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'Obesing' pregnant women

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Ruth Deery asks by whom and for what reasons?

Anti-obesity campaigns and policies remain rife in the media, occupying a high profile in health policy and public health agendas, often interpreting obesity as a disease of global epidemic proportions and a 'health time bomb'.

Not surprisingly, obesity is similarly conceptualised, both scientifically and medically, by those working in and writing about the maternity services. The moral agenda attached to the anti-obesity culture has many similarities to the presentation of the AIDS epidemic in the 1980s, where stigmatisation and marginalisation from mainstream citizenship were clearly evident.

Pregnant women receive clear messages that if they are obese they have a greater risk of developing a range of complications in pregnancy and childbirth.[1] As a result obesity becomes increasingly and unevenly medicalised through so-called 'authoritative' accounts[1, 2] that arbitrarily label obesity as a cause rather than a correlation – smoking causes lung cancer comes to mind. These 'authoritative' accounts often contain unsubstantiated or overstated claims about the damaging effects of body fat on the health of pregnant women and their babies and can transmit a culture that health professionals know best about risk.[3]

In this respect the 'black box, junk in; junk out' scenario comes into play – inconclusive, incorrect evidence is deposited into the box, and reappears at the other side of the black box as legitimate conclusions.[4] As a result the media and health professionals (to mention but a few) leap to groundless conclusions that any possible health problems (such as hypertension, diabetes, heart disease and cancers) are caused by obesity. Other legitimate forms of evidence simply do not enter into the public domain for discussion and debate; the regurgitated 'junk' is merely asserted without reference to work that demonstrates otherwise, or questions the credibility of the findings. This situation has created a powerful and pervasive discourse where the health risks associated with obesity are often communicated as scientifically based fact and obesity is viewed as a dangerous disease.

As well as having health issues blamed on their body size, obese pregnant women are also more likely, than their counterparts, to receive judgemental comments from medical staff.[5, 6] Clearly when a more accepting approach to medicalisation by health professionals does not happen, social discrimination, stereotyping and stigmatisation occur much more frequently. When these negative social responses come into play the effect on pregnant women is easily ignored or forgotten and women are judged on the

basis of their size and appearance.[6]

When pregnant women receive judgemental or negative feedback from health professionals these comments can become internalised, causing women to become withdrawn and feel isolated. Crucially, words are not always necessary and our own internalised views and opinions about 'obesity' can easily be transmitted subliminally to women and their families, thereby increasing the potential for marginalisation even further.

Additionally, some health professionals view obese women as 'a statistic waiting to happen'[5] but not all obese women will present as problematic; the degree of risk will vary, for example there will be a difference between a well nourished and an under nourished pregnant woman. Research suggests there is a lack of knowledge amongst health professionals of the social, psychological and economic effects that influence obesity and personal wellbeing.[7] Again, this adversely influences access to maternity services, quality of care, health equity, and outcomes of care, for women who are more vulnerable and disadvantaged.[7]

A consensus has emerged that obesity is neither genetic nor physiological.8 Rather, being obese is associated with a broad range of social, psychological and economic effects on a pregnant woman's life.[6], [7] At the same time, the failure of dietary approaches has led to a greater consideration of a wide range of possible risk factors that appear to be correlated with obesity. These include psychological factors, eating patterns, activity levels, family background and amount of sleep. Eating in response to emotional rather than hunger cues could also be more prevalent among overweight and obese individuals. This is an area that warrants much more urgent attention from health professionals and researchers. Associated with discrimination and stigmatisation, obese people may externalise a sense of guilt that will impact on their social interactions, possibly leading to more negative experiences with health care. There is no reason to believe that this situation will be any different for pregnant obese women. Likewise, as obesity has become progressively medicalised, midwives have become either blind to, or more accepting of, social discrimination, stereotyping and stigmatisation that can occur as they work with pregnant 'obese' women.[5], [6], [7]

Those pregnant women who come from communities with low levels of social capital may be particularly at risk – both of being obese and of suffering from the associated effect of low self-esteem.[8] Lower socioeconomic status also seems to be a risk factor for increased levels of obesity, particularly in women and members of ethnic minorities.[8] Environment may also be related to the accessibility of healthy food although proximity to appropriate shops does not necessarily make healthy food accessible to everyone.[9] Financial resources, mobility, and expertise in cooking are also factors to take into account.

Environmental factors may also contribute towards weight gain. People in areas characterised by lower social support, and therefore higher levels of stress, may be at higher risk of becoming obese. In addition, being overweight has been associated with many different negative psychosocial consequences that may in turn further contribute to higher levels of stress.[5], [6], [7] If obese pregnant women feel that they are entering into a maternity culture that deplores and labels obesity as antisocial, stress levels will increase

even further, encouraging marginalisation and increasing vulnerability.

All those people coming into contact with pregnant women would do well to heed the advice of Lucy Aphramor, a dietician who founded the group Health at Every Size (HAES). She advocates the removal of weight loss goals promoting a healthy relationship with food, including the importance of learning to recognise internal signals rather than ignoring them in favour of rigid eating plans. HAES encourages activity for general well-being, for pleasure in movement and abilities and not as a calorie-burning mission.[10] What better advice could midwives give to pregnant obese women?Aphramor also advocates that bodies should not be disliked or despised for their lack of conformity to a particular size or shape. Whilst the HAES approach may or may not result in a weight change, the point is that HAES improves health outcomes long-term, and dieting does not, making HAES an ethical and effective choice. However, and crucially, how confident do those people (especially midwives) coming into contact with obese pregnant women feel giving advice regarding dietary issues? My guess is that much work needs to be done in this area in order to build confidence in the health professionals and to instil a sense of safety and trust for obese pregnant women.

Conclusion

Further research needs to explore to what extent poor health outcomes for mother and baby areactually linked to obesity. The role of health professionals in the planning of care for pregnant obese women may in some way subliminally effect poor maternal outcomes. Acceptance and further understanding of diverse body sizes is crucial if we are to ensure equal access to excellent standards of care in the maternity services. Eating less and moving more is not an all-encompassing answer to the so-called 'obesity epidemic' – all bodies are worthy of respect whatever their size or shape and account must be taken of the different ways in which some people 'use' food. Health professionals must be sensitive to the current obesity rhetoric, recognising how misconceptions can easily influence the way we care for pregnant women. This will only be achieved if those coming into contact with obese pregnant women are given the oppor tunity to become skilled in their approach to advice giving.

References

1. Lewis, C (2007) Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer – 2003-2005. The Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom, London. CEMACH

2. Moon, MA (2009) Maternal obesity doubles risk of neural tube defect. Clinical Endocrinology News, 4 (4): 17.

3. Heyman, B, Shaw, M, Alaszewski, A & Titter ton, M (2010) Risk, Safety, and Clinical Practice, health care through the lens of risk, Oxford University Press, Oxford.

4. Harding, S (1986) The Science Question in Feminism. Milton Keynes: Open University Press.

5. Vireday, P (2002) 'Are you a size friendly midwife?' Midwifery Today, Spring: 28-32.

6. Deery, R. & Wray, S. (2009) 'The hardest leap': acceptance of diverse body size in midwifery, The Practising Midwife, 12 (10): 14-16.

7. Nyman, VMK, Prebensen, AK & Flensner, GEM (2008) Obese women's experiences of encounters with

midwives and physicians during pregnancy and childbirth. Midwifery, 10.1016/jmidw.2008.10.008.
8. Cohen, DA, Finch, BK, Bower, A & Sastr y, A (2006) Collective efficacy and obesity: The potential influence of social factors on health, Social Science and Medicine, 62: 769-778.
9. Cummins, S (2006) Neighbourhood food, environment and diet - Time for improved conceptual models. Preventative Medicine, 44(3): 196-197
10. Aphramor, L (2009) All shapes and sizes. www.guardian.co.uk/commentisfree/2009/may/09/obesity-weight-health, Accessed 3rd May 2011.

Government Position

The Department of Health has published *Healthy Lives, Healthy People: A call to action on obesity in England*. The document can be found here: www.dh.gov.uk/health/2011/10/call-to-action

The Scientific Advisory Committee on Nutrition (SACN) *Dietary Recommendations for Energy* report can be found here: www.sacn.gov.uk/reports_position_statements/index.html