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A postcolonial feminist discourse analysis of urban Aboriginal women's description of pregnancy-related weight gain and physical activity

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ABSTRACT

Problem: Excessive weight gain and physical inactivity in pregnancy have been identified as risk factors for negative health outcomes for mothers and fetuses, particularly among Aboriginal women.
Question: In this paper we engage with postcolonial feminist theory and critical discourse analysis to examine the question, "how do urban Aboriginal women understand pregnancy-related weight gain and physical activity."
Methods: We conducted focus groups and semi-structured interviews with 25 urban Aboriginal pregnant or postpartum women between the ages of 16 and 39 in Ottawa, Canada.
Findings: Three prominent discourses emerged: Aboriginal women have different pregnancies than non-Aboriginal women because Aboriginal women gain more weight and are more likely to develop gestational diabetes; Aboriginal women feel personally responsible for and shameful about excessive weight gain; finally, Aboriginal women need culturally safe pregnancy resources.
Discussion: Our results illuminate the complex and often paradoxical ways in which discourses around weight gain and physical activity are produced and taken-up by Aboriginal women and their healthcare providers.
Conclusion: Based on these findings, we argue there is a lack of accessible and culturally safe resources for urban Aboriginal women, specifically concerning weight gain and physical activity in pregnancy. We recommend the development of resources that are created for/by/with Aboriginal women to better address that issues that urban Aboriginal women themselves identify as being of key importance.

1. Introduction

Aboriginal (i.e., First Nations, Metis, and Inuit) women have the highest birth rates in Canada[1] and experience higher rates of poor outcomes in pregnancy and postpartum compared to non-Aboriginal counterparts.[2,3] Aboriginal women are more likely to be overweight/obese prior to pregnancy, to gain excessive amounts of weight in pregnancy, and to retain it postpartum.[4,5] Startlingly, First Nations status alone predicts significantly higher rates of gestational diabetes.[3] Subsequently, gestational diabetes may contribute to an increase in type 2 diabetes in First Nations women, whose prevalence of type 2 diabetes is higher than First Nations males'.[3,6] Moreover, Dyck et al.[7] noted that the prevalence rate of type 2 diabetes is particularly startling during reproductive years. Since excessive weight gain in pregnancy, physical inactivity, and poor diet increase the risk of gestational diabetes and other negative maternal and fetal outcomes,[8–10] it is important to understand how Aboriginal women take-up dominant pregnancy weight gain and physical activity discourses.

Through focus groups and semi-structured interviews with 25 pregnant and postpartum Aboriginal women in Ottawa, Canada, we identified four main discourses that the women drew upon: Aboriginal women have different pregnancies than non-Aboriginal women; overweight, obesity, and excessive weight gain are normal within Aboriginal communities and gestational diabetes is expected; Aboriginal women feel personally responsible and shameful for excessive weight gain; finally, Aboriginal culture must be included in pregnancy-related health messages. These

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findings suggest that urban Aboriginal women simultaneously accept and challenge dominant discourses concerning pregnancy-related weight gain and physical activity. These findings make an important contribution to strengthening the development of strategies with/for Aboriginal women to contest health disparities and to optimize pregnancy experiences and outcomes.

2. Literature review

In order to contextualize our research, we begin by providing a description of the distinct Aboriginal groups in Canada. We then provide a literature review of existing epidemiological data on physical activity and health outcomes for Aboriginal women, a review of the benefits of physical activity and healthy weight gain in pregnancy, and literature related to dominant discourses of weight gain and physical activity in pregnancy in general. Finally, we provide an overview of discourses concerning Aboriginal women from both bio-medical and critical public health approaches to pregnancy. We do so to illustrate the complexity of the issues at hand and the need for engagement with both schools of thought in order to the garner increased insight needed to generate effective interventions. We draw on data from Aboriginal women overall and First Nations women in particular due to the paucity of data that exist that pertain to these populations.

2.1. Aboriginal peoples of Canada

'Aboriginal peoples' in Canada are the Indigenous peoples of Canada, the original inhabitants of Canada and their offspring.[11] Aboriginal peoples are comprised of First Nations, Metis (mixed First Nations and European heritage), and Inuit (original inhabitants of the Arctic regions).[11] There are over 600 distinct First Nations communities or bands and 60 different languages. The most recent Canadian census data from 2011 indicate that there are approximately 1.4 million self-identified Aboriginal peoples, making up 4.3% of the total Canadian population.[12] Upwards of 56% of Aboriginal peoples in Canada live off-reserve in urban settings, with the population of Aboriginal peoples in Ottawa estimated to be 30,000 peoples.[12] The major shift of Aboriginal peoples to urban settings such as Ottawa, has led to the call for more research to understand the complexities of urban Aboriginal determinants of health.[13] Despite varied and distinct cultures among Aboriginal peoples, one common experience that all of these peoples endured is colonization.

2.2. Aboriginal women and health

Colonialism in what is now known as Canada has had extremely damaging impacts on Aboriginal peoples,[14] especially for Aboriginal women's health when compared to the general Canadian female population.[15] Tang and Browne[16] have pointed out that Aboriginal women have raised concerns over epidemiological profiles that are used in public health campaigns, as they can further stigmatize women. These profiles that present worse health outcomes for Aboriginal women have led to them being pathologized for poorer health[16]; the time period surrounding pregnancy is no exception. While health statistics can further stigmatize marginalized peoples, our purpose in presenting recent health statistics in Canada is to demonstrate the vast and continuing impacts of colonization. By acknowledging that these data are collected and produced within colonial context, we aim to remove the emphasis on personal responsibility and instead to point to the ways in which Aboriginal women's poor health is in fact a product of particular socio-economic-historical conditions.

Pregnant Aboriginal women, their fetuses, and infants have elevated risks of ill health. Aboriginal women are at two-to-five times greater risk for gestational diabetes than their non-Aboriginal counterparts.[17] Importantly, gestational diabetes is a predictor of macrosomia (high infant birth weight), which is associated with a number of adverse maternal and fetal outcomes.[18] As a result, Aboriginal women have increased rates of macrosomic infants compared to Canadian women in general (20.4% versus 12.2%).[19] High birth weight and gestational diabetes contribute to the intergenerational cycle of diabetes, as they increase the risk of type 2 diabetes in both mother and offspring.[6,17,20,21] The disproportionate burdens of overweight/obesity and gestational diabetes among Aboriginal peoples are multi-faceted. They are a result of the complex interplay of the social determinants of health and colonialism,[14] and the resulting and ongoing disruption to social-cultural experiences of Aboriginal peoples.[22–24] Physical activity and healthy eating in pregnancy may be tools to combat excessive weight gain, prevent gestational diabetes and other chronic diseases, and provide protective health factors for fetus and mother in pregnancy.[25]

2.3. Benefits of physical activity and prevention of excessive weight gain in pregnancy

Physical activity has numerous physical, emotional, and psychological benefits, particularly for pregnant women.[25] Physical activity during pregnancy has been found to reduce maternal weight gain, improve cardiovascular function, reduce the risk of gestational diabetes, and facilitate mood stability.[10,26] Gaston and Vamos[25] recommended that the promotion of prenatal physical activity should continue to be a public health priority. In order to support Aboriginal women in continued participation in or commencement of physical activity and healthy eating in pregnancy, an understanding of how Aboriginal women take-up discourses of physical activity and weight gain in pregnancy and the factors that influence this uptake is needed. Such knowledge can then be used to inform the development of relevant interventions, resources, and policies to support pregnant Aboriginal women.

2.4. Interventions to prevent excessive gestational weight gain

In both a recent systematic review[27] and a Cochrane review[28] it was demonstrated that there have been numerous lifestyle intervention studies to prevent excessive weight gain in pregnancy, a number which have been successful. It should be noted that despite effective interventions with general population groups, no interventions with high-risk groups have been found to be effective.[28] However, few interventions have been created to address the prevention of excessive weight-gain and physical inactivity in pregnancy among Aboriginal women. One initiative on four reserves in rural Quebec that examined this issue failed to have success in changing dietary and physical activity behaviors in Cree women. The researchers found that the diet and physical activity intervention had only minimal impact on diet and concluded that "finding ways of encouraging appropriate body weight and activity levels remains a challenge"[29] (p. 1247). In fact, more women in the intervention group developed gestational diabetes than those in the control group (16.2% versus 14.7%).[29] In response to the poor outcomes in this intervention, the Special Working Group of the Cree Regional Child and Family Services Committee[30] suggested that researchers and health professionals need to ensure a better understanding of local and historical factors prior to implementing any initiatives and that they need to involve local pregnant women in the planning processes.[31] A second initiative in Saskatoon, Canada offered PA classes for pregnant women over a 2 year time period in 1995–1997.[32] There were a total of 69 participants, 51% only attended one to three sessions and the 49% attended four or more classes.[32] The