

Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care

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Abstract

Fat pregnant women are being targeted with obesity management strategies in maternity care as a result of contemporary anxieties about the future health harms and health care costs of obesity in pregnancy. This paper reports on interviews with 27 self-identified fat, ethnically diverse pregnant women and new mothers. It asks what it is like for fat pregnant women to be on the receiving end of discourses and practices in maternity care that problematise their bodies and whether this contemporary approach to maternal fatness fulfils its ambition of improving population health.

Keywords

Fat pregnancy, obesity management, medicalisation, fat phobia, health promotion

Introduction

“Pregnant women are packing on too many kilograms, risking their health and that of their babies – and costing the health system a fortune”. (Grunwell, 2011)

Burgeoning medical scientific interest in the health consequences of ‘maternal obesity’¹ is leading to an unprecedented problematisation of fat pregnant bodies in Western medical settings (McPhail, Bombak, Ward, & Allison, 2016; Parker, 2014). Studies have suggested growing rates of ‘obesity’ amongst women of reproductive ages and an association between fatness and an increase in almost all pregnancy and birth complications; for example, caesarean section, postpartum haemorrhage, miscarriage, congenital abnormalities, and stillbirth (for example, see Denison & Chiswick, 2011; Heslehurst et al., 2008). In tandem, studies drawing on the technological developments of epigenetics have progressively traced the origins of the so-called global obesity epidemic to life in the womb, emphasising the role maternal weight and diet plays in programming infants for future obesity (for example, see Gluckman, Hanson, & Beedle, 2007). These studies have been extensively and sensationally reported in the Aotearoa/New Zealand news media, placing fat maternal bodies at the epicentre of contemporary anxieties about the population health problems and health care costs facing modern Western societies (Parker, 2014).

Health systems have responded by introducing a suite of guidelines and interventions intended to regulate and manage fat maternal bodies. In Aotearoa/New Zealand, this has included the introduction of body mass index (BMI) cut-offs for access to publically funded fertility treatment (Farquhar & Gillett, 2006), restrictions on fat pregnant women’s birthing options such as place of birth (Ministry of Health [MoH], 2012), and a narrowing of population-wide ‘obesity-prevention’ strategies such as exercise and diet advice to the new priority area of pregnant women, new mothers, and young children (see, for example, MoH, 2014). Pregnant women are now tasked with securing their child’s future health, indeed the health of the nation, long before they have even given birth. In the midst of these contemporary anxieties about fat

pregnant bodies, the voices of fat pregnant women and new mothers themselves have been excluded. This research seeks to address this omission. It asks what it is like for fat maternal subjects to be on the receiving end of discourses and practices that problematise and govern their fatness, and whether this contemporary approach to maternal fatness, deployed in pursuit of population health improvement, actually fulfils its ambitions.

Framing the fat female body

Contemporary anxieties about the health effects of fat, fuelled by a proliferation of obesity science and its widespread circulation in the mass media, have coalesced in recent years, leading to articulations of an epidemic of obesity (Saguy & Riley, 2005). Obesity epidemic discourse posits that there has been an exponential increase in body weight in the population, resulting in a substantial and avoidable disease burden with significant social and economic costs. Obesity is thus framed as a public health crisis that requires a massive mobilisation of state and community resources in response (Rail, 2012). A range of actors have taken up this task. State investment to address the obesity epidemic has been concentrated in national public health initiatives that aim to promote weight loss by emphasising the need for individuals to make healthy choices in regards to physical activity and diets (MoH, 2009). In tandem, health care services have been re-orientated to a weight-based focus, leading to the introduction of routine opportunistic BMI screening (MoH, 2009), weight management programmes (MoH, 2009), and body weight restrictions on eligibility for some publically funded treatment and surgery (Farquhar & Gillett, 2006).

However, while this dominant discourse of fatness as a medical condition that requires prevention and treatment constitutes a contemporary truth within and outside of the health sector, it is far from universally accepted. Critical scholarship from a variety of disciplines and from diverse epistemological positions has questioned many of the tenets of this dominant discourse, noting contradictions and problems regarding obesity's measurement, causes, and solutions (Campos, 2004; Cogan & Ernsberger, 1999; Gard & Wright, 2005; Saguy & Riley, 2005). Research has also highlighted the social stigmatisation of fatness experienced by fat people in Western society, including in the areas of health care, education, and employment. Studies have demonstrated how the social stigmatisation of fatness itself functions as a health risk, for example, by disengaging fat people from health services, increasing vulnerability to depression and poor body image, and creating barriers to fat people's participation in recreational pursuits (Carryer, 2001; Puhl & Heuer, 2010).

A number of scholars have drawn on post-structural theoretical perspectives to argue that the medical category 'obesity' is socially constructed (Gard & Wright, 2005; Rail, 2012). For these scholars, obesity science represents an overly mechanistic and reductionist version of body weight and health that is highly inflected with moral and economic valuations of fat bodies as deviant, lazy, greedy, unproductive, and in need of expert control. Feminist scholars have made a significant contribution to critical obesity scholarship from a social constructionist perspective. They argue that dominant obesity discourse intersects with longer-standing Western cultural imperatives of slender femininity that result in pressure on women to regulate their bodies (Bordo, 1993). Pregnancy has traditionally been regarded by feminist scholars as a time of release from the pressures to uphold the 'feminine ideal' of a slender body and thus as a time in which women may experience a more enjoyable and less anxious experience of embodiment (Earle, 2003; Williams & Potter, 1999). However, feminist scholars are increasingly noting the contemporary encroachment of the slenderness ideal during pregnancy (Harper & Rail, 2012; Johnson, Burrows, & Williamson, 2004; Longhurst, 2005; Nash, 2012, 2011, 2006; Tyler,

2011). Scholars attribute this both to the rise of popular cultural representations of fit, fat-free, and sexy pregnancies (Longhurst, 2005; Nash, 2012) and to growing anxieties about the health effects on the ‘child-to-be’ of maternal fatness (McPhail et al., 2016; Parker, 2014).

Feminist scholars within the field of fat studies have drawn attention to the gendered implications of contemporary obesity epidemic discourse in constituting unliveable subjectivities for fat women (Cooper, 2010; Fikken & Rothblum, 2012; LeBesco, 2004; Murray, 2008). These scholars point to the disproportionate levels of weight bias and discrimination experienced by fat women (Fikken & Rothblum, 2012). Further, these scholars argue that women fare particularly badly within dominant biomedical discourse about obesity. They argue that this discourse intersects with long-standing negative cultural significations of fat women as compulsive eaters, hyper-emotional, lazy, and deviant, serving to ‘(re) produce popular anxieties about, and rejection of, the “fat” female body’ (Murray, 2008, p. 213). This in turn constrains the cultural possibilities for fat female embodiment, constructing female fatness as a ‘spoiled, uninhabitable, invisible identity’ (LeBesco, 2004, p. 3). This spoiled identity is argued to be compounded for fat mothers (Boero, 2009; Rail, 2012; Warin, Turner, Moore, & Davies, 2008). Scholars point to the tradition of mother blame in Western cultural discourse, its manifestation in social discourse about child obesity, and its progressive extension to reproductive physiology aided by medical science and technologies such as ultrasound screening (Warin, Moore, Zivkovic, & Davies, 2011; Warin, Zivkovic, Moore, & Davies, 2012). The moral panic about child obesity is highlighted to demonstrate how women’s weight, along with the weight of their children, has increasingly become a litmus test of ‘good mothering.’ This in turn is resulting in gendered, individualised blame placed on women, particularly mothers, for the obesity epidemic, helping to obscure the social structural inequalities, including racism and economic inequality, that have such a significant impact on the health of families (Boero, 2009). In response, feminist fat studies scholars and activists are engaged in attempts to generate a more inhabitable and stronger subject position for fat women outside of medical and scientific discourses (Cooper, 2010; Lebesco, 2004; Pausé, 2012).

A small number of studies have examined the reproductive health care experiences of fat women in the context of increasing medical concern with the health effects of obesity (Furber & McGowan, 2010; Nyman, Prebensen, & Flensner, 2010; Smith & Lavender, 2011). Participants in these studies described negative interactions with maternity care professionals, including derogatory comments about, and constant references to, their weight (Furber & McGowan, 2010; Smith & Lavender, 2011). Such interactions resulted in women’s feelings of embarrassment, humiliation, and guilt. For some women, the experience or fear of humiliating treatment meant avoiding or delaying seeking care altogether (Furber & McGowan, 2011). Participants also reported being labelled with a higher risk of developing medical complications because of their size and stereotyped as unlikely to be able to give birth normally (Furber & McGowan, 2010; Nyman et al., 2010; Smith & Lavender, 2011). This led to their exclusion from low-risk care options that promote low interventionist birth, such as midwife-led care, birth in primary maternity facilities, and the use of water and other aspects of active birth (Smith & Lavender, 2011, p. 787). It also increased women’s exposure to screening and surveillance, leading to a cascade of medical interventions (Furber & McGowan, 2010; Smith & Lavender, 2011).

Research design

In light of the recent embrace of ‘maternal obesity’ in contemporary health discourses and practices in Aotearoa/New Zealand, it is timely to ask how fat pregnant, or recently postnatal,

women are experiencing the problematisation of their fat pregnant bodies. The research reported here was undertaken to examine what kinds of maternal identities, subjectivities, and embodied practices related to health seeking were constituted through self-identified fat women's interaction with the problematising discourses of 'maternal obesity' in the course of their maternity care. The goal was to trouble the health-promoting rationale of current obesity management strategies in maternity care, asking how women take up and make sense of medical discourses of their fat bodies during pregnancy. Participants' self-identification as large/fat² was considered important in order that the research be unaligned with biomedical definitional schema of dominant obesity discourse and because fat identity is subjective and rooted in self-perception and lived experience. No particular ethnic groups were targeted for inclusion but – given the ethnic diversity of Auckland and the on-average higher BMI amongst Māori and Pacific communities (MoH, 2017) – both a Māori and Pacific cultural advisor were engaged in the research to advise on cultural competency.

Ethical approval for this study was gained from the University of Auckland Human Participants Ethics Committee and Auckland District Health Board's Research Committee. Participants were recruited through stories in local newspapers and the distribution of fliers through social media networks, midwifery clinics, and lead maternity carer midwives. The invitation to participate was extended to those who were currently pregnant or who had delivered their most recent child in the past two years. The main criteria for inclusion, consistent with the research objective of centring the voices of fat women in discourses about their bodies, was that participants experienced themselves as subjectively 'fatter than the norm', and were open to exploring their maternity care experiences in relation to their fatness. Other inclusion criteria included that participants be aged over 16 years and located in the Auckland region to contain the research to a scope appropriate for a doctoral research project.

In total, 27 in-person, one-on-one interviews were conducted. Many took place in women's own homes, others in a church or community centre. Participants were asked to complete a brief demographic survey at the beginning of the interview, which included questions about their ethnicity/ies, household income, occupation, number of children, where they gave birth, the level of medical involvement in their birth, and who had provided or was providing their maternity care. Callister (2004) has suggested women often need a reflective period following the birth of their babies to make sense of their childbirth experiences. Interestingly, all but one of the participants already had a born child/children and were either discussing a current pregnancy or the birth of their most recent child. Consistent with the general population, most participants had received care from a lead maternity carer midwife and had given birth in a tertiary hospital. Participants represented a wide diversity of household incomes, occupations, and ethnicities. The sample included five Māori, six Pacific, ten Pākehā/European, four other European, and two Asian participants.

Interviews were semi-structured, and participants were invited to tell their maternity care story in a conversational style, with most participants requiring little prompting (Longhurst, 2003). As in other studies exploring fat women's experience (for example, see Longhurst, 2010), the interviews were often highly emotional and included the disclosure of intense pain and distress. While participants were asked to specifically explore their most recent maternity care experience, many participants wove in a diversity of other life experiences into their interviews, which enriched the data. Due to the scope limitations of the current article, the following discussion is primarily limited to participants' experiences of maternity carers/the maternity care system of their most recent reproductive experience. As a Pākehā, an academic researcher, a former midwife, a mother, and a sometimes fat person, I am positioned in complex ways to the research as both insider and outsider. For most of the interviews, I was visibly

pregnant. My perception was that this helped to foster warmth and rapport and in this way my pregnant body could be said to have functioned as an ‘instrument of research’ (Longhurst, Ho, & Johnston, 2008). However, my own body size changed significantly throughout the research, from a ‘normal’ body weight while pregnant (having previously been a fat younger person) to a return to fatness in my postnatal body. I have employed self-reflexive tools such as journaling to make sense of my evolving positionality and embodiment in relation to the research (Greene, 2014).

Interviews were transcribed and analysed using a form of Foucauldian-inspired discursive thematic analysis (Braun & Clarke, 2013). This is a theoretically driven interpretive method of analysis concerned with identifying discourses and the ways in which they constitute particular knowledges or truths and regulate practices, experiences, and subjectivities (Malson, 1998, p. 42). This form of analysis is characterised by its concern with the ‘global’ analysis of discourse in contrast to other more ‘fine-grained’ discourse analytic approaches that focus on detailed discursive or linguistic procedures (Malson, 1998, p. 43). The primary aim of this research method is cultural analysis and critique, with the goal of understanding and opening up the ‘cultural conditions of possibility for being in the world’ (Gavey, 2011, p. 186). It does not seek to represent participants’ experiences in any ‘straightforward and transparent way’ (Weatherall, Gavey, & Potts, 2002, p. 533). Rather, it seeks to interpret talk in ways that reveal the discursive influences on subjectivity. This does not indicate a lack of interest in participants’ experiences but rather draws attention to the ways in which experience and culture are enmeshed (Gavey, 2011). However, this can create tensions, such as the possibility that participants feel silenced or that they disagree with the researcher’s interpretations of their experiences (Weatherall et al., 2002). The solution to this research dilemma, argues Gavey (2011), is a ‘(careful and wise) theoretical impurity’ whereby participant’s experiences can be heard as ‘a reasonable (albeit mediated) description of “the real”’ (p. 187) while at the same time being analysed for the discursive forces that shaped the conditions of possibility for those experiences.

Through the analysis of the data, I attempted to incorporate the principles of intersectionality. Intersectional analysis seeks to ensure attention to the ‘interlocking effects of identities, oppressions, and privileges to fully understand the range and complexity of women’s experiences’ (Price, 2011, para 55; see also Collins, 1986). Examined intersectionally, the experiences of pregnant fat embodiment described in this study were refracted through the axes of privilege and oppression, most clearly those of race and class. For example, participants with a lower household income expressed their frustration at not being able to afford the lifestyle practices recommended to them by maternity carers for weight management such as gym memberships and fresh fruit and vegetables. Some participants of colour described their sense that the politics and practices surrounding ‘maternal obesity’ were simply the latest expression of longer-standing racist and eugenic policies aimed at controlling the reproductive lives of black and brown bodies. Due to limitations in the scope of this article, I have not explored the intersectional aspects of the fat experience described in any depth, but it is important to note that the experience of fatness cannot be universalised or generalised, and contemporary fat politics could be argued to perpetuate and amplify the legacy of reproductive injustices endured by minority women, particularly indigenous women, women of colour, and poor women (Roberts, 1993, 1996).

Three themes developed from the data are explored below. Within these themes, participants described the meanings about their bodies produced through the discourses and practices of contemporary maternity care with its focus on obesity management.

Weight matters

In the first theme, participants explored how their fatness was problematised as a health issue during their pregnancies through their encounters in maternity care. Reflecting on their pasts, participants described long struggles with poor body image and a history of fat shaming and bullying encounters both outside of and within health services, all of which they carried with them into their maternity care experiences. As Eva described,

I've been a big girl the whole time, I've been through it, I've had the comments, I've had things yelled at me, you know, on the motorway driving along and people yell abuse out of the car, things like that.

While the problematisation of their fatness was not new, participants were confronted by the focus on their weight as a pregnancy health issue when they embarked on maternity care. Some participants described having their weight screened by maternity carers who they approached for care and being turned away or being told from the outset that their pregnancies would likely be complicated by their weight, limiting their choices and increasing their risk of poor outcomes. As Eva described,

It was initially, I was deemed as kind of high maintenance at the start and did find it difficult to find a midwife. When I'd phone around and they'd ask me the simple questions and I'd say well I'm a bigger girl, 'oh well that's going to take a bit more attention so I don't have the space for you now'.

Participants described their dread of being weighed during antenatal visits and felt that the number on the scales often eclipsed the ability of maternity carers to view them as a whole person, leading to assumptions that they were lazy, greedy, and unhealthy. As Hana observed,

Oh well, if you're big you're going to get diabetes, you're going to get heart attacks, you're going to get all these terminal illnesses, oh not terminal, whatever they are, sickness, you're a no good, fat waste of space ... so yeah in society's eyes we're all a cost to the taxpayer and the health system ... You don't even have to be weighed, they just look at you and you're automatically placed into this category.

In general, being cast as 'unhealthy' was at odds with participants' much more positive view of their general health and wellbeing, and participants expressed great frustration at the perceived judgments about their lifestyles by maternity carers. As Lisa described,

Yeah, I didn't really enjoy it [visits to the obstetrician], just cause it's like, you know, I kept saying well I'm eating really healthy and they were still going well you know, your BMI is too high and you're going to have to have a caesarean and it was like, well you're not even listening to me, you're not even listening to the fact that I'm telling you I'm actually really healthy and I'm not putting on weight, and stuff.

Interestingly, the intense focus on participants' weight and its potential reproductive health impacts was not usually accompanied by the offer of help or assistance to manage their weight, leaving participants feeling guilty and unsupported. As Maia observed,

Yeah so they've kinda, they're saying you can't birth at [birth centre] and that your weight's a problem but they're not offering you anything, they're not explaining to you why and they're not offering you anything to do about it.

Rather, the intense problematisation of their weight left participants deeply worried about the potential harm posed to their babies by their fatness, leading some to question whether they should ever have become pregnant in the first place and others to grapple with the idea that they had failed at being a mum before they had even begun. As Talia described:

I felt throughout my pregnancy that I got no support, between my midwife and my doctor they were just looking down at me like I'd made the biggest mistake and that I'm going to fail my child when it's born because I was overweight.

Swept away

In the second theme, participants described how their exposure to weight-focused advice and assessments catalysed a cascade of medical interventions, which left them feeling ‘swept away.’ Participants speculated whether the processes of medicalisation to which their pregnancies were subjected was based more on generalised medical anxiety about fatness than an accurate assessment of their individual risk and, as such, wondered whether medical management caused more harm than good. As Kahu suggested,

Is there really a drama or are they just assuming that because you’re fat, well, because you’re fat you’re going to have more problems, is that it? That’s stupid, they just end up making the problems.

Participants described lack of continuity of care resulting from midwives handing over to tertiary services for birth management; restricted choice or no choice at all about birth environment, with active discouragement of birthing in primary settings; increased exposure to scans and other screening tests; and routine referral for obstetric and anaesthetic consultations during their pregnancies. These consultations tended to lead to the development of highly medicalised birth management plans, including early placement of epidural anaesthesia and preparation for caesarean section at the start of labour, regardless of participants’ wishes for their labour. In other words, participants described very little or no support to birth without medical assistance. Lisa described how disempowering it felt to have it assumed that she could not birth without medical assistance:

So I had to go for extra scans because they said he was going to be a giant baby, they were picking that he was going to be 9 pounds, or over 9 pounds, and yeah just the whole kind of you know, ‘you’re not going to have a natural birth or anything like that,’ was really kind of upsetting.

Nadine described an interaction with her midwife during labour that left her feeling disempowered about her birthing capacity as a fat woman:

And when she ... when I finally got on the phone with her and I said well that I may as well just get an epidural and she goes of course you’re going to have an epidural, dear, this is what I have been telling you all the way through your pregnancy, ok, you’re a big woman, you might as well get it over and done with now because it will probably end up being that because of your size there was no way you would ever not have it.

However, ironically, when women did experience complications, the medical focus on their weight was perceived as eclipsing maternity carers’ ability to see their whole person, compromising medical decision making and treatment. Talia described her traumatic experience of miscarrying a pregnancy:

I get to the hospital and they said, oh, what’s happened? I said look! And I remember going in and out of consciousness and they had to do a D&C in the emergency room because they had forgotten the afterbirth and I had big clots, and that’s what was making me bloated. And everyone was saying it was just me overeating through the pregnancy. So no one wants to take you seriously, they just think oh, you’re eating too much, you’re overweight, that’s what it was, and it wasn’t. I knew my body and nobody was listening to me.

While participants questioned the need for, and benefit of, medical management of their fat pregnant bodies, they described finding it difficult to resist medical interventions, with submission to medical management perceived as something they needed to tolerate to ensure they had done everything they could for their babies.

Sticks and stones

In this final theme, participants described a series of fat phobic encounters during their maternity care – overt and/or subtle expressions of dislike or fear of their fatness (for a full description, see Parker & Pausé, in press). Participants’ described feeling singled out because of their

fatness and being offered a poorer standard of care than more slender pregnant women. They perceived maternity carers' annoyance if they required extra assistance because of their size yet generally perceived that they got less help and a lower standard of care. Ultrasound scans were a particularly common site of fat phobia, where uncomfortable body exposure combined with negative commentary by sonographers proved very distressing. Skye emotionally recalled her pregnancy ultrasound experience and its impact:

Everything she said was she was like ... oh you're going to have to move closer because you're such a big girl, oh you know it's taking longer because you've got all that fat on your stomach, your midwife is not going to be able to palpate you cause you know, cause you're such a big girl, she won't be able to find the position of your baby, oh you better make sure you have your anatomy scan at about 22 weeks cause you're a big girl they won't be able to ... like every sentence had that in it, and I went away just like, I think kind of in shock and I remember sitting here crying and feeling guilty for having gotten pregnant when I was so big, like I wasn't worthy of having a baby because of the way my body was.

Emma described coming out of general anaesthesia after a traumatic caesarean birth and being confronted by the obstetric registrar insisting she agree to the placement of a contraceptive device before she had even met her baby:

Well she just came and was like, she didn't ask me how I was, if I'd seen my baby, she didn't explain to me what had happened to me, why I was there, she just said to me, gave me these two pamphlets, and said 'which one of these permanent contraception will you be choosing because we will not be delivering another baby for you.' That was the first thing that I got told when I woke up.

Nadine described a pattern of abusive and intimidating behaviour from her midwife, targeted at her size, including name calling:

Interviewer: So she [midwife] called you names?

Nadine: Yeah, well it would only be piggy, piggy was the name, but all the way through ... during the weigh-ins.

Interviewer: What effect did that have on you?

Nadine: It was like yeah, no, really ... just really sad, really emotional ... very stressed. Always, always stressed, to make sure like I'm thinking my baby's not going to be ok.

The exposure to fat phobia was experienced as highly traumatic by participants, resulting in feelings of guilt, shame, and fear. However, like the medicalisation of their pregnancies, participants struggled to speak back to fat phobia for fear that it would compromise their care and impact on their babies. As Nadine reflected,

I know I was lying down and taking it because my friends and family had told me that. It was like, hey that's bullying, don't even go and take any of that. But I had to because I just wanted everything to be right for my baby.

In this way, maternal care and concern became a powerful vector allowing the negative sequelae wrought by the problematisation and medical management of fat pregnant women's bodies to go unchecked. Ultimately, all participants wanted was to be treated the same as everyone else. As Emma reflected, 'I was really aware throughout my whole pregnancy of being abnormal, and not being the same, and not having the same choices and opportunities and care as everybody else.'

Shamed into health?

As demonstrated at the beginning of this paper, much has been made of the health problem of 'maternal obesity' and the need to target obesity management interventions at pregnant women and new mothers. Such interventions are undertaken with the accepted logic that excess weight is harmful and that women will respond unproblematically to weight-related advice

and interventions by adopting the recommended behaviour changes, leading to improved population health outcomes. However, the research findings presented here challenge this logic. The fundamental flaw in the logic underpinning contemporary responses to maternal obesity is the failure to take into consideration the social stigmatisation of fatness and the physical and psychological toll it takes on women.

The social stigmatisation of their fatness was a part of the lived experience of my participants and was carried by them into their maternity care experiences. This meant that weight-focused advice and interventions could never be unproblematic and would always be filtered through often-traumatic embodied histories. In the context of pregnancy, obesity management packed an extra punch as it became encoded with responsible maternal identity, leading fat women to question their fitness as mothers long before they even held their babies in their arms. Further, participants' accounts of their maternity care experiences demonstrated that the social stigmatisation of fatness is already well entrenched in maternity care and that the growing focus on body weight escalates and legitimises fat stigma and discrimination. In other words, if women's fatness is accepted as a serious reproductive health problem requiring intervention, then dislike of and intolerance towards it can be viewed as officially sanctioned or, more problematically, as a social or moral good.

The danger here is that the social stigmatisation of fatness has itself been shown to lead to a range of poor health outcomes (Puhl & Heuer, 2010; Tomiyama, 2014; Wiley, 2012). This was true for my participants, who described the toll fat shaming and bullying encounters, intersecting with the barrage of weight-focused advice and interventions, had on their pregnancies. This included a triggering of self-loathing and/or anxious concern for their babies, leading to excessive or sub-optimal eating and exercise behaviours, social isolation, and anxiety and depression, all of which compromise a healthy pregnancy. As Alice reflected,

Oh I think it just makes you stressed, and it's a time when you should be relaxed, and happy, and taking care of yourself, you're going to not, you're going to want that bag of chips, and that chocolate, and then you feel like 'oh god, I'm destroying my baby,' those really extreme negative views come into your head because of what you've been told.

For other participants, fat phobic encounters in maternity care left them feeling deeply dispossessed with health care, resulting in a desire to avoid future health care encounters for themselves and their children. As Leilani described:

If you have a good experience with all health professionals during your pregnancy and throughout then you're more likely to seek advice when you do have a baby and if something's wrong, because if you don't feel that they care about you, you're not going to ... it's going to ripple on to your children, you're going to think that it's a waste of time ringing them [health services] cause they're not going to care about you.

The great irony then is that weight-focused advice and interventions intending to improve maternal and child health may in fact have the exact opposite effect or at least be entirely ineffective. As Tomiyama and Mann (2013, p. 4) assert, 'If shaming reduced obesity, there would be no fat people.'

Conclusion

The question then becomes what do we do in the face of an overwhelming body of evidence that calls for action on maternal weight in order to secure maternal and child health? The short answer may be, when it comes to the complexity of women's weight, we leave well enough alone and do nothing at all. As demonstrated, weight management approaches, intersecting with and perpetuating fat phobia, were not found to promote maternal and child health. Rather, in their precipitation of feelings of anxiety, guilt, shame, and fear, pregnancy health and

wellbeing was compromised. In the wise words of Alice, ‘I mean, you can’t fat shame someone and expect them to want to take care of themselves, it’s just not the right approach.’ Rather, efforts to improve health outcomes for fat women and their babies may be better spent bringing to light the nature and dynamics of the stigmatisation of fatness in maternity care and its intersections with other processes of marginalization, including institutional and interpersonal racism, classism, ableism, and heteronormativity, and developing strategies to address them. Insisting on compassion and social justice, rather than blame and shame, as cornerstones of care will help to re-humanise maternity care, ensuring confident and supported new mothers, surely the foundation stone of any healthy society.

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Notes

- 1 I use single inverted commas around terms such as ‘obesity’, ‘maternal obesity’, and ‘obesity epidemic’ on first usage to mark these terms as constructed and contested and to note that I use them without intention to reproduce their dominant discursive meanings.
- 2 The use of language used to describe the body weight of participants has evolved with the research. Whilst fat identity has been reclaimed in the context of fat studies and fat activism, I was concerned this may not apply to the general population. Likewise, I felt the term ‘obese’ reproduced the dominant biomedical meanings attached to it. Therefore, I chose the term ‘large woman/en’ as I felt it to be more neutral and accessible to the general population (Carrier, 2001). Participants’ views on the use of language to describe their bodies were discussed during the interviews and, consequently, I have moved more confidently to the use of fat/fatness to describe participants’ bodies.

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