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Experiences of a lifestyle intervention in obese pregnant women – A qualitative study

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ABSTRACT

Objective: to describe obese women's experiences of participating in a lifestyle intervention and its experienced impact on health and lifestyle.
Design: qualitative method with a phenomenological lifeworld approach. The interviews were analyzed in accordance with the phenomenological method.
Participants and setting: 11 women who had participated in a lifestyle intervention project, targeting pregnant women with BMI ≥30 in southwestern Sweden, were interviewed a few weeks before delivery.
Findings: the essence of these women's experiences was expressed as: implementing new habits required support, from midwives, partners, relatives, friends, or obese pregnant women in the same situation, or by participating in the intervention itself. The support had to be non-judgmental and with a balanced outlook on weight. Participation had taught them about weight gain control. The women were motivated to try to control their gestational weight gain, although not all of them were initially convinced that this would be possible. The essential structure of participation can be described with the following constituents: "pregnancy encourages change", "to be supported by non-judgmental people", "from bad habits to conscious choices" and; "barriers to change".
Key conclusions: in order to implement new habits, participants expressed a need for support, given with a non-judgmental attitude and a balanced outlook on weight. The women experienced that the lifestyle changes could be less burdensome than previously imagined, and that slight changes could yield unexpectedly successful results. In order to maintain a lifestyle change, obese women must perceive some kind of results, i.e. increased quality of life or weight gain control.
Implications for practice: non-judgmental support from midwives is crucial. Affinity with other pregnant obese women in an exercise group or dietary group setting is supportive.

1. Introduction

Overweight and obesity are growing public health problems and globally represent leading mortality risks (WHO, 2012). Today, more than 10% of the world's adult population is obese (WHO, 2012). It is well known that maternal obesity is associated with adverse maternal and neonatal outcomes, including gestational diabetes mellitus (GDM), hypertension, preeclampsia, cesarean delivery, large for gestational age and postpartum weight retention (Sebire et al., 2001; Linne, 2004; Kiel et al., 2007; Vesco et al., 2009; Margerison Zilko et al., 2010; Vesco et al., 2011). These risks increase with the degree of obesity (Sebire et al., 2001). For example, overweight and obese women have a 17% risk of GDM, compared to 1–3% among normal-weight women (Sebire et al., 2001).

Obese women are recommended a gestational weight gain (GWG) of 11–20 lb (IOM, 2009). However, Campbell et al. (2011) report that 20–40% of obese pregnant women exceed this recommended GWG. Excessive GWG predicts long-term obesity in both the mother (Rooney and Schauberger, 2002) and the child (Margerison Zilko et al., 2010).

Pregnancy is an opportune time when women are generally more

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willing to change behaviors with the aim of improving maternal and fetal health. However, it also appears to be a time when messages about the importance of counteracting excessive weight gain seem to be less welcome (Claesson et al., 2008, Campbell et al., 2011). Accordingly, many weight management strategies have been developed especially for pregnant women. Most of these interventions focus on dietary changes, sometimes combined with increasing physical activity (Campbell et al., 2011). In a review, Campbell et al. (2011) conclude that there is a lack of sufficient evidence to indicate which interventions are effective in reducing GWG. Thangaratinam et al. (2012) conclude that weight control interventions do reduce GWG and dietary interventions are most effective. No evidence of harm as a result of GWG control interventions has been reported, such as small -for –gestational -age or low birthweight (Thangaratinam et al., 2012). The authors of these reviews generally recommend further research.

Despite the growing attention to GWG control, there are **only a** few studies investigating women´s perspectives on such interventions during pregnancy. Obese pregnant women participating in lifestyle intervention programs have reported that the most positive experiences were the recommendations concerning dietary and physical activity behaviors (Poston et al., 2013, Atkinson et al., 2016**), non-judgmental support (**Atkinson et al., 2016**)**, regular weight monitoring (Claesson et al., 2008), motivational interviews conducted by midwives (Claesson et al., 2008) and the advice-based approach (Claesson et al., 2008). The aim of this study was to describe obese women's experiences of participating in a lifestyle intervention, and its experienced impact on health and lifestyle.

2. Methods

The phenomenological lifeworld approach was chosen to explore the experiences of obese pregnant women, as it focuses on everyday life. A phenomenological attitude requires the researcher to be open to the lived experience and to continuously reflect on meaning, while withholding his/her own knowledge and experience (Giorgi, 1997; Dahlberg et al., 2008).

2.1. Setting and participants

This study is based on interviews with women about their experiences of a lifestyle intervention project. The intervention (“Mighty Mums”) was tailored for pregnant women with BMI ≥30 and was ongoing in all of the prenatal centers in a western Swedish city during 2011–2013 (Haby et al., 2015). The intervention included (1) systematised, individualised counselling and motivational sessions with a midwife, who emphasised diet, physical activity and weight monitoring; (2) the option of individual or group discussions with a dietician; (3) aquanatal classes with a midwife and physiotherapist; (4) guidance concerning suitable and locally available physical exercise activities; and, (5) pedometers and walking poles. Midwives were offered general education about obesity during pregnancy and specific education about nutrition and, healthy physical activity, diet and motivational interviewing.

Between July and December 2012, fifteen women from two different socio-demographic areas, who had completed their participation in the intervention and were in the last weeks of pregnancy, were invited to take part in the interview study by the researcher running the intervention. They were then contacted by telephone by the first author. A maximum variation sampling was recruited to ensure a variation in ethnicity, age, parity and geographical area. Demographic data for the participants are presented in Table 1. Women accepting participation were scheduled for a personal interview. Eleven women agreed to participate and the remaining four declined, due to lack of interest (2) and time constraints (2). The interview was conducted in pregnancy week 36–39.

Table 1
Demographic data for 11 obese pregnant women engaged in a lifestyle intervention during pregnancy.

Socio-demographic and life factors	*N*
Age (yr)	
25–29	4
30–34	4
35+	3
Parity	
Primipara	5
Parous	6
Ethnicity	
Swedish	8
Somali	2
Egypt	1
Education	
Nine years of primary school	2
High school or some higher education	6
College graduate	3
Occupation	
Employed	8
Unemployed	1
Student	2
Body Mass Index prepregnancy (kg/m^2)	
30–32	7
33–35	2
36+	2
Weight gain during pregnancy (pounds)	
0–9	3
10–19	6
20+	2

2.2. Interview

At the interview, the women were informed that the questions would be broad and open-ended, and would focus on their experience of participating in the lifestyle intervention; furthermore, that a healthcare professional not involved in the intervention would conduct the interview. The women themselves chose the location for the interviews; eight women were interviewed at health care facilities, two were interviewed by telephone interview and one was interviewed at home. The interviews were digitally recorded and lasted 29 minutes on average (19–36 minutes).

The opening question was ‘What´s it been like to participate in ‘Mighty Mums'?’. In order to clarify, further narrative was drawn out using follow-up questions, such as ‘Can you explain that?’ and ‘Can you tell me more about that?’ Thus, each woman had sufficient opportunity to express her viewpoint more fully (Giorgi, 1997) yielding a deepened understanding of the women's lifeworld. The first author was experienced in primary care rehabilitation and obstetrics but had no experience of obesity care. During the interview the interviewer tried to be as open as possible concerning the experiences being described, making an effort to refrain from questions, particularly related to physiotherapy, e.g. physical activity, as well as to remain aware of her personal preconceptions. The interviews were carried out in Swedish and all the interviews were completed before analysis of data. Approval was obtained from the Regional Ethical Review Board at the University of Gothenburg (D No 310-12).

2.3. Analysis

The analysis was conducted in accordance with Dahlberg et al. (2008) by the first (physiotherapist) and last (midwife) authors together. First, the interviews were transcribed verbatim and reread several times to obtain a global sense of the data. In order to analyze the data and thus gain a deeper understanding, the text was divided into smaller parts, i.e. meaning units (Giorgi, 1997). In two of the interviews, meaning units were identified with a high degree of consistency between both researchers, while they were identified by