## Presenter Disclosures

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## *What do Women Think about Gestational Weight Gain?*

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## Weight Gain During Pregnancy

- In 1990, the Institute of Medicine (IOM) convened an expert panel to review existing evidence and provide updated guidelines for optimal weight gain in pregnancy.
- At that time, the prevailing concern was for insufficient nutrition, inadequate weight gain, and resultant adverse outcomes including preterm delivery and low birth weight.

## Almost 20 years later…

- New IOM recommendations
- New concerns
- Far more common for women to gain too much weight in pregnancy, rather than too little.
- Studies consistently show that 40% to 50% of normal-weight women and 60% to 70% of overweight and obese women exceed the IOM recommendations.
- Two-thirds of the adult population in the U.S. meet the criteria for being overweight or obese
  - Thus more women are entering pregnancy overweight or obese
  - Poor women at disproportionate risk for pre-gravid obesity and excessive gain

## Why Do Women Gain Too Little or Too Much Weight During Pregnancy?

- Appropriate counseling?
- Inability to comply with nutritional and/or exercise recommendations for economic or cultural reasons?
- Distrust of provider counsel?
- Competing needs (e.g., food has an emotional meaning)?
- Competing counsel (e.g., cultural norms, specific family members)?

## *Helping Women Achieve Healthy Weight Gains in Pregnancy Project*

- **Focus groups designed to solicit advice from pregnant women about how to develop effective prenatal weight gain messages**
- **Women asked about their experiences, expectations and opinions about prenatal weight change**
- **What messages do they hear?**
- **Who are their health confidantes and pregnancy counselors?**
- **Funded by a small grant through the Academic Health Center, University of Minnesota**

## Participants

- 25 pregnant women receiving prenatal care at 4 Twin Cities clinics
  - Three clinics served primarily low-income women
  - One clinic served Spanish-speaking women
- Eligibility:
  - Second or third trimester of pregnancy
  - 18 years or older
- Recruited by clinic liaisons between December 2007 – February 2008

## Study Conduct

- 1.5 hours of participation: group + questionnaire
- Groups at the client's clinic (one conducted in Spanish), without clinic staff present
  - audio-taped
- Women provided written consent and received a $50 Target gift card for participation.
- Women were asked about:
  - expectations about weight change during pregnancy
  - trusted advisors about health during pregnancy
  - advice received about weight gain, eating and exercise during pregnancy
- Transcribed information was analyzed by all study authors to identify major themes

## Characteristics of Participants (n = 25)

| | |
|---|---|
| Age | |
| Mean | 25.5 years |
| Range | 18 – 40 years |
| Race | |
| American Indian | 2% |
| Asian | 24% |
| Black | 16% |
| White | 44% |
| Multiple | 8% |
| Hispanic | 24% |
| Married or living with man involved in pregnancy | 24% |
| Insurance source<br>Government<br>Employer | <br>68%<br>32% |

## Pregnancy Characteristics

| | |
|---|---|
| Gestation | |
| Mean<br>Range | 28.5 weeks<br>13 - 39 weeks |
| Number of times pregnant (including study pregnancy) | |
| Once<br>Twice<br>Three or more times | 44%<br>24%<br>32% |

## Pre-gravid Weight

| | |
|---|---|
| Pre-gravid body mass index | |
| Mean<br>Range | 25.2<br>17.0 – 33.0 |
| Pregravid status (IOM, 1990) | |
| Underweight (<18.5)<br>Average (18.5 - 24.9)<br>Overweight (25.0 - 29.9)<br>Obese (≥ 30.0) | 8%<br>36%<br>28%<br>20% |
| | |

## Weight-related Characteristics

| | |
|---|---|
| Perceptions about weight most of adult life<br><br>Underweight<br>About average<br>A little overweight | <br>16%<br>52%<br>32% |
| As adult, how often dieted to lose weight<br><br>Never<br>1 – 2 times<br>3 – 4 times | <br>60%<br>24%<br>16% |

## *Inability to control the rate and amount of gestational weight gain*

- Low control often mentioned. Related to:
  - understanding educational messages
  - accessing information
  - valuing conventional messages
  - a sense of general uncertainty about what happens
  - opinions that the provider—not the client—had the greatest responsibility for monitoring gestational weight gain

Several women noted that *"every pregnancy is different"* and there is no logic to weight gain. Some women expressed defensiveness about meeting (or exceeding) weight gain recommendations.

**"When you are pregnant you really can't control your weight gain or weight loss. It all depends…I mean, you can watch what you eat or whatnot, but you're still going to gain weight."**

## *Best for Baby*

- Several women also stated that excessive weight gain could be justified for the health of the fetus.
- A few women noted that body weight monitoring could be dangerous if it led to body weight obsession.

## *Prioritizing: Pregnancy Makes Many Demands. Weight Gain is Not Everything*

- Some women discussed the demands of pregnancy (e.g., the inevitable changes in body size and well-being, not being able to smoke or drink alcohol)
- Diverting from recommended weight gain was one of several concerns and perhaps not the most important

## *Trust Everyone–Most of the Time*

- Women often named physicians, nurses, and midwives as their most trusted advisors about pregnancy health—and some stated that sources like WIC counselors were most helpful
  - They trusted these advisors because they were educated, while acknowledging that their life circumstances may be different.
- Some women stated that advisors in their social network gave confusing, wrong, and/or irrelevant advice about eating, exercise, and weight gain during pregnancy
- Some women valued information from media or commercial sources like Dr. Phil, Weight Watchers, or posters they had seen in clinics

## *Context and Comprehension*

- Understand our lives.
  - Women often noted that behavior was associated with stress or physical symptoms of pregnancy, like nausea
  - The context of their lives had to be understood
- *Mixed messages and comprehension.*
  - Many women were able to give good examples of healthy eating (e.g., eat fruits, vegetables, and dairy products; abstain from alcohol) BUT
  - Several gave questionable examples (e.g., eat fatty foods to "fatten up", eat beef, cheese, and bread)
  - Some acknowledged they had trouble understanding mixed messages (e.g., fish consumption).

*"I do day care, so I've got eight kids. I get enough exercise."*

*They say exercise is good, but I get enough exercise living on the third floor. Once you get to a certain stage, trimester, or whatever, I don't need exercise."*

## Strengths and Limitations

- Like many focus group studies, our participants were self-selected, geographically homogeneous, and, to some degree, economically homogeneous
- Our participants were more likely to be average weight than women their age and, relative to results from other studies of pregnant women, less likely to present body weight concerns
- Qualitative data provide leads for future research questions, but they do not provide evidence
- Whenever we listen to women who are affected by the programs we provide or the educational materials we develop, it is a strength

## Conclusions

- **The health information clients receive and perceive can be different.**
- **Our participants stated that they trusted their providers (and presumably received counsel to gain weight within IOM recommendations), but they often described attitudes that excess gestational weight gain was inevitable and/or not necessarily health-damaging.**
- **Patient-friendly educational materials are needed to optimize gestational weight gain and to decrease maternal (and offspring) complications of excess gestational weight gain that may be lifelong.**