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ORIGINAL RESEARCH – QUALITATIVE

The perspectives of obese women receiving antenatal care: A qualitative study of women's experiences

Catherine R. Knight-Agarwal [a,*], Lauren T. Williams [b], Deborah Davis [c], Rachel Davey [d], Rebecca Shepherd [a], Alice Downing [a], Kathryn Lawson [a]

[a] Discipline of Nutrition and Dietetics, School of Public Health and Nutrition, Faculty of Health, The University of Canberra, University Drive, Bruce, ACT 2617, Australia
[b] Discipline of Nutrition and Dietetics, School of Allied Health Sciences, Griffith University, Gold Coast Campus, Parklands Drive, Southport, QLD 4215, Australia
[c] Discipline of Nursing and Midwifery, Faculty of Health, The University of Canberra, University Drive, Bruce, ACT 2617, Australia
[d] Centre for Action and Research in Public Health, Faculty of Health, The University of Canberra, University Drive, Bruce, ACT 2617, Australia

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ABSTRACT

Background: The prevalence of overweight and obesity is increasing amongst women of child bearing age. Maternal obesity has implications for both mother and baby including increased health risks from gestational hypertensive disorders, caesarean section and stillbirth. Despite the increasing prevalence of maternal obesity little is known of the experiences of these women within the health care system. The aim of this research was to investigate the perspectives of pregnant women with a body mass index (BMI) of $\geq$30 kg/m^2 receiving antenatal care.
Methods: A qualitative study using individual interviews was undertaken. Sixteen pregnant women with a BMI $\geq$30 kg/m^2 participated. Interviews were audio recorded, transcribed, cross checked for consistency and then entered into a word processing document for analysis. Data was analysed using Interpretative Phenomenological Analysis. In any phenomenological study the researcher's objective is to elicit the participant's views on their lived experiences.
Findings: Four major themes emerged: (1) obese during pregnancy as part of a long history of obesity; (2) lack of knowledge of the key complications of obesity for both mother and child; (3) communication about weight and gestational weight gain can be conflicting, confusing and judgmental; (4) most women are motivated to eat well during pregnancy and want help to do so.
Conclusion: Specialist lifestyle interventions for obese women should be a priority in antenatal care. Extra support is required to assist obese women in pregnancy achieve recommended nutritional and weight goals. Health professionals should approach the issue of maternal obesity in an informative but non-judgmental way.
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1. Introduction

Worldwide, obesity is identified as a major public health problem. In Australia, the prevalence of overweight and obesity has been steadily increasing for the past three decades. In 2011–12, approximately 60% of Australian adults were classified as overweight or obese, and more than 25% of these fell into the obese category.[1] There is an increasing incidence of obesity in young women with the Australian Health Survey reporting 42.4% of women in the peak child bearing years of 25–34 to be overweight or obese.[2] Maternal obesity and excess weight gain during pregnancy are associated with increased incidence of gestational diabetes, caesarean sections and increased stillbirth and neonatal death.[3–6] Along with the personal consequences, obesity significantly burdens the current health care system. A US study estimated that maternal obesity is associated with an increased direct cost of $US2387 per pregnancy.[7] Occupational health and safety issues can be encountered by staff caring for obese pregnant women including difficulty lifting patients and obtaining access to bariatric beds and operating tables.[8,9]

* Corresponding author at: Locked Bag 1, University of Canberra, ACT 2601, Australia. Tel.: +61 0407806663.
E-mail address: Cathy.Knight-Agarwal@canberra.edu.au (C.R. Knight-Agarwal).

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At the same time, there has been less emphasis on weighing pregnant women in Australian antenatal clinics despite both national and international recommendations.[10] While acknowledging the limitations of body mass index (BMI), it is considered to be reliable at a population level.[11] The Australian Government released clinical practice guidelines for antenatal care in 2013 which recommend gestational weight gain advice to women in relation to their BMI at conception.[10] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists advocate for women to have their BMI documented at their first antenatal appointment. They also recommend those in high BMI categories be offered referral to allied health services such as dietetics.[12] The US Institute of Medicine recommends health professionals record women's weight, height, and BMI as part of routine antenatal and post-natal care.[13] Likewise, the UK National Institute for Health and Care Excellence encourages maternity care providers to monitor and assess weight management before, during and after pregnancy.[14]

Perhaps as a result of weighing no longer being a significant part of antenatal practice, there appears to be a lack of knowledge amongst pregnant women about the effects of obesity on maternal and child health.[9] In a prospective cohort study, Sui and colleagues reported that obese pregnant women were significantly ($p < 0.001$) less likely to correctly identify their BMI and more likely to experience higher gestational weight gain than women of normal BMI.[15] These results are supported by Shub and colleague's[16] who interviewed 364 pregnant women regarding their knowledge of weight, gestational weight gain and complications of obesity. They found that women had little knowledge of the risks associated with excess gestational weight gain and maternal obesity. Conversely, another Australian survey of 412 pregnant women carried out by Nitert et al.[17] found that the majority of women in their cohort identified that overweight and obesity increases the overall risk of complications for pregnancy and childbirth. The researchers concluded that level of maternal education status was a main determinant of the extent of knowledge.

Many women with obesity receiving antenatal care perceive it in a negative light. In a UK study, pregnant women with a BMI of 30 kg/m^2 felt stigmatised and that strong lines of communication between themselves and their maternity care providers were often lacking.[18] These findings were replicated in one phenomenological Danish study where obese pregnant women felt they were treated with a lack of respect compared to normal weight women. They expressed dissatisfaction that information provided by healthcare professionals, including gestational weight gain advice, was vague and often inconsistent.[19] In a series of semi-structured interviews, Stengel and colleagues[20] found that many obese women desire and value gestational weight gain advice from their health care provider. Our previous qualitative research has shown that health professionals themselves acknowledge that the advice offered to pregnant women, particularly in regards to gestational weight gain, was inconsistent.[9] A sense of frustration was expressed by obstetricians and midwives, that clear Australian evidence based guidelines for gestational weight gain are lacking and that international recommendations are out-dated.[9] The initiation of a conversation about weight with applicable women was viewed as a sensitive issue by health professionals and we note the voices of those providing antenatal care is as important as the voices of those receiving it.[9] The aim of this study was to add the voices of the women who are obese, pregnant and receiving antenatal care. In choosing Interpretative Phenomenological Analysis as the methodological approach we committed to exploring and interpreting the means by which obese pregnant women make sense of their lived experiences.[21] Incorporating such perspectives into the development and implementation of maternity services may encourage women's positive engagement with them. This research is not trying to create a representative study but rather to understand the manner in which obesity impacts the lives of those pregnant women interviewed.

2. Methods

2.1. Design

Methodological experts recommend employing a qualitative approach when the research aim is to answer complex questions such as those relating to lifestyle related behaviours.[22] The analytical process in Interpretative Phenomenological Analysis is often described in terms of a double hermeneutic as firstly, the participants make meaning of their world and, secondly, the researcher tries to translate that meaning to make sense of the participants' meaning making.[21] The result is a method which is descriptive (concerned with how things appear) and interpretative (recognises there is no such thing as an un-interpreted phenomenon). At the same time Interpretative Phenomenological Analysis is inherently idiographic[23] and qualitative researchers who use this approach explore every single case transcript by asking critical questions such as *Do I have a sense of something going on here that maybe the participants themselves are less aware of*?[23] Smith emphasises that conclusions need to be firmly rooted in what the participants have actually said with wide application of direct quotes to substantiate findings.[21] Smith et al.[24] have welcomed and encouraged health professionals without formal training in psychology, such as midwives and dietitians, to use Interpretative Phenomenological Analysis to explore subjective questions of importance to their discipline. Therefore, the objective is not to test a predetermined hypothesis rather to explore, flexibly and in detail, an area of concern.

2.2. Setting

The health facility chosen as the site for the research is the largest public hospital in the region, supporting a population of over 500,000 people with approximately 3700 deliveries per annum (Knight, personal communication).[25]

2.3. Participants

Researchers attended the waiting room of the antenatal clinic during hours of operation and approached all women about the study. Those who expressed interest (and provided permission) were asked some basic questions such as *What is your height?*, *What is your weight?*, *What is your date of birth* and *How many weeks pregnant are you?* Researchers then calculated BMI and determined the woman's eligibility to participate. Eligibility criteria included a BMI of $\geq$30 kg/m^2, aged 18 years or older, of at least 12 weeks gestation and who were accessing care through the local area health service. Women who were eligible and agreed to be interviewed provided signed consent and were given unique identifying numbers to ensure anonymity.

2.4. Procedure

The questions for the semi-structured interview protocol were based upon a discussion between the primary researchers and a review of the published literature.[12–16,26,27] Demographic data were also collected. Grades of obesity were categorised using self-reported height and weight to calculate BMI and the classification system of the World Health Organisation.[28] Interviews were conducted between September 2012 and November 2013. Participants were asked to choose a time for the interview that suited

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