stage identified her baby as the primary motivation for controlling her intake, however, now her baby was born she did not feel as motivated and found managing her diet much harder.

While some felt they were judged by staff because of their weight, these feelings appear to be related to specific individuals rather than a systemic concern. Women in this study did not experience the level of humiliation and negative treatment reported in previous studies (Nyman *et al*. 2010; Furber & McGowan 2011; Smith & Lavender 2011). Women's expressions of discomfort were more likely to arise from how they felt about themselves, a concern what others might think of their body or as a result of their interactions with the general public. Women also reported 'affirming encounters' in their interactions with health care professionals.

One of the issues raised by the women in this study and by health professionals in our earlier study (Schmied *et al*. 2011) shows health professionals often struggled with how best to talk about or address the subject of being overweight with women. Identifying the preferred language or terminology for health professionals when discussing weight has been the focus of a number recent studies (Thomas *et al*. 2008; Dutton *et al*. 2010; Vartanian 2010; Gray *et al*. 2011; Volger *et al*. 2011); these authors all recognise the sensitive and emotive nature of the subject, and the importance of developing, what Dutton *et al*. (2010) refer to as a 'shared terminology', to enhance rapport between patient and health professional. These studies were consistent in finding 'obesity' as the least favoured term, with 'weight' being the generally preferred terminology (Thomas *et al*. 2008; Dutton *et al*. 2010; Vartanian 2010; Gray *et al*. 2011; Volger *et al*. 2011). The current analysis identified at least three techniques employed, intentionally or otherwise, by health professionals, when talking with women about their weight; avoidance of the topic, framing discussions within a medicalised model by referring to BMI, and labelling women as 'high risk'. Described in this study as being put in a 'bucket', others have noted such labelling may result in women being seen 'as statistics' (Nyman *et al*. 2010, p. 428), feeling disempowered and with 'little choice' (Furber & McGowan 2011, p. 442). While the women in the current study acknowledged talking about their weight might make some women feel uncomfortable, they noted a preference for openness and honesty in discussions. These women believed health professionals should address the issue of their weight with them in a supportive and positive way that recognised their individual needs and expectations.

There is a growing body of literature linking being overweight and stigma (see for example Puhl *et al*. 2008; Puhl & Heuer 2009; Creel & Tillman 2011). Link & Phelan (2001) define stigma as comprising the following five co-occurring elements: labelling, stereotyping, separation, status loss and discrimination. Through classifying overweight pregnant women as 'high risk' they are not only labelled but experience discrimination and separation from normal-weight pregnant women through being directed to attend doctor-led antenatal care. Challenging the consequences of this, women asked for the opportunity, where weight was the only 'risk' factor, to be treated the same as other women. Women talked about stereotyping but this occurred in the context of community views seeing them as lazy, rather than within the health care system. Finally these women experienced a loss of status, losing their personal identity and individuality when labelled and put into 'buckets', women's comments suggest their identity has become secondary to that of the growing baby. Furber & McGowan (2011) discuss this loss of identity with one woman 'who felt like an oven' (p. 6).

The theme of 'getting alongside' women provides a framework for discussing the elements of relevance to practice. To successfully be alongside women who are overweight involves an understanding of the concerns and experiences of this group of women. At an individual level, this requires working to overcome discomfort of talking about weight with women and developing skills and strategies to do this; at the policy level this requires consideration and review of the models of care available to care for overweight pregnant women.

The theme of 'getting alongside' also reflects many of the characteristics or features of the midwife-woman partnership described by Guilliland & Pairman (1995) as 'a relationship of "sharing" between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding' (p. 7). Adopting this model in practice would see women engaged as active participants in their care, and have the potential to

help them engage with the continuum of change. The 'skills' needed by the midwife to work in partnership with women are more clearly expressed in the family partnership model described by Davis & Day (2010). These 'skills' would assist midwives to listen attentively to women, to explore and clarify issues of concern, to set goals and to challenge constructs if necessary, in this case, to challenge ideas that women may have of their bodies, their health, healthy eating and exercise.

As discussed earlier, hospital policies are developed to guide elements of patient care, support clinical decisions, ensure patient and staff safety and are generally based around the probability or likelihood of an event occurring. As a consequence of the increased maternal and/or health risks associated with being overweight, women in this study were directed to attend 'high risk' doctor-led antenatal clinics. A rigid approach to viewing excess weight as a medical issue could disadvantage women who, aside from being overweight have no other health or medical issues. Some of the women who participated in this study requested midwifery-led models of care, having either previous experience of midwife-led care or believing that these models had something to offer them. This suggests women are seeking care that will offer them continuity of carer where they will be approached as an individual rather than as a number in the system, as reported in other studies (Leap 2000). It is not known whether a midwife-led or caseload model of care would improve outcomes for women who are overweight but have no other risk factors. Regardless of whether care is provided by a midwife or a doctor, it is important that, where women do have additional health or medical issues arising from their being overweight, these are discussed with sensitivity and an awareness of the individuality of each woman.

Conclusion

The findings from this study exploring women's perceptions and experiences of being overweight and pregnant identified some positive experiences and also highlighted a number of important concerns. Key points when talking with women about their weight health professionals include: not to avoid it, not to hide behind technical terms and jargon such as BMI and 'risk', to be honest, sensitive, respectful and tell the truth when discussing weight. While discussion may cause some discomfort, women know they are overweight and prefer honesty. It is important to recognise that even where there is no discussion between the woman and health professional about weight, women do and are thinking about their weight and how to manage this throughout and after their pregnancy. The time while women are regularly attending antenatal care provides an opportunity for discussion/referral to help women plan post-natal weight management. This concept supports an encouraging, individualised approach to caring for overweight pregnant women during and after pregnancy.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

All the authors were involved in study conceptualisation and design, data analysis and manuscript revision. AM collected data and prepared the manuscript.

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