Body of Evidence: A Post-intentional Phenomenological Study of Women's Maternal Body Experiences

Susan Knox

A thesis submitted to Auckland University of Technology in fulfilment of the requirements for the degree of Doctor of Philosophy (PhD)

2021

School of Clinical Sciences

ABSTRACT

This thesis illuminates women's maternal body experiences to show the meanings that come into being for women labelled as clinically 'overweight' and 'obese'. Phenomenological interviews with 16 women were used to gather data. Using a post-intentional phenomenological design, phenomenology was put into dialogue with theories of pregnant embodiment, distressed embodiment, and salutogenic understandings of health. Crafted stories provided the practical framework to show how contexts produced and provoked women's experiences.

Women described care as being preoccupied with control and surveillance of maternal bodies. In biomedical contexts, narrow versions of normality existed. Weight-focused advice was received by women in a climate of risk. Women's stories tell of a patterning of care that led to disconnection from others, creating intense emotional, bodily, and cultural disruption. In restrictive care contexts, women's bodies and experiences were marginalised. Understandings of wellbeing as holistic and interconnected were neglected, provoking a variety of responses which helped women to re-harmonise a disordered world. Women sought humanised and empathy-based care which reflected their cultural values, social contexts, and clinical needs. For women, health was not only based on weight; rather, it was framed by holistic understandings of wellbeing.

The findings prompt a shift from weight-focused behaviour change approaches and call for more aspirational approaches to wellbeing which are defined by women themselves. They challenge the current paradigm of contemporary maternal health promotion and reveal how the biomedical model lacked relevance—exposing the tensions that women experience when their values are in conflict with maternity's idealising of specific body weights. Insights generated through this study uncover how current trends in public health policy and health promotion practice privilege science and professional knowledges while marginalising women's embodied knowledge.

Practice shifts are urgently needed to realign care to focus on indigenous perspectives and embodied knowledge to shift the conditions that problematise women in larger maternal bodies. A realistic approach to wellbeing begins by valuing and accepting diversity. The voices in these pages show that transformative innovation is needed to reinvigorate health promotion as a relational practice. The findings represent a body of evidence that prompts new directions for reimagining more equitable, responsive health promotion.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed ……..

28 February 2021

Dated ……

ACKNOWLEDGEMENTS

It's the women's voices in my thesis that will remain with me. Women who shared their stories so generously, even when that wasn't easy, because they trusted me to do good and use their voices to make a change so that maternity care is fairer for all people and all bodies. Personally, my research took me in unexpected directions. I've come to understand the power of dwelling in the minutiae of life through qualitative research and how powerful the details can be. I've loved writing this thesis and trust it can become a powerful resource for reimagining health promotion.

I am grateful to my supervisors—Judith and Andrea—who have nurtured and influenced this research. Thank you for helping me learn to trust my own voice and challenging me to think phenomenologically. Your reminders to paddle longer in the shallows, as a way of uncovering the 'in-between', helped me work through a necessarily complex method.

I appreciate the other academic relationships that have shaped this study. In the Centre for Midwifery and Women's Health Research, I found my methodological clan. I am grateful to Susan Crowther for introducing me to Vagle's post-intentional phenomenology and to Leon Benade for sharing his insights of applying the method.

I thank Jennie Billot and Julie Trafford, for their coaching at the AUT writers retreats. Thanks also to the brilliant team in the Graduate Research School. I appreciate the financial assistance provided through the AUT Doctoral Fees Scholarship and the fees stipend. I was grateful for the financial support from the Maurice and Phyllis Paykel Trust Scholarship in Health Science and the Heart Foundation New Zealand.

In particular, thanks to the clinical and cultural advisors to this research, and for my close public health friends and colleagues who supported me throughout this process.

Special thanks to Shoba Nayar for editing the work and to Marty Wilkinson for drawing the visuals.

Above all, I appreciate being loved by Martin, Tom, Eva, and Pickles when I happily skipped off to write.

Ethics approval for the research (16/126) was granted by Auckland University of Technology Ethics Committee (AUTEC) on 1 June 2016.

DEDICATION

In dedication to Fiona; an inspiring researcher and friend.

CHAPTER ONE: ORIENTATION TO THE STUDY

> As we've seen in the debates over abortion or plastic surgery or pregnancy nutrition, everyone has an opinion about what women should and should not do with their bodies – even if they don't inhabit a female body themselves. (Schrobsdorff, Sifferlin, & Bajekal, 2018, p. 18)

These words, in *Time* magazine, on July 23, 2018, point to how women are becoming overwhelmed by the debates surrounding protection of pregnancy health. The statement boldly captures the dynamic tensions women experience in managing their bodies as their own. Furthermore, the authors illuminated how pregnancy nutrition is deeply embedded in public consciousness; showing the upward momentum which positions nutrition alongside other critical public health and ethical issues affecting women today.

In recent years, nutrition-programme policy, targeting pregnant women, has been developed (Ministry of Health, 2015); however, increasing policy focus on promoting healthy weight gain in pregnancy is challenging for midwives and women alike. Midwives concerned with promoting person-centred practice encounter ethical and moral tensions when implementing policy recommendations which are in conflict with women's understandings of gestational weight gain (Knox, Crowther, McAra-Couper, & Gilkison, 2018). The contexts in which women live are diverse and complex. Policy approaches, and weight management guidance which fail to consider these complexities are challenging for midwives as they attempt to practice in ways aligned with midwifery philosophy.

Study Aim and Research Questions

In this study, of women's maternal body experiences[1], the primary research question was: What are the experiences of ethnically diverse maternal women labelled as clinically 'overweight' and 'obese'[2]? The secondary research questions focused on how the various contextual aspects of the study produced and provoked the phenomenon:

- How do contemporary public health policy and practice contexts produce and provoke women's understandings of health and wellbeing in pregnancy?

[1] While this work focuses on the experiences of women, not all pregnant people are women. Transgender and gender nonbinary people have reproductive body experiences and perspectives on maternity care which may be both similar and unique from cisgender women.

[2] I use single quotation marks around terms such as 'overweight' and 'obesity' to cast doubt on the reality of this phenomenon and highlight the contested nature of the use of these terms.

- How do socio-cultural narratives concerning body size and pregnancy provoke women's beliefs, understandings, and health behaviours?
- How do medicalised weight-focused narratives in maternity care contexts unfold, and what is the meaning of these narratives for women?
- How do women's experiences change as they find-themselves-being and becoming in relation to others and things?

Justification for this Study

There has been an inexorable increase in obesity in almost all countries (NCD Risk Factor Collaboration, 2016), with obesity and its determinants identified as risk factors for non-communicable diseases (Swinburn et al., 2019). Like other countries, obesity prevalence rates are rising in Aotearoa New Zealand with one in three adults (32%) classified as 'obese'. Māori and Pacific adults; and those with the highest levels of deprivation are disproportionately affected (Ministry of Health, 2018). Economic inequality represents a growing concern with rising obesity prevalence amongst people experiencing income inequalities. Whilst there is clear evidence of a worldwide problem, beyond establishing this fact, little progress has been made (Kleinert & Horton, 2015). Of concern, urgent recommendations and policy has not led to positive change which Swinburn et al. (2019) attributed to policy inertia and "strong opposition to those policies by powerful commercial interests, and a lack of demand for policy action by the public" (p. 1).

A key area of concern in public health policy has been the impacts of obesity on maternal health (Torloni, Betran, & Merialdi, 2012). Obesity in pregnancy substantially increases the risk of adverse maternal and infant outcomes (Marchi, Berg, Dencker, Olander, & Begley, 2015), and of specialist care admissions (Denison et al., 2014). Such evidence has contributed to obesity-targeted policy recommendations in Aotearoa New Zealand (Ministry of Health, 2015), and guidance for healthy gestational weight gain (Ministry of Health, 2014) leading to pregnancy being viewed as a critical period for primary prevention of obesity (Huda, Brodie, & Sattar, 2010). Furthermore, it has been suggested that the potential for health gain through improved diet is enormous, providing a basis for targeted action to reverse the cycle of poor health (James, Nelson, Ralph, & Leather, 1997). However, critics, such as Cain (2013), argued that the personal choice narrative, which provides the broader framing for the obesity epidemic debate, makes (in)visible the structural and political forces which maintain poor health. Concurring, Kleinert and Horton (2019) added it is unacceptable that obesity is still regarded by some as individual responsibility resulting from bad decision-making. In their view, "obesity is often a chronic, progressive disorder leading to poor health, unwarranted stigma,

and increased mortality" (Kleinert & Horton, 2019, p. 1). Yet, the prevailing policy climate fails to acknowledge the complex social, cultural, political, and economic factors that exist in the wider environment, which may limit the success of pregnant women in making and sustaining healthy change. Policy discourses represent narrow, medicalised perspectives on the management of gestational weight gain. Weight-focused medicalised narratives are prominent in health policy and related guidance, which have contributed to risk-based messaging and health promotion approaches in contemporary maternity care.

Focusing on weight, rather than approaching the midwife-woman partnership from a holistic perspective, can pathologise the whole pregnancy for the woman (Knox et al., 2018) and calls on pregnant women to have increased vigilance on their maternal bodies. Concurring, Parker (2017) noticed that, "health systems have responded by introducing a suite of guidelines and interventions intended to regulate and manage fat maternal bodies" (p. 22). What is more important is that pregnant embodiment and the related notions of the social and cultural pregnant-body-as-lived have not been acknowledged in prevention approaches (Warin, Turner, Moore, & Davies, 2008) and, consequently, "fails to integrate to integrate people's lived experience as gendered, situated bodies in an inequitable world" (Aphramor, 2005, p. 315).

Ultimately, obesity is a complex phenomenon, intimately tied to the way we lead our lives in the modern world (Hannah, 2014). Thus, women's maternal body experiences cannot be disentangled from the complex contemporary contexts in which women live. Few studies have explored the experiences of women in Aotearoa New Zealand which are required to provide much needed insights into larger maternal women's lived experiences, and the meaning of weight-focused policy and maternal health promotion for ethnically diverse women.

Research Approach

Guba and Lincoln (1994) argued that questions of philosophical position are the fundamental starting point guiding qualitative inquiry. Emphasising this point, Avis (2005) agreed that evidence gathered during a research project cannot be separated from the standpoint of the researcher. The inter-connectedness of my own theoretical position with the research questions and methodology facilitated a transparent and rigorous approach to gathering, analysing, and interpreting phenomenological material from the women.

Women typically gain weight during pregnancy. As such, weight gain could be considered a universal physiological phenomenon that women must manage, no matter their cultural or socio-economic position. At the same time, differences in contemporary social, cultural, and medical responses to weight gain affect women's experiences of weight gain, as well as their

ability to comfortably engage in relationships. This research brought into nearness the experiences of clinical 'overweight' and 'obesity' for women of diverse ethnicities and social circumstances and required a philosophical stance which illuminated women's experiences of being pregnant in a large body–a body which is considered a deviation from the ideal. It is no longer the case, as Counihan (1999) once suggested, that pregnancy, "allows women to 'be ample' and free of the negative societal gaze that comes with being overweight" (p. 201). Therefore, a methodology which enabled an uncovering of women's experiences of weight-focused health promotion amidst medical narratives and contemporary maternal health promotion was important.

I drew from a post-intentional phenomenological approach to answer the research questions. Mark Vagle, an American phenomenological curriculum and educational theorist, whose work underpinned this research, opened-up post-phenomenological ways for me to explore how women find-themselves-being in relation to others and things in the world. Vagle (2018) believed that the phenomenon is seen both as something experienced by an individual and as a social apparatus. In other words, "the post-intentional phenomenon is produced and produces, is provoked and provokes–through social relations in the world" (Vagle, 2018, p. 140). My goal in this research was to demonstrate that, "a phenomenon is, at best, insight into a particular shape the phenomenon has taken within a specific context at a given moment in time for a given group of people" (Vagle, 2018, p. 97). The unit of analysis, therefore, was not the women themselves or maternity care professionals who pathologise women in bodies above 'normal' weight. Neither was it the public anxieties about these women. Rather, the unit of analysis was how the women were in different states of being and becoming through their interconnected relations with others. In the same way, from a post-intentional phenomenological perspective, the theoretical concern was not whether women felt inhibited in a large body. The concern was how the perception of inhibited was produced in that moment and how this production connected with other productions, assumptions, and meanings associated with large maternal bodies. Consequently, and in accordance with Vagle's theorising, this research conceived post-intentional phenomena as circulating through social relations and social spaces and produced through the dynamic entanglements among direct lived experience, contexts, discourses, policies, practices, social histories, language, habits, popular media, politics, objects, etc. (Vagle, 2018). In utilising a post-intentional approach, I probed for alternatives, other ways of understanding what it is like to be pregnant in a large body; understandings that went beyond the dominant medical narratives of authority which medicalise the female body, positioning clinically 'overweight' and 'obese' maternal bodies as the site of disease and failure (S. Murray, 2008). Thus, Vagle's theorising offered a philosophical

and methodological foundation to explore the multiple influences operating on women in large maternal bodies as they navigate relationships in ever changing contexts and situations.

Post-intentional phenomenological approaches are noticeably absent in midwifery research. There is value in exploring how a 'posted' phenomenology can enable midwifery to better understand contemporary patterns of 'dis-ease' arising from being in a large maternal body as part of an approach to enhancing health and wellbeing. The tenets of post-intentional phenomenology align with those of midwifery practice, which is focused on partnership and person-centred approaches. Therefore, my research questions were a response to the concerns and insights of women, midwives, and subversive scholars. These concerns led to the focusing question: What are the interconnected meanings that come-into-being for ethnically diverse women living in different cultural and socio-economic communities?

My Positioning as Researcher

I am drawn to social justice-inspired public health, which is why I oriented to post-intentional phenomenology as a research approach. Contemporary public health is characterised by caring values and an unrelenting pursuit to shift the conditions that hold injustice and inequality firmly in place. Thus, a post-intentional approach, with its commitments to social change, drew me in. My phenomenological interest in doing this research materialised from practice concerns as a public health programme manager and previous midwife. In a recent role as a programme lead for a government-funded maternal nutrition intervention, evaluation methodology focused on measuring if the programme led to pregnant women making the changes intended by the programme. The intervention was unsuccessful, and the evaluation failed to uncover the wider contextual forces at play which influenced women's responses to maternal health promotion efforts. The current focus in Aotearoa New Zealand intervention programmes is on impact evaluation. Such evaluation rarely, though, uncovers the nuances or complexity of our everyday lives.

I became more conscious of the need for public health programmes, such as the maternal nutrition intervention, to be underpinned by social justice perspectives. Seeing that a different way of responding to public health challenges in an individualistic market driven society was needed, I realised that a more curious response to measuring the worth of interventions was required. It became apparent there was more to why women did not make the intended changes. I became intrigued with the things or entities that mattered more to women and how they found themselves inseparably connected with other people (subjects) and animate, inanimate, ideas, and discourses (objects in the world) (Vagle, 2018).

A further positioning occurred through my disciplinary socialisation to particular research approaches (Ray, 1999). Through my affiliation to public health, I am familiar with qualitative approaches to inquiry. The semi-structured interview is a common approach to elicit rich data on human experience (Bearman, 2019); and I have become familiar with this method through collecting data from small-scale health service research and evaluations. I utilised this approach in my earlier post-graduate research to gather sensitive data from young, male consumers of mental health services.

Uncovering My Preunderstandings

I chose this research topic because the phenomena came into prominence in the professional context of my life. My public health career has spanned more than two decades. Throughout this time, obesity has become increasingly politicised. Obesity is an example of a policy issue that is occurring in a values-ridden domain. It is apparent that obesity has the complexity, "typical of 'post-normal' science – where the science is complex, the facts uncertain, the issue is urgent and of high public interest, there is a high values component and those values are in dispute" (Gluckman, 2015, p. 3). Through the obesity epidemic, body size has become a focus for public health interventions. Obesity has been described as a wicked problem in Aotearoa New Zealand (Signal et al., 2013) and the pervasive discussion of obesity in the media and academic literature has often taken on a moral tinge. For example, in their conceptual paper on fat shaming in public health, one emotive issue has been how racism manifests for Māori through colonising contexts (Warbrick, Came, & Dickson, 2018). My own view is that lifestyle politics, western-dominated perceptions of weight, and resultant ineffective policy and health promotion approaches may actually be increasing obesity-related inequities. Gluckman's (2015) observations challenge public health to see the complexities of the issue.

The complexities seem even greater for maternity care. Undertaking a collaborate writing project, during this thesis, Knox et al. (2018) explored the unanticipated negative consequences of BMI-focused health policy for midwife-woman partnerships. We endorsed the view that maternal 'obesity' has serious medical implications; however, we warned against an uncritical uptake of the 'healthy gestational weight' discourse underpinning much of maternal health promotion. Midwifery is challenged to reflect on the value of positioning itself more explicitly in a public health context to better enable critique of health policy and health promotion practice.

I drew on my preunderstandings as an interpretative tool through which I viewed the phenomena (Thompson, 2018). Gustin (2018) emphasised the importance of being mindful as a phenomenological attitude. She described the need to observe, with a neutral mind, what is

happening and stay present in the moment. Post-reflexivity is essential to post-intentional phenomenology (Vagle, 2014, 2018) and refers to an untiring vigilance of one's knowledge as opposed to suspending knowledge. In designing the research, I made my assumptions and preunderstandings of the phenomenon explicit at the beginning of the study. Post-reflexing happened throughout the different stages of this inquiry, even before the gathering of phenomenological material (Vagle, 2014, 2018). My process was ongoing and subsequent chapters reveal how my positionality is in flux and contextual. Rather than putting my preunderstandings aside, I have made them visible. One of the ways which I uncovered my preunderstandings before data gathering was through being interviewed by my supervisor. Additionally, during the period of data gathering, I created a post-reflexion journal; extracts from this journal are shown in subsequent chapters to reveal how my preunderstandings and assumptions influenced my early interpretations. Finally, post-reflexing occurred during the crafting of the post-intentional text. This pushed me to question my understandings, the tradition I was operating within, and the history from which I was launching (Vagle, 2018). It was through this process that I gained increased openness by being more aware of my preunderstandings.

Thesis Structure

This thesis comprises of 10 chapters:

Chapter One has outlined the aim, research questions, and justification for this inquiry. The research approach and rationale for choosing Vagle's post-intentional phenomenology are briefly described. In doing so, it shows why this topic is important to me. My presuppositions have been identified.

Chapter Two presents the findings of a narrative review of the literature on women's experiences of maternal 'overweight' and 'obesity'; literature related to women's experiences of maternity care; as well as women's understandings of the broader social and cultural factors which affect engagement with weight-focused messaging during pregnancy.

Chapter Three presents the research methodology. The theoretical perspective that informed my methodological decisions for answering the research question is outlined. Chapter Four outlines the methods utilised to enhance trustworthiness of the research findings and provides an overview of the participants.

Chapter Five introduces the findings, or tentative manifestations, from the data. Chapters Six, Seven, and Eight reveal the tentative manifestations of the phenomenon of being labelled as

clinically ‘overweight’ and ‘obese’ in pregnancy. Chapter Nine provides a synthesis of the tentative manifestations.

Chapter Ten is a critical analysis and discussion of the wider contextual factors, namely health policy and maternity practice contexts, which influenced women’s experiences. The chapter concludes by arguing the significance of the study for future policy reviews, practice, education, research, and service provision.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents findings from the review of literature and places the study in the context of what has been researched and written in relation to the research topic. Specifically, the review draws on literature from women's experiences of maternal 'overweight' and 'obesity'; literature related to women's experiences of maternity care; as well as women's understandings of the broader social and cultural factors which affect women's engagement with maternity care providers. This narrative literature review is organised thematically. Themes important to understanding the phenomenon are summarised and synthesised to evaluate the previous research and identify unexplored areas in the current literature.

Context for the Review

Aotearoa New Zealand has among the highest prevalence rates of 'overweight' and 'obesity' in comparison to other developed countries (Organisation for Economic Co-operation Development, 2017). In their analysis of age, period, and cohort effects on BMI, Wilson and Abbott (2018) found that BMI has risen sharply in Aotearoa New Zealand adults in recent years. Based on current data, it is expected that the population mean BMI will exceed 30 kg/m^2 – the clinical cut-off for obesity – in the next decade. The authors also found that, within the Aotearoa New Zealand context, social, and environmental factors were clearly associated with population level increases in BMI. Data indicate the strong possibility of increasing obesity-related ethnic and socioeconomic inequalities (Wilson & Abbott, 2018).

The serious impacts associated with maternal 'overweight' and 'obesity' for women and their infants are well documented. Excessive gestational weight gain has been purported to be the most deleterious consequence of pregnancy (Gilmore, Klempel-Donchenko, & Redman, 2015). Maternal 'obesity' leads to an increased risk of both gestational diabetes and hypertensive conditions for women; and, for the infant, perinatal death, congenital anomalies, birth trauma, and high birth weight (Adamo et al., 2013; Catalano & Ehrenberg, 2006; Dodd, Grivell, Nguyen, Chan, & Robinson, 2011; Furber et al., 2013; Galtier-Dereure, Bogner, & Bringer, 2000; Galtier, Raingeard, Renard, Boulot, & Bringer, 2008; Lashen, Fear, & Sturdee, 2004; Leslie, Gibson, & Hankey, 2013; Ramachenderan, Bradford, & McLean, 2008; Ryan, 2007; Stotland, 2009). Future generations are considered at high risk of experiencing health harms caused by gene-related obesity risks (Mourtakos et al., 2015; Pirkola et al., 2010). Furthermore, low-income women were found to be more at risk than middle- and high-income women for excessive gestational weight gain (Yeo & Logan, 2014).

The available literature is dominated by the consequences of maternal 'overweight' and 'obesity' in pregnancy and the evidence has led to increasing pressure to improve health and health care through more appropriate interventions (Sutherland, Brown, & Yelland, 2013). Despite the call for improved public health interventions, a systematic review of pregnancy lifestyle interventions in 'overweight' and 'obese' pregnant and postnatal women concluded the certainty of evidence was too low to determine whether weight management interventions starting in pregnancy are effective (Dalrymple, Flynn, Relph, O'Keeffe, and Poston (2018). Furthermore, there is little consensus around effective strategies to engage with women about weight management (Dodd et al., 2011; Thangaratinam & Jolly, 2010).

Scope of Review

There is a growing literature on the experiences of health professionals in providing care to 'overweight' and 'obese' pregnant women (Foster & Hirst, 2014; N. Heslehurst, Lang, Rankin, Wilkinson, & Summerbell, 2007; Kerrigan, Kingdon, & Cheyne, 2015; Mulherin, Miller, Barlow, Diedrichs, & Thompson, 2013; Schmied, Duff, Dahlen, Mills, & Kolt, 2011; Wennberg, Lundqvist, Hogberg, Sandstrom, & Hamberg, 2013). Conversely, there is a paucity of literature describing women's experiences of being in larger maternal bodies; although a small body of research is becoming concerned with uncovering the experiences of women, considered central to increasing the effectiveness of public health measures targeted at pregnant women (Khazaezadeh, Pheasant, Bewley, Mohiddin, & Oteng-Ntim, 2011). Furthermore, obesity prevention interventions differ in their effectiveness across socio-economic groups (Backholer et al., 2014) and few studies have explored the social and cultural factors that shape women's behaviours during pregnancy. Studies which include the experiences of Aotearoa New Zealand's most economically disadvantaged women are required to provide much needed insights into women's lived experiences of maternal 'overweight' and 'obesity', and the impact of education and behavioural interventions and contemporary discourses on behaviour change in such groups. Therefore, this review focuses on qualitative studies concerned with examining the phenomena of being pregnant in a large body as their primary or secondary aim. It aims to provide the context for this research and so focuses on studies concerned with exploring pregnant women's lived experiences of maternal 'overweight' and 'obesity' and identifies knowledge gaps relating to women's experiences of weight-normative maternity care.

Approach to Reviewing the Literature

In accordance with Vagle's post-intentional phenomenology, a partial review of the literature was conducted prior to the study to situate the research problem in existing scholarly conversations. Although partially reviewing the literature could be considered contrary to

conventional norms in qualitative studies, Vagle (2014) argued the importance of not being overly influenced by descriptions of phenomena in similar studies, so as to remain as open as possible to the phenomenon. For Vagle then, "the primary goal in post-intentional phenomenological approaches is to capture tentative manifestations of the phenomenon as it is lived – not to use existing theories to explain or predict what might take place" (p.124). Thus, during the analysis and interpretation phase of the research, I sought to avoid published literature to minimise external influences on my data during the beginning stages. Rather, literature was fully brought to bear and expanded upon in the final stage of research. Therefore, the approach to reviewing literature in this study represents a staged approach. I had considered using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) but, due to the methodological requirements to conduct the review in a number of stages, I found that the use of the PRISMA framework was not relevant. Reviews of the most recent relevant publications and fields that were not integrated in the preliminary review were included at the final stages of crafted stories. Findings of the partial and revisited review were accumulated.

Search Strategies

Inclusion and exclusion criteria for considering studies in this review were developed and literature selected accordingly. The criteria included: literature which focused centrally on 'obesity' in relation to maternity care (including women's lived experiences of maternity care and delivery of health care, encounters with health professionals, and understanding of risks of excess weight gain); publications in English language journals; and mixed methods designs with a variety of philosophical lenses. Studies were excluded where they did not centre on the maternity care experiences, including studies with a specific focus on the beliefs of 'obese' pregnant women related to being physically active and their perceptions of barriers and enablers of behaviour change. Studies were also excluded where they had a specific focus on weight stigmatisation or weight bias, as there is a separate body of literature on weight stigma in pregnancy care. While weight stigma may be a finding of my research, I am not aiming to explore women's lived experiences of weight stigma.

An electronic literature search of articles published in the English language between 2010 and 2020 was conducted using the following databases: CINAHL Plus with Full Text (via EBSCO), MIDIRS Maternity and Infant Care, Intermid.co.uk, Joanna Briggs Institute EBP (Ovid) and Web of Science. The following search terms were used: *maternity experience*, obes** and *pregnan*.* Terms were exploded, and medical subject headings resulted in a retrieval of 148 references. Following the removal of duplicates, titles and abstracts relevant to the research question were

reviewed for subject relevance. Articles (n=86) were discarded because they were not directly related to my research question. Articles (n=22) were included in the review where the primary focus was on women's experiences of being 'overweight', 'obese' and pregnant, or perspectives on maternity care.

Findings

Nineteen studies, two meta-syntheses of qualitative research on the maternity experience for women with a BMI ≥30 m/kg^2, and a scoping review of qualitative evidence were selected. No additional studies for inclusion were identified from the bibliographies of key references. Each paper was read to identify the main concepts of the study. The quality of the research was assessed in accordance with the framework produced by L. Spencer, Ritchie, Lewis, and Dillon (2003). Ten of the 19 primary research papers originated from the United Kingdom. Three were Scandinavian, three studies were conducted in Australia, and one study was set in Aotearoa New Zealand. Participants in the Aotearoa New Zealand study represented two of the largest ethnic groups: Māori and Pacific peoples. The remaining two studies were conducted in Canada and the United States. As shown in Table 1, although studies utilised different research designs and were conducted in different settings, consistent themes were identified across the studies.

Table 1. Characteristics of included studies

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
1.Saw, Aung, & Sweet (2020), Australia	To examine the evidence of maternity care experiences of 'obese' women	Scoping review using a thematic synthesis process to collate findings	English language studies using qualitative data	n/a	Four themes were identified: (1) inconsistent or absent information regarding weight management, (2) weight-based stigma, (3) medicalisation and depersonalisation of pregnant women with obesity, and (4) a desire for information need for change.
2. Cunningham, Endacott, & Gibbons (2018), UK	To uncover the experiences of maternal women with raised BMI to investigate if their pregnancies were affected by their interactions with maternity care professionals	Exploratory qualitative approach using individual and group interviews	Maternity setting	11 women with a BMI ≥30 kg/m^2	Three themes were identified: (1) 'feeling judged', (2) 'knowledge gap', and (3) 'doing your best'.
3. Lauridsen, Sandøe, & Holm (2018), Denmark	To investigate women's experiences of being targeted as severely 'overweight' during pregnancy when they	Interpretive analysis, based on semi-structured interviews	Scientific studies	21 women with a BMI ≥30 kg/m^2	The women were identified as "severely overweight pregnant women". Though women held differing perspectives on this classification, they described that weight-based approaches were justified. Most women

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
	look back at the intervention 4-5 years later				reported that the interventions during pregnancy did not lead to any lasting lifestyle change.
4. Atkinson & McNamara (2017), Ireland	To provide a bio-psycho-social understanding of the experience of women with a BMI ≥30 kg/m^2	Interpretive phenomenological analysis using semi-structured interviews at 6-10 weeks postnatally	Maternity setting	15 women with a BMI ≥30 kg/m^2	Participants were conscious of the problematics of communicating obesity in pregnancy. Data revealed an unconscious collusion between women and maternity care providers during weight-focused conversations.
5. Holton, East, & Fisher (2017), Australia	To describe the dual perspectives of weight-based care management from women's and midwives' viewpoints	Qualitative study using thematic analysis approach using semi-structured interviews	Maternity setting	17 women with high BMI and 2 midwives	Five themes were identified: (1) reluctance to and difficulties discussing weight and its implications, (2) maternity providers' barriers to caring for women with high BMI, (3) inconsistent weight management practices, (4) beliefs about the drivers of obesity, and (5) opportunities to support women with behaviour change.

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
6. Jarvie (2017), UK	To explore the lived experiences of women with co-existing obesity and diabetes mellitus in pregnancy and the post-partum period	Qualitative, sociological design which used a series of sequential in-depth narrative interviews	Maternity setting	27 women with co-existing BMI ≥30 kg/m^2	Women experienced a number of social and economic stressors that compromised their ability to manage complicated pregnancies. Women experienced weight-based stigma.
7. Jones & Jomeen (2017), UK	To explore the experiences of women with a BMI ≥30 and their maternity care	Systematic review methods using meta ethnographic synthesis	12 qualitative studies about women's experiences of maternity care when their BMI is over 30	n/a	Findings described four key concepts which reflect the experiences of maternity care for women with a BMI ≥30: (1) initial encounters, (2) negotiating risk, (3) missing out, and (4) the positive intervention.
8. Keely, Cunningham-Burley, Elliott, Sandall, & Whittaker (2017), Scotland	To explore the experiences, attitudes, and health behaviours of pregnant women with a BMI >40 kg/m^2	Prospective serial interview study using semi-structured interviews	Maternity setting	11 women with BMI >40 kg/m^2 and 7 partners	Six themes were identified: (1) the complexities of weight histories, (2) relationships with food, (3) resisting risk together, (4) pregnancy as a 'pause', (5) receiving dietary advice, and (6) postnatal intentions.

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
9. Parker (2017), New Zealand	To explore what it is like for fat pregnant women to experience practices in maternity care that problematise their bodies	Foucauldian inspired interpretive study using individual interviews	Maternity and community setting	27 self-identified fat women	Three themes developed from the data: (1) weight matters, (2) swept away, and (3) sticks and stones; within which participants described meanings related to their bodies produced through medicalised narratives and practices.
10. DeJoy, Bittner, & Mandel (2016), US	To explore the experiences of women with maternal obesity in the US maternity care system	Descriptive phenomenology using in-depth telephone interviews	Online community setting	16 women with a BMI ≥30	Women described mixed experiences of maternity care; some considered care as appropriate and satisfactory care, others reported at least one negative encounter. Three themes emerged: (1) personalised care, (2) depersonalised care, and (3) setting the tone.
11. Knight-Agarwal et al. (2016), Australia	To investigate the experiences of pregnant women with a BMI ≥30 kg/m^2 receiving antenatal care	Interpretive phenomenological analysis using individual interviews	Hospital setting	16 women with a BMI ≥30 kg/m^2	Four themes were identified: (1) a long history of obesity, (2) lack of knowledge relating to the consequences of obesity, (3) conflicting messaging about weight and gestational weight gain, and (4) motivation to eat well during pregnancy and the seeking of support.
12. Spencer & McIntosh (2016), UK	To determine women's lived experiences of weight management in	Interpretive phenomenological analysis	Existing weight management intervention	4 women with a BMI of 37-40 kg/m^2	Four themes were derived from the data including, (1) changes women made, (2) motivation, (3) issues of control, and (4) perceptions of self.

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
	pregnancy	using one-to-one interviews			
13. Lavender & Smith (2016), UK	To uncover insights into the experience of pregnant women with BMI ≥30 kg/m^2 when accessing maternity care and participating in a lifestyle intervention	A general interpretive approach using focus groups and semi-structured interviews	Scientific study	34 women with a BMI ≥30 kg/m^2	Three themes were identified: (1) disappointment that informational expectations were not met, (2) readiness to make a lifestyle change yet this was not encouraged during routine antenatal care, and (3) changing behaviour.
14. Murray (2014), Canada	To investigate the meaning and experiences of women with high gestational weight gain	Phenomenology using face-to-face interviews	Maternity setting	7 women with high gestational weight gain	Four themes were revealed: (1) being caught off guard, (2) losing your bearings, (3) hanging on for dear life, and (4) hoping for health.
15. Heslehurst et al. (2015), UK	To explore 'obese' pregnant women's experiences to inform service development	Interpretive approach using low structured depth interviews	Maternity setting	15 women with a BMI ≥30 kg/m^2	Key findings included: (1) women's weight, (2) families, (3) experience of negativity, and (4) priorities and desired outcomes.

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
16. Lindhardt, Rubak, Mogensen, Lamont, & Joergensen (2013), Denmark	To examine the experience of women with a pre-pregnant BMI ≥30 kg/m^2 during their interactions with maternity care providers	Qualitative study using a phenomenological methodology approach	Maternity setting	16 women with a BMI ≥30 kg/m^2	Two themes were identified: (1) negative responses from maternity care providers, and (2) perception that helpful information related to how being 'obese' during pregnancy might affect maternal health and fetal health.
17. Mills, Schmied, & Dahlen (2013), Australia	To explore the perceptions and experiences of 'overweight' maternal women	Qualitative descriptive study using face-to-face methods	Maternity setting	14 women with a BMI ≥30 kg/m^2	Four themes were identified: (1) being 'overweight' and pregnant (women expressed discomfort with their weight and discussed frustration with public perceptions and stereotypes), (2) being on a continuum of change (women were at various stages of change with some women actively managing their weight), (3) get alongside us (a variety of responses from health professionals) and, (4) wanting the same treatment as everyone else (women's perceptions that reliance on clinical guidelines led to a loss of personalised care).
18. Furness et al. (2011), England	To explore the experiences and perceptions of pregnant women, midwives and obstetricians to inform	Exploratory, qualitative study using semi-structured	Unclear	6 women with a BMI ≥30 kg/m^2 and 7 midwives	Women and midwives held different perspectives. Women identified eating and activity were related to weight and improved health but felt confused due to conflicting messaging and reported a lack of nutritional advice. Midwives perceived that women did not realise

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
	weight management in pregnancy services	focus groups			the implications of high BMI, neither did they have nutritional understanding or skills to cook healthy food.
19. Keely, Gunning & Denison (2011), Scotland	To explore 'obese' women's perceptions of obesity as a pregnancy risk factor and their experiences of maternity care	Semi-structured interviews	Maternity setting	8 women with a BMI ≥40 kg/m^2	Women perceived themselves as generally healthy and did not consider their weight had a negative effect on their health in pregnancy. All women were aware that there were risks associated with high BMI in pregnancy; however, they were not aware of risks until during pregnancy.
20. Smith & Lavender (2011), UK	To increase understanding of the maternity experience for pregnant women with a BMI ≥30 kg/m^2	Meta-synthesis of qualitative research studies using an interpretative approach	English language studies using qualitative data	n/a	Six papers were synthesised following a search of electronic databases. Five studies were conducted in England and the sixth study was Swedish. The authors concluded that pregnancy is a critical period for lifestyles intervention as women perceive obesity and weight gain are acceptable in pregnancy and are likely to initiate weight loss in the postnatal period. Women reported lack of advice and perceived negative treatment from health professionals.
21. Furber & McGowan, (2011), England	To explore the experiences of maternal women with a BMI >35 kg/m^2	Qualitative design using semi-structured interviews	Maternity setting	19 women with a BMI ≥35 kg/m^2	Women experienced humiliation and weight-based stigma, describing how their weight led to increased medicalisation of their pregnancy.

Author(s), date, and country	Aim	Theoretical framework and method	Study setting	Sample size	Key findings
22. Nyman, Prebensen, & Flensner (2011), Sweden	To describe 'obese' women's experiences of encounters with midwives and physicians during pregnancy and childbirth	Qualitative study using a phenomenological approach	Maternity setting	10 women with a BMI ≥30 kg/m^2	Women described the meaning of their experience as living with a constant awareness of the body. Negative emotions and feelings of being vulnerable were reported, and women reported negative experiences of health care and judgemental attitudes from health care providers.

Smith and Lavender's (2011) meta-synthesis found six studies directly related to the scope of their review. Since then, a systematic review and meta-ethnography of the experiences of women with a BMI ≥30 m/kg^2 (Jones & Jomeen, 2017) identified 12 qualitative studies, three of which were included in the earlier review (Furber & McGowan, 2011; Nyman, Prebensen, & Flensner, 2010; Weir et al., 2010). Most of the papers included in the reviews focused on women's experiences of maternal 'overweight' and 'obesity' as their primary aim. In a smaller number of studies, lived experiences data were a small component of the main study.

The primary studies included in this review differed in their approach to exploring women's experiences of maternal 'obesity'. Explicit theoretical frameworks, commonly used in midwifery research, were applied in just under half of the studies. Qualitative research seeks to produce new knowledge grounded in human experience (Sandelowski, 2004) and it is important to apply a rigorous methodological approach to generate meaningful insights on the phenomena. B. C. Evans, Coon, and Ume (2011) suggested, "theoretical frameworks can provide navigational devices through the 'low, swampy ground' of practice disciplines in studies concerning complex human behaviours" (p. 13), ensuring congruence between the stages of the research process and the selected theoretical framework to produce findings firmly grounded in theory.

Eleven of the primary research studies (Cunningham et al., 2018; Furber & McGowan, 2011; Furness et al., 2011; Heslehurst et al., 2015; Holton et al., 2017; Jarvie, 2017; Keely et al., 2017; Keely et al., 2011; Lauridsen et al., 2018; Lavender & Smith, 2016; Mills et al., 2013) selected general interpretive approaches or did not make the paradigmatic underpinnings of the research explicit. Given the process for conducting analysis has not been adequately described in the studies not associated with specific paradigms (Nowell, Norris, White, & Moules, 2017), evaluating the trustworthiness of the research process is difficult (Braun & Clarke, 2006) as it unclear if these studies achieved congruence with the traditions of the research discipline. One study employed a sociological design, and another a Foucauldian-inspired discursive approach to analyse lived experiences. Phenomenological research approaches have been relatively neglected in favour of general interpretive approaches. Only six studies selected phenomenology method variations to explore women's maternity experiences (DeJoy et al., 2016; Knight-Agarwal et al., 2016; Lindhardt et al., 2013; C. L. Murray, 2014; Nyman et al., 2010; J. Spencer & Mcintosh, 2016). Post-intentional phenomenological methods were not used to uncover insights on women's lived experiences of maternal 'overweight' and 'obesity'. The absence of this approach, points to the unexplored opportunities to apply a deeply congruent

philosophical and methodological configuration to studies that seek data on the meaning of contemporary maternity practices for diverse women.

Subject selection was purposeful across all studies. Participants were recruited from specialist clinics (n=6), behavioural interventions (n=3), or larger studies (n=1). The remaining studies recruited participants from maternity and/or community settings. One study used online recruitment. Selection bias may occur when demographic representativeness has not been achieved (Malone, Nicholl, & Tracey, 2014). In nearly all the studies women with a BMI ≥30 kg/m^2 were selected as the target population; the exceptions being Holton et al. (2017) who included participants with or without a high BMI and C.L. Murray (2014) who focused on women who were over-gaining during pregnancy. In Parker's (2017) study, 27 self-identified fat women were recruited. In two studies (Holton et al., 2017; Murray, 2014), BMI category was unknown. Only one study (Holton et al., 2017) included women with normal BMI (n=8) and 'overweight' women (n=3). Findings indicate that 'overweight' women BMI ≥25-30 kg/m^2 are underrepresented in the literature. Given the importance of exploring a phenomenon in varied contexts (Vagle, 2014), it could be argued that women's experiences of 'overweight' are appropriate to the research as it enhances understanding of the phenomenon. Moreover, the findings from women in 'obese' categories may not have generalisability for women with 'overweight' or women who experience increasing weight gain in pregnancy.

While studies in this review identified participants who were able to illuminate important features of the phenomenon, it is possible that samples lack diversity. The researchers' selection of women from specialist clinics, behavioural interventions, and larger studies, may not be representative of the target population and, therefore, represents a limitation of the studies. Communities often are made up of distinct subgroups or individuals with similar and disparate perceptions of particular phenomena (Suzuki, Ahluwalia, Kwong Arora, & Mattis, 2007); thoughtful decisions regarding sampling are required. It is important that cultural diversity in samples is achieved to foster a layered approach to understanding the psychological, social, and cultural facets of the phenomenon.

Studies included in this review collected data at a single point in time (either during the antenatal or postnatal period), excepting three studies (Furber & McGowan, 2011; Jarvie, 2017; Keely et al., 2017) that interviewed the same women more than once throughout pregnancy and the postpartum period. The strength of this design feature meant that issues raised before birth could be explored and developed further. Overall, although the primary studies utilised different research designs and were conducted in different settings, consistent themes were identified. Three dominant themes included: (1) medical problematising of large maternal

bodies (DeJoy et al., 2016; Furber & McGowan, 2011; Keely et al., 2017; Mills et al., 2013; Nyman et al., 2010; Parker, 2017); (2) navigating weight-related conversations (S. Atkinson & McNamara, 2017; Cunningham et al., 2018; Furness et al., 2011; Holton et al., 2017; Jones & Jomeen, 2017; Keely et al., 2011; Knight-Agarwal et al., 2016; Lindhardt et al., 2013; Saw et al., 2020; D. Smith & Lavender, 2011); and (3) maternal anxieties and negative impacts on mental wellbeing (DeJoy et al., 2016; Furber & McGowan, 2011; Furness et al., 2011; Jarvie, 2017; Lindhardt et al., 2013; Mills et al., 2013; C.L. Murray, 2014; Nyman et al., 2010; Parker, 2017). A critical and comparative analysis of these themes is outlined below.

Medical Problematising of Maternal Bodies

The problematisation of fatness in pregnancy was produced through women's encounters in maternity care (Parker, 2017). In this study, participants described how their weight became the focus of pregnancy care; "…being cast as 'unhealthy' was at odds with participants' much more positive view of their general health and wellbeing" (Parker, 2017, p. 27). Participants speculated whether care was based on biomedical health frames rather than an accurate assessment of women's individual risk. As a result, they questioned the benefits and harms of medicalisation processes. Parker's (2017) findings challenge the accepted logic that women will accept biomedical message frames by taking up the recommended behaviours and point to women's rejection of maternity's idealising of specific body weights.

Similar issues relating to the increased medicalisation of obesity when pregnant were identified by Nyman et al. (2010) and Furber and McGowan (2011). Women in these studies described a sense of personal responsibility for being 'overweight'. Women equated 'overweight' with being high risk which necessitated medicalised care processes. Moreover, several women perceived that a holistic focus on health was minimised in a model of care which prioritised fetal wellbeing. These pregnant women provide evidence of being classified as at higher risk of medical complications because of 'overweight' or 'obesity'. In a study by DeJoy et al. (2016), some women were transferred to specialist care without medical indication, with many participants reporting that, "providers conflated an elevated risk for certain complications with certainty that the client would develop those complications" (p. 220).

In Mills et al.'s (2013) study, women were concerned that health professionals' reliance on the medicalised model of care contributed to a lack of personalised care and reluctance by providers to assess risk on an individual basis. Viewing high gestational weight as a medical issue is likely to disadvantage women who, aside from being classified as clinically 'overweight' or 'obese', have no other health issues. An over-riding emphasis on weight messaging may impact the opportunity to promote good nutrition during pregnancy, especially if the clinical

focus on weight is not provided in the context of healthy eating. Women in two studies (Jarvie, 2017; Keely et al., 2017) employed neutralisation strategies to defend and normalise the issue of weight. Keely et al. (2017) illuminated the limitations of engaging with maternal 'obesity' primarily as a nutrition phenomenon; they argued that weight is more complex than nutrition alone. Overall, findings show that most of these women considered their weight to be an issue both for their own health and for its impact on the baby.

However, in their study of two maternity units in New South Wales, Mills et al. (2013) reported exceptions which they attributed to cultural norms. Three Pacific Island women were included in this sample, none of whom felt concern or dissatisfaction with their weight when compared with (other) Australian women in their sample. This finding is similar to that of other studies which have reported that Pacific women labelled as 'overweight' or 'obese' were as positive about their weight and health as their slimmer peers (Brewis, McGarvey, Jones, & Swinburn, 1998). The authors concluded that while there is evidence of a preference for a healthy body size, Pacific women reported less weight bias compared with Australian women. This theme 'being on a continuum of change', is described by Mills et al. (2013) in relation to the Pacific sample. Some women were comfortable with their weight: "I'm fine with it (weight) 'cos I come from a background where they're pretty overweight, I'm a Pacific Islander I'm from Tonga" (Mills et al., p. 314). This comment illustrates the influence of cultural norms and social ideals, and points to the significance of further research exploring the awareness of risk on women's lived experiences.

Navigating Depersonalised Care

In their meta ethnographic synthesis, Jones and Jomeen (2017) found that many women with a BMI ≥30 kg/m^2 were dissatisfied with how maternity providers approached weight-focused conversations and described how risk-focused conversations had become a dominant theme in antenatal care. S. Atkinson and McNamara (2017) reported that women were cognisant of the inherent challenges for maternity providers in communicating weight-focused advice. Findings showed that providers used colluding approaches with women to avoid difficult conversations.

Several studies suggested that the stigma associated with obesity made communication between midwives and women problematic. For example, Furness et al. (2011) noted that:

> As a result of sensitivity surrounding language and anxiety about creating offence, it was perceived that women's obesity may be 'skirted around', not acknowledged

> properly during midwife consultations, and that messages were given in a vague, indirect manner to 'protect' both parties. (p. 5)

In other words, messages about obesity and weight management may be blurred, and ambiguous obesity messages produced feelings of discomfort and unease. Women, in Furness et al.'s (2011) study, described hearing mixed messages and spoke of the need for messages with clear and consistent framing to support them to make informed decisions about weight management. Comparable findings arose in Lindhardt et al.'s (2013) study which showed that women felt that obesity was addressed in a vague manner. Furthermore, women experienced a lack of information about referral to specialist obesity units without their knowledge and were often not informed of the consequences of being 'obese'. Lindhardt et al. also reported that advice about gestational weight gain was inconsistent and without follow-up support, noting that women did not receive information about the implications of 'obesity' for their pregnancy. Concurring, Saw et al. (2020) described inconsistent or absent information as a major theme represented in the studies included in their scoping review. Where women did receive advice, it focused on potential negative outcomes of 'obesity'. Furthermore, Saw et al. reported that where women experienced stigma and bullying from health professionals, this undermined their relationships and compromised women's desire to engage with weight management advice. Similar findings were shown by Mills et al. (2013) who described how women found maternity providers used avoidance tactics or were critical of women's lifestyle behaviours.

Lindhardt et al. (2013) found that women experienced weight bias in maternity settings and they described experiences of discrimination which elicited feelings of being marginalised in health interactions. Participants felt misunderstood and accused by maternity care professionals and reported lack of empathy and understanding. According to Saw et al. (2020), how women respond to care provision determines how likely they will be to engage with it. Similar examples of negative treatment, such as being treated in a sarcastic and negative manner were also reported as a core theme in many of the studies which D. Smith and Lavender (2011) included in their meta-synthesis, although the authors noted that few examples of such treatment were provided in the form of quotations.

One study found a variety of experiences. Mills et al. (2013) found some women described weight-focused conversations as unhelpful, yet others reported non-judgemental approaches by maternity providers which did not lead to discomfort about their weight. Most women in the study did not experience discriminative maternity care as reported in previous studies (Fraser et al., 2011; Furber & McGowan, 2011; Nyman et al., 2010). Similarly, Keely et al. (2011)

reported that no women had received negative treatment; it was surprising to these women that maternity providers did not discuss their weight.

Lavender and Smith (2016) revealed that women had openness to being approached and were ready to make lifestyle change. These authors concluded pregnancy was an opportunistic time to intervene, as women considered it more acceptable to be 'overweight' in pregnancy (Saw et al., 2020). However, this sample was obtained from a larger study and all 34 women had attended five sessions of a lifestyle programme. In another study, which purposively recruited participants from an existing weight management intervention, J. Spencer and Mcintosh (2016) reported that all participants made changes to food, shopping, cooking, and eating habits which they attributed to increased nutritional knowledge acquired during the pregnancy. Motivation to manage their weight through goal setting was evident in participants' narratives, though only four participants took part in the study. The methodological approach in this study drew on the principles of interpretative phenomenological analysis (IPA) to understand women's lived experiences of weight management in pregnancy. While it is likely that this study was conducted in a way which embraced IPA's idiographic commitment in terms of small, homogeneous samples (J. A. Smith & Osborn, 2015), appraisal of sample size sufficiency is absent, neither were any potential negative influences on recruitment discussed, thus making it difficult to determine data adequacy in this study. Findings from both studies recruiting from interventions (Lavender & Smith, 2016; J. Spencer & Mcintosh, 2016), reported experiences of increased motivation through attending weight management programmes which began the process of behavioural change. Overall, it is apparent that women's perceptions of encounters with health professionals is subjective, with participants describing both positive and negative health care experiences which may differ within maternity care settings and across study settings.

Negative Impacts of Medicalisation

Lindhardt et al. (2013) found that psychological and emotional wellbeing was reduced in 'obese' pregnant women. Concurring, DeJoy et al. (2016) noted that psychosocial distress was experienced by women who gained more than the recommended limits, with participants reporting that the quality of their interactions with providers had an impact on their emotional adjustment to pregnancy. The majority of women described the ongoing consequences of these interactions beyond pregnancy (DeJoy et al., 2016). Furthermore, Jarvie (2017) found that weight recommendations are unrealistic and increased women's experiences of stress. Women were concerned about being perceived as irresponsible, deficient mothers.

Emphasising this point, Parker (2017) found that intense problematising of weight left participants deeply worried about potential harm posed to their babies by their fatness.

Mills et al. (2013) found that most women experienced discomfort with their weight. Data revealed women's frustration with weight-based stereotyping. Furber and McGowan's (2011) study in English maternity units, found that many women described situations that highlighted the stigma associated with being pregnant and 'obese'. Stigma was particularly reinforced during interactions with health professionals which generated a range of negative feelings. Experiences of body shame arose from feeling purposely stigmatised and women described loss of status which they attributed to labelling and stereotyping.

Nyman et al. (2010) showed that women did not believe weight should be the focus for caregivers. Being 'obese' contributed to the guilt that women experienced due to the perceived inevitability of risk, "…both for their own life and the baby's, along with fear of death and not being able to be there for the child/children" (Nyman et al., 2010, p. 426). Feelings of shame and guilt were evident where weight-bias was prevalent. Women experienced being told not to become pregnant, eliciting feelings of anger and guilt, and described care providers' behaviour as offensive which increased shame and feelings of low self-worth. The authors further reported that women labelled as 'obese' are at risk of feeling discrimination which may lead to substandard care and, subsequently, increased negative emotions and discomfort. Although Nyman et al. talked about humiliating treatment, women in their study also reported affirming encounters where they were "seen behind the fat" (p. 427). Of the 10 women included in their study, it is not clear how many women reported positive interactions.

Gaps in the Literature

The review of the literature proved unproductive in uncovering the lived experiences of maternal 'overweight' and 'obesity' for diverse women in Aotearoa New Zealand maternity contexts. In fact, the literature related to maternal 'overweight' and 'obesity' does not adequately address questions related to the meaning of wider contextual factors on women's experiences, the views of women in larger maternal bodies, or of women's experiences of weight-focused advice. In this regard, the present inquiry aims to significantly contribute to understanding how health policy and maternal health promotion practices impact on the experiences of women of diverse ethnicities and socioeconomic statuses (Harper & Rail, 2012), and uncover how women are meaningfully connected to others and objects as they move through the world.

The review of the literature identified 19 primary studies, two meta-analyses and a scoping review that met the criteria for inclusion. These studies were limited by sample composition. Common to most of the studies, selection criteria were rarely detailed as was justification of sampling strategy. The population of interest was predominantly white women from the UK, Scandinavia, Australia, and Canada. Ethnicity and social backgrounds of samples were not adequately described in all studies. Despite the importance of including ethnically diverse samples to address disparities in health care, non-dominant ethnic groups continue to be under-represented in health care research (Renert, Russell-Mayhew, & Arthur, 2013). Research into the cultural dimension of 'obesity' is required to avoid exacerbating 'obesity' related inequalities (Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008).

Potential limitations to what are evident in the literature reviewed are:

- The lack of specificity of findings from an Aotearoa New Zealand context represents a significant limitation in the knowledge base. Only one study included in the review was based in the Aotearoa New Zealand context. The extreme inequalities facing Aotearoa New Zealand is a strong argument for building culturally responsive interventions which take account of cultural needs and priorities. Further research on these women's experiences of maternity care is necessary to improve the evidence base. The impact of social, cultural, and environmental context on the meaning of maternal 'overweight' and 'obesity' has been relatively unconsidered in the literature. An approach that focuses on health promotion and addresses the social determinants of health may be appropriate in pregnancy, but research is needed in this area (Bacon & Aphramor, 2011; C. L. Murray, 2014).
- Current approaches do not acknowledge maternal 'obesity' as a phenomena occurring within and shaped by families and communities (Keely et al., 2017). Further consideration of interventions which view food, bodies, and eating as highly embodied within social contexts is urgently needed. Even where studies promise a bio-psycho-social understanding of maternal 'obesity' (e.g., Atkinson & McNamara, 2017), analysis of wider contextual aspects is missing from the discussion.
- Literature points to the pivotal roles of maternity care professionals providing mechanisms for enabling women to realise their wellbeing aspirations (Saw et al., 2020). There is a paucity of evidence which considers how women utilise their inner resources to enable wellbeing. Thus, research which considers salutogenic understandings of wellbeing is urgently required.

- Diversity sampling is required and even more important is analysis and interpretation of demographic variables such as ethnicity and socio-economic status.
- Most studies recruited women from maternity unit contexts, which can be considered an appropriate setting. However, in Aotearoa New Zealand primary maternity care services can be delivered by a community-based lead maternity carer or a District Health Board (DHB) funded primary care provider (Ministry of Health, 2000). Inequalities in access to maternity care have been identified for Māori and Pacific groups (Craig, Taufa, Jackson, & Han, 2008; Ratima & Crengel, 2013) with women being more likely to have late presentation at maternity care and attend infrequently. This is significant as recruitment of Māori and Pacific women in future studies needs to take account of barriers to initiation of maternity care and consider the experiences of women who do not access mainstream antenatal care.
- Rand et al. (2017) explored the psychosocial, emotional, and social experiences of predominantly non-pregnant 'obese' female participants. Research indicates that internalised weight stigma negatively impacts on mental health, leading to greater psychological distress (Forbes & Donovan, 2019) for 'overweight' and 'obese' women. Where physical health is perceived to be poorer due to obesity-related conditions, psychological and mental wellbeing appears to be intensified (Taylor, Forhan, Vigod, McIntyre, & Morrison, 2013). Furthermore, the social wellbeing of individuals may be negatively affected due to the social conditions and negative attitudes that are associated with stigmatisation (Makowski, Kim, Luck-Sikorski, & von dem Knesebeck, 2019). There is a gap in those studies included in this review on the lived experience of maternal 'obesity' in relation to mental wellbeing, cultural, and social influences on women living in multiple and diverse situations and contexts. There is an urgent need to address this gap and obtain a full picture of the broader dimensions of how maternal women labelled as clinically 'overweight' or 'obese' describe their experiences within psychological, emotional, medical, and social issues.
- Psychological aspects of being classified as clinically 'obese' need to be considered, especially in relation to the impact of increased medicalisation of pregnancy for women where 'obesity' is the only risk factor. As observational work was not carried out at antenatal clinics it is impossible to say whether these accounts mirrored reality in terms of actual advice given by health professionals. Therefore, studies cannot provide data generalisable to the Aotearoa New Zealand setting.

- Women in diverse maternal bodies require different maternity care considerations (Saw et al., 2020) to women with 'normal' weight which warrants a need to better understand diverse women's preferred discourses.
- Clear theoretical perspectives were not outlined for most of the studies and it is difficult to conclude if the designs commonly applied were consistent with research intent.
- Only one study specifically investigated the lived experience of gaining weight while pregnant regardless of pre-pregnancy BMI (C. L. Murray, 2014).
- Many studies involved midwives as interviewers, increasing the potential for recruiter bias. McNeill and Nolan (2011) reported that midwives are increasingly involved in conducting research where the setting is familiar. There was little discussion of the influence of insider researcher status on emergent data and research findings.

Chapter Summary

Post-intentional phenomenology holds promise for generating new insights through an expansive unfolding of the multiple and varied meanings surrounding the phenomena of being labelled as clinically 'obese' and 'overweight' in pregnancy. There is a need for post-intentional approaches to consider larger cultural and historical contexts, power differentials, or societal structures beyond individuals' experiences. The review of literature sought to situate the study by identifying existing research on women's experiences of maternal 'overweight' and 'obesity'. Available evidence offers little understanding on the lived realities of pregnant Māori, Pacific, and New Zealand European women, and their journey through the maternity care service. Given the persistent inequities in Aotearoa New Zealand, research is needed to understand Māori and Pacific perspectives to develop more inclusive policy and practice approaches which resonate with these population groups. Despite its obvious significance, the influence of social context and contemporary cultural discourses on weight in pregnancy remains a relatively neglected area of research. The current research will uncover a deeper understanding of lived experiences of Māori, Pacific, and New Zealand European pregnant women living in a variety of social and cultural contexts. Thus, the proposed study will go some way to ensure that the needs of diverse maternal women are met with a culturally responsive maternity care pathway. The reasoning and justification of this research topic has been established through the iterative dialogic conversation with the literature.

CHAPTER THREE: METHODOLOGY

This chapter presents the philosophy and methodology chosen to explore women's maternal body experiences. I discuss the rationale for selecting a post-intentional phenomenological approach–a contemporary tradition–to inform the research. Key concepts and principles important in a post-intentional approach to phenomenological research are outlined. First, a brief synopsis of Husserl and Heidegger's notions of intentionality is provided to illuminate how the concept of intentionality has come to be defined in post-intentional phenomenology. Then, I show how leveraging post-intentional phenomenology, alongside other politically oriented theories and ideas, can be used to reveal the complexities for women in managing their bodies as their own. To this end, I draw from feminist theorising of pregnant embodiment (I. M. Young, 1980, 1990), distressed embodiment (Leder, 2004, 2016), and salutogenic understandings of health (Antonovsky, 1979) to inform the analysis. Finally, I introduce Vagle's five-component methodological process which served as the overarching guide in this inquiry.

Coming to Post-intentional Phenomenology

In the planning phase of the study, theorists and theories were selected that were seen as fitting well with an exploration of pregnant women's lived experiences of maternal 'overweight' and 'obesity'. Initially, van Manen's hermeneutically oriented phenomenology was considered. At that point, hermeneutic phenomenology offered a substantive philosophy and supported my early conceptualising on the topic. However, in the process of developing this inquiry, a number of factors provoked me to seek a different philosophical and methodological ground. First, early gathering of phenomenological material uncovered the complexity of the topic in the broadest sense. Deeply listening to the women's stories and turning to feminist perspectives on the body saw me enter into a critical dialogue with medicalised and social narratives that run through women's relationships with others. Second, dialoguing with experienced academics on policy issues, particularly the phenomenon of BMI as a pathologising marker of health in pregnancy (Knox et al., 2018) afforded a reimagining of the study and uncovered what frames my seeing:

> It is not a matter of looking harder or more closely, but of seeing what frames our seeing-spaces of constructed visibility and incitements to see which constitute power/knowledge. (Lather, 1993, p. 675)

Third, following a partial review of the literature, I observed that some of the articles which met the criteria for review felt incomplete, in that aspects of women's experiences went

unexplored and meaning was not uncovered. Through exploring relevant literature, I understood this phenomenon was about the failings of maternity care and the wider health system to value diverse bodies and experiences, those outside of mainstream understandings of health. For instance, a producer and provoker of the phenomenon, feminist fat studies scholar George Parker (2017), argued that the dominant focus on body weight in maternity contexts reinforces and legitimates fat stigma and discrimination. Rather than women being shamed into health, Parker contended that,

> 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 marginalisation, including institutional and interpersonal racism, classism, ableism, and heteronormativity, and developing strategies to address them. (p. 31)

Perhaps the phenomenon 'shamed into health' represents a kind of system failure; perhaps the maternity care system is forging disconnect and divide between women and those who are there to partner with women? Being in a disconnected and divisive maternity care system is producing and provoking this phenomenon. Furthermore, the complexity of post-normal science phenomena, such as maternal 'obesity', points to ethical and moral complexities associated with health promotion policy and practice in maternity contexts. I struggled with the impact that possible findings would have for deepening understanding of how women are positioned in biomedical maternity contexts where weight-focused neoliberal discourses are being produced and reproduced. In particular, I became concerned about how BMI weight messaging was meeting the needs of ethnically diverse women and the equity impact of weight-focused individualistic interventions. To reframe the issue it was critical that a politically orientated phenomenology was selected to uncover the influence of contexts, such as policy and practice, in producing and provoking the phenomenon.

Following presentation of my research proposal, and debriefing with AUT academics, Vagle's (2014) post-intentional phenomenology was recommended, to discern how elements of post-structural thinking could inform the research (S. Crowther, personal communication, October 30, 2015). Upon further reading, I found resonance in post-intentional phenomenology, given its potential for capturing the complex and dynamic productions of a phenomena as it moves-in-and-through the often contradictory discourses surrounding the topic (Soule & Freeman, 2019). I felt inspired that Vagle's approach held the potential for disrupting the neoliberal discourses on body weight circulating in maternity contexts. Coming to post-intentional phenomenology opened up possibilities to unsettle and disrupt contemporary health

promotion practices, particularly the narrow definitions of normality neoliberal narratives. Consequently, to open-up the phenomena I became more intentional in my efforts; producing both an interpretive and a descriptive representation of women's lived experiences, while including elements of post-structural thinking to reveal the power dynamics impacting the provision of maternity care.

Thus, I moved from a hermeneutically oriented phenomenological approach to a more politically oriented philosophy. My aim was to open up phenomenology as a catalyst for political possibilities (Vagle, 2018). I developed a method for gathering and interpreting data in accordance with a new approach to phenomenology which Vagle (2014, 2018; Vagle, Clements, & Coffee, 2017) referred to as post-intentional phenomenology. I reshaped the research design to align with Vagle's post-intentional phenomenological concepts and adapted the research question to focus on the phenomenon – being labelled as clinically 'overweight' and 'obese' in maternity contexts – as the unit of analysis. The research question became, "What are the experiences of ethnically diverse maternal women labelled as clinically 'overweight' and 'obese'"? The secondary research questions focused on how the various contextual aspects of the study produced and provoked the phenomenon, and became the lenses through which the data were explored.

A 'Posted' Intentionality

Phenomenology seeks to explore phenomena as they manifest through lived experiences (Valentine, Kopcha, & Vagle, 2018) and "attempts to explicate the meanings as we live them in our everyday existence, our lifeworld" (van Manen, 1990, p. 11). In phenomenology, intentionality is where meaning resides. Intentionality has been described as an active relationship in which we experience the world as bestowed with meaning (K. Dahlberg et al., 2008); that is, "the inseparable connectedness of the human being to the world" (van Manen, 1990, p. 181). As such, intentionality does not mean one's purpose; rather, an interconnectedness among people and all things in the world (Vagle, 2020a).

This study drew on classical phenomenological notions of intentionality. From Husserl, the notion of intentionality, ultimately, consciousness of the world (of-ness), was an indissoluble relationship between knowing self and the object of its consciousness. In Husserlian orientated phenomenology one is studying the of-ness of a phenomenon (the intentional relationship between subject and object). For Husserl, any type of entities produce conscious intentional thought – "Entities could be physical objects, people, ideas, particulars (this patch of colour),

universals (the general concept of colour), states of affairs and mental entities, such as thoughts, images, and feelings" (Benade, 2016, p. 137).

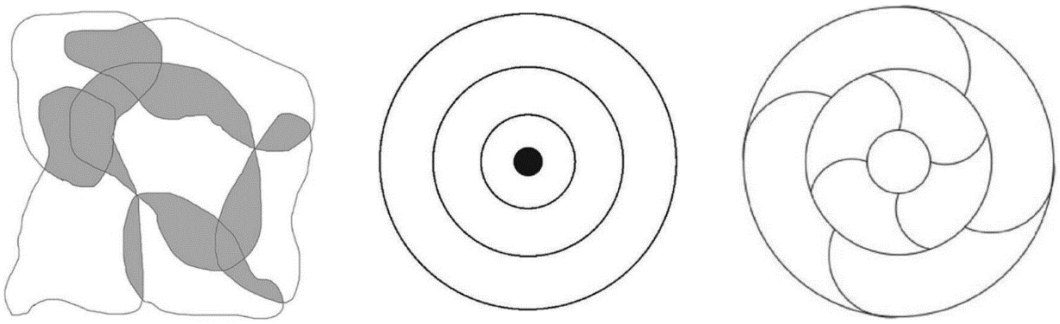
From Heidegger, being-in-the-world, that is, self-world inseparability, goes deeper than pre-consciousness to our very being; a shift in ontology rather than epistemology (Muth, 2016). Heidegger (2002) described intentionality as an embodied experience of a conscious subject finding one's self in relation to (in-ness) an intended object. As such, through intentionality the unit of analysis is neither the experiencing subject nor the experienced object, but the intentional relationship manifested between the two (Kumm & Johnson, 2014). The focus becomes more on what it is to be in the world in various intentional ways.

Drawing on Ihde's (1993) post-phenomenological theorising to construct a post-intentional phenomenology, Vagle re-envisioned intentionality through bringing a post-structural lens to the notion (Valentine et al., 2018). In Ihde's conception of intentionality, the shape and direction of experiences are constantly shifting and changing over time; intentionality being the meaningful ties that link people to the world in which they find themselves. Similarly, post-intentional phenomenology applies post-structural thinking to intentionality, drawing on the post-structural perspectives that knowledge is tentative and ever changing (Vagle & Hofsess, 2016).

In a similar way to van Manen (1990), Vagle (2018) described intentionality as interconnectedness, noting intentionality to mean, "the inseparable connectedness between subjects (this is, human beings) and objects (that is, all other things, animate and inanimate, and ideas) in the world (p. 28). This distinction is important because Vagle signified intended meanings are generative. Vagle's focus on through-ness is used to represent movement, moving from a focus on being to a focus on becoming, production, and provocation. In doing so, he claimed that this, then, allows us to see intentionality as intentionalities; that is, "as multiple, partial, fleeting meanings that circulate, generate, undo, and remake themselves" (Vagle, 2018, p. 45). Post-intentional phenomenological approaches address the through-ness of intention in which Vagle contended the social aspects of a phenomena are engaged as intentionalities take shape in complicated contexts.

Distinguishing post-intentional phenomenology from earlier phenomenologies, Vagle illustrated the differences between Husserl's essentialised intentionality and a de-centred intentionality (see Figure 1). Vagle's (2014, 2018) take shape image can be juxtaposed with images of an essential core (Husserlian) and a hermeneutic spiral (Heideggerian). In juxtaposition to the image of meaning as a defined, bounded, essential core structure; post-

intentional phenomenological inquiry aims to consider phenomena as tentative, fleeting, and incomplete (Kumm & Johnson, 2014).



Take shape *Essential core* *Hermeneutic spiral*

Figure 1. Distinguishing post-intentional phenomenology

Figure 1 represents a post-intentional shift that resists locating essences and embraces contexts, situations, and the partial (M. Freeman & Vagle, 2009); thus showing there is no essence of a phenomenon. Rather, essences are replaced with productions (the continual and multiple ways in which the phenomenon is being shaped through time) and provocations (features which ignites something about the phenomenon), which represent the most prominent insights that reveal the social features of the phenomena. Hence, replacing essences with plausible interpretations of manifestations and appearances, extends the interpretive focus on being towards revealing deeper insights into how the phenomena is socially produced. "*Becoming* reflects the post-structural notion that phenomena are constantly changing and our understanding of them is inherently partial" (Valentine et al., 2018, p. 466).

The conceptual move to post-intentionality reflected Vagle's move to dancing around the edges of phenomenology (Adsit-Morris & Gough, 2017) using post-structural ideas. In this study, I attempted to work along the margins of post-intentional phenomenology to see how the phenomena might take shape through plugging-in Deleuze and Guatarri's lines of flight concept (Vagle, 2015). Lorraine (2005) argued that Deleuze and Guatarri were interested in the endless ways in which things connect rather than on what things are. Given the post-structural commitment to perceiving things as interconnected, Deleuzean perspectives can help us begin to see that we might aim to enter the middle of strongly ravelled contexts (Vagle, Monette, Thiel, & Wester-Neal, 2017) in which large maternal bodies are simultaneously celebrated *and* problematised in today's contexts.

In accordance with Deleuzean understandings, this means, "one does not start with the stable subject and try to follow that subject's intending on and with the world" (Vagle & Hofsess, 2016, pp. 336-337). In post-intentional phenomenology we are encouraged to pursue these lines of flight, actively searching for new analytical insights to see how knowledge might take off. In this inquiry, lines of flight, as a philosophical construction, provided a way to explore how women conceptualise encounters as fluid and shifting connections with people, discourses, objects, and things; rather than perceiving them as stable essences as pregnancy is lived out, in, and over time. As such, post-phenomenological texts are, "…fluid, shape-shifting assemblages continually on the move in interacting with the world, rather than perceiving them as stable essences" (Vagle & Hofsess, 2016, p. 337).

Putting Phenomenology into Play with Other Theories

Finding the essence of the phenomenon, as Vagle (2020a) explained, is not the central goal of phenomenology; rather, phenomena are conceived as dialogic. Thus, another key phenomenological idea of importance throughout the inquiry was putting post-intentional phenomenology into dialogue with complementary theories. It is important to bring all helpful texts to bear on one's interpretive understandings; yet, to remain open to questioning what other theories assume and how they might influence how the phenomenon was approached (Vagle, 2018). Being encouraged to play with other theories, I sought to put philosophy and theories in conceptual dialogue with each other to explore new ways to open-up the phenomenon. I read critical theories, such as race theory and labelling theory, and theories informing philosophies of the body (e.g., Merleau-Ponty's ideas about perception), being open to how these ideas might see my knowledge take-off in new directions.

I initially considered Bourdieu's social theory as a tool to interpret the data and analyse the complex interplay between social structure and women's health behaviours. While a Bourdieusian critique has potential to inform health promotion practice by fostering new understandings of the relationship between health knowledge and behaviour change, it became clear that this study needed a stronger emphasis on gender given society's preoccupation with surveillance of the pregnant female body and the political agenda which places women as being responsible for the health of their families (Parker, 2014). Without modification of Bourdieu's theory, specifically the integration of gender, I felt a Bourdieusian critique had limitations in explaining how maternal 'obesity' is contested and political. I needed an approach that put phenomenology in dialogue with disruptive theories to imagine new possibilities of meanings.

To inform the analysis, I drew from feminist theorising of pregnant embodiment (I. M. Young, 1980, 1990), distressed embodiment (Leder, 2004, 2016), and salutogenic understandings of health (Antonovsky, 1979). At the beginning of the inquiry I looked at Iris Marion Young's (1990) philosophical ideas, and her theory became a central part of this approach to enable a deeper understanding of the 'problem' of large maternal bodies. Young's work on female body experience, specifically her essay on pregnant embodiment, was put into play with women's lived experiences data, Illuminating how pregnancy for women in clinically 'overweight' and 'obese' bodies was an, "observable process coming under scientific scrutiny" (I. M. Young, 1990, p. 160). Young's analyses continue to be relevant to exploration of how women are positioned in biomedical maternity contexts and were relevant to this study at several levels. First, Young's work pointed to the ways in which gender and social norms produced restricted female embodiment. Through Young's experiential lens, she sought to lessen the focus placed on the female body as an object to be studied. Young shed light on how medical institutions and practices constitute the experience of pregnancy as one of alienation (Al-Saji, 2010), bringing to light female experiences in political contexts. In doing so, a critical function is performed as we appraise the potential for affecting social change through asking uncomfortable questions such as: "How does medicine exacerbate the disconnections of body and world"? Young blamed societal structure rather than the individual and brought a tension to the fore–increased policy attention which places women at the centre of being responsible for the future health of generations. Young's lens enabled me to explore broader political and social influences on pregnant women's ability to see pregnancy as a physiological process and not a disorder.

Second, my understanding of Young's work pointed to women's experiences of bodily movement in socially constructed and medicalised spaces and women's forms of expression given the rules and norms of these spaces. Drawing upon Merleau-Ponty's ideas about perception, in her recent work, Young's (1990) analysis focused on the kind of movement where the body aims at accomplishing a definite purpose or task. Young described feminine bodily existence as an inhibited intentionality, in that women appeared uncertain of their body's capabilities and felt like their bodies were not completely under their control (perhaps due to factors such as pregnancy). According to Young, this factor often produced in maternal women a feeling that pregnancy does not belong to women themselves, rather they experience their whole body as objectified. In this way, women learn to experience their bodies as a burden and become conscious of the physicality of their bodies. Women's consciousness of the massiveness of their maternal bodies disconnects them from what they want to achieve *through* their bodies. Even when Young described the difficulties that women and

others face in oppressive situations, she alluded to the positive ways in which these situations are subverted and even enjoyed. While in the experience of pregnant women, "…weight and materiality often produce a sense of power, solidity, and validity" (I. M. Young, 1990, p. 166), Young's interpretation shows that maternal embodiment is defined as a disorder and becomes incompatible with 'normal' or holistic understandings of health, creating a tension for women as they try to manage their bodies as their own.

Thinking with theory involved openness and creativity (Vagle, 2018), and as the inquiry progressed I drew on other conceptual ideas and frameworks to explore the phenomenon more deeply, following the flows and swells of phenomena (Vagle & Hofsess, 2016). Leder's theorising on distressed embodiment became an important theory to think with and was put into dialogue with Young's (1990) theory and the phenomenological data gathered. In '*The distressed body*', Leder (2016) discussed the nature of distressed embodiment and reminds us of the "inescapable force of embodiment" (p. 16). He said that it is with and through our body that we rush out to meet the world; yet, to inhabit a distressed body changes things. The harshness and complexity of distress was shown by Leder who considered the etymology of distress and disease. Since di or dis, meaning 'apart, away from', suggests the privative of what is being modified, words like 'dis-ease' confers the absence of ease (Leder, 2016). Leder argued that distressed bodies are dis-placed or pulled away from our usual place in the world; and in-dis-ease, the body becomes a thing that feels separate from the world. Leder's theorising on distressed embodiment within carceral contexts, specifically his strategies of escape and reclamation, were used to illuminate the possible meanings for women as they encountered others in restrictive biomedical maternity contexts. For Leder (2004, 2016), escape emphasised flight from an oppressive reality, whereas reclamation emphasised redeeming that reality and rehumanising the lifeworld. Contending that aspects of his carceral theorising were applicable to other institutions in which similar mechanisms of power mechanisms are at play, such as hospitals and health care (Leder, 2004), the insights generated reveal women's strategies for reclaiming autonomy for bodies that fall outside clinical measures of normality.

Women's maternal body experience was interwoven with strategies of escape and reclamation to illuminate how contexts produced or provoked different aspects of the phenomena. Antonovsky's (1979) concepts on salutogenic understandings of health were combined with Young and Leder's theories. Salutogenesis, meaning the origins of health, is a theory of health promotion (Antonovsky, 1979) which emphasises health rather than illness. Social change is a commitment or goal that needs to be explicitly located within post-intentional phenomenological research (Vagle, 2018). Thus, putting phenomenology into play with

Antonovsky's theory of salutogenesis might help affect social change through a critique of health promotion policy and practice to disrupt illness-focused approaches for 'high-weight, high-risk' women. While being mindful that new creations of phenomenology may be critiqued for moving too far away from their philosophical roots, Vagle's (2019) assertion was that new possibilities emerge in the making and remaking of phenomenology. Congruent with post-intentional philosophy-methodology, this inquiry sought to build on foundational concepts in phenomenological and hermeneutic inquiry, "while 'unsettling' these traditions to invite and provoke something new" (Vagle, Thiel, & Hofsess, 2020, p. 427). Utilising a contemporary approach in this inquiry supports my interest in the complexities of promoting health for ethnically diverse women and enabled me to explore the lived experiences of women who are considered outside the definitions of 'normal' weight, as well as the power dynamics impacting the provision of care. Considering all facets of pregnant embodiment and women's social and cultural understandings of maternal bodies, their connections or disconnections with medicalised 'obesity' narratives, post-intentional approaches offered potential to capture this complexity. Thus, a post-intentional approach sought both to reveal the multiple experiences women have in maternity care contexts, while simultaneously disrupting power structures, factors important to midwifery because of the politicisation of maternal bodies.

The Post-intentional Methodological Process

With these theoretical ideas providing the basis for the study, this post-intentional inquiry was underpinned by the following five methodological components (Vagle, 2014, 2018):

Component 1: Identify a post-intentional phenomenon in context(s) around a social issue.

Vagle (2014) explained, "…phenomena are the ways in which we find ourselves being in relation to the world through our day-to-day living" (p. 20). Phenomena are self-showing and reveal themselves and, as Soule and Freeman (2019) showed, "…it is not enough to simply describe these phenomena as they appear, for there is also meaning in what is concealed behind that appearance" (p. 861). The goal in post-intentional phenomenological research is to bring to nearness the multiple influences that are concealed by a phenomenon's appearance. For example, BMI measurement has become a taken-for-granted aspect of pregnancy care, yet the forces which are driving such universal approaches often go unnoticed. Post-intentional approaches can help us see things in new ways and reveal the things that have become so 'normal' – such as the medicalisation of diverse maternal bodies - that we do not notice what might be at work and what might be assumed (Vagle, 2019).

Post-intentional phenomenology is a blended approach which bridges the transcendental/hermeneutic divide (Neubauer, Varpio, & Witkop, 2019); the phenomenon is treated as the unit of analysis, yet phenomena are multiple, partial, contextual, and in-flux (Vagle, 2014, 2018). The phenomena were approached as though they were constantly being made and unmade, done and undone (Vagle, 2020b). This understanding is always coming-to-be-known, not final, and, in this way, it represents a type of post structural and phenomenological philosophy-methodology. The goal was to approach a phenomenon openly, allowing for individuals' lived experiences and their expressions of those experiences to provide context. Vagle (2018) explained that a phenomenon is, at best, insight into the social processes surrounding a phenomenon which produce the shape of the phenomenon for a particular group of people. This inquiry is not focused on identifying structure and qualities of experiences, but explores how phenomena are produced in maternity and social contexts. This through-ness approach assumes, then, that maternal 'obesity' as a post-intentional phenomenon is produced and provoked by women; their social contexts; the contemporary and traditional discourses about maternal bodies; the degree to which their bodies are respected; and the maternity and health care systems, policies, and practices that explicitly and implicitly influence women's understandings of wellbeing.

In this inquiry, the post-intentional phenomenon is diverse maternal bodies; it aimed to articulate the meaning for ethnically diverse women with lived experiences of clinically defined maternal 'overweight' and 'obesity'. Valentine et al. (2018) argued that post-structural methodologies offer new ways of answering phenomenological questions to create possibilities for revealing glimpses of the phenomena across contexts, cultures, discourses, and genders. This is important because of the complexities of the contexts in which women receive care and reside. The questions that guided the study focused on what it meant to be and exist in diverse maternal bodies (i.e., bodies labelled as clinically 'overweight' or 'obese' in pregnancy and thus constituting 'high-weight, high-risk' bodies); bodies which are outside of medicine's definition of 'normal' weight.

Component 2: Devise a clear, yet flexible process for gathering phenomenological material.

To gather post-intentional phenomenological material for this study, I wanted to learn from women who had experienced the phenomenon. Consequently, to better understand the phenomenon of being in diverse maternal bodies in complex contexts I interviewed women with clinically defined maternal 'overweight' and 'obesity' with lived experiences within a variety of socio-cultural contexts. The semi-structured interview and lived experience descriptions was selected as the primary source of phenomenological material in this inquiry.

Component 3: Make a post-reflexion plan.

A reflexive phenomenology of practice was advocated by Vagle. For Vagle, the concept of post-reflexivity in post-intentional phenomenological research was an out-growth of descriptive phenomenology's focus on bracketing (Giorgi, 2009) and reflective lifeworld approach's focus on bridling (K. Dahlberg et al., 2008). Describing post-reflexivity as, "…a dogged questioning of one's knowledge as opposed to a suspension of this knowledge" (Vagle, 2014, pp. 74-75), Vagle (2018) later said, "post-reflexing is not about setting aside our prior knowledge, assumptions and beliefs about the phenomenon, but about exploring how they play a part in producing the phenomenon" (p. 153). Thus, we are asked to critically engage and interrogate our preunderstandings in the research process, exploring how these play a part in producing and provoking the phenomena.

Muth (2016) reminded us that findings in post-intentional phenomenology are not really 'findings' as if they were discovered out there; rather, understandings formed through the researcher's own lived experiences of doing the research. Early into the research process, I created a post-reflexion journal which I have used to draw on my self-reflexive thoughts to consistently examine my position in the research as I crafted phenomenological material. I occupy the position of both insider and outsider to this research; inextricably linked to the study and the situations and contexts of the women. My identity as Scottish, white, working class mother, former midwife, and public health practitioner with a biomedical way of seeing, and with a body that is of 'normal' weight is an inseparable aspect of the study. Applying a post-structural lens to this study enabled me to post-reflex and enter an ongoing critique of a contemporary binary position, noticing the different line of flights operating on me and the phenomena in this study. Post-structuralist philosophical ideas tend to resist or even reject the notion that there is such a thing as a pure experience or that there is a structure that can be systematically representative of experience, truth, etc. It also rejects binary positions; instead, offering ongoing critiques of structures and binaries (Vagle, 2018). The social and biomedical models of 'overweight' and 'obesity' represent an example of opposing conceptual discourses and frameworks which reveal a rigid dichotomy of health and pathology. As I post-reflexed, I examined how my positionality, background, and insights had the potential to influence the study. I became aware that both models were operating at a pre-conscious level making it difficult for me to address the issues. Tethered to my disciplinary past, I found myself entering the middle of an existing debate of extreme views on the alleged health crisis and moral panic which wraps the production of obesity as a societal problem. I felt in flux as I recognised my positionality changing towards a perspective which was becoming more critical of the dominant medical positioning of obesity. Previously I was ambivalent. I never challenged

myself to consider how the existence of biases with regard to ethnicity, social class and gender affected women's experiences of pregnancy care. While I had been focused on ensuring the best use of 'authoritative' sources of public health evidence I neglected to pay attention to 'non-medicalised' accounts of fatness. B. Evans and Cooper (2016) cautioned that neglecting non-medicalised accounts will leave little room for alternative understandings. Whereas before, I saw obesity as a behavioural problem caused by modern lifestyles, now I am challenged to critically explore the debates rather than treat it as axiomatic. This has been a difficult and disturbing tension for me. I have come to see how women in diverse maternal bodies experience maternity care and through this inquiry the powerful forces which problematise and stigmatise women's maternal bodies are exposed.

Vagle (2018) advocated a reflective approach, noting:

> As we post-reflex through a study it is important to document, wonder about and question our connections/discussion, assumptions of what we take to be normal, bottom lines and moments when we are shocked. (p. 154)

Approaching a post-reflexive practice involves an analytical noticing of moments in which we connect and disconnect from the phenomenon, our assumptions of normality, our bottom lines that we refuse to shift and the moments in which epiphanies are revealed (Vagle, 2014). There were moments when I connected with the participants and their stories and moments where I disconnected; for example, when stories appeared contradictory. During these moments of disconnection, I still marvelled at how women viewed the phenomena, specifically women who at first resisted nutrition advice only to accept it shortly thereafter. Post-intentional phenomenology helps us embrace these moments, reminding us that findings are expected to be tentative and possibly paradoxical. In other words, an examination of the lived experiences of women as malleable and contextually situated. An approach in which each woman's experience was valued as knowledgeable and accurate, despite any contradictions between and within their perspectives and experiences, was important in this study.

Component 4: Explore the post-intentional phenomenon using theory, phenomenological material, and post-reflexions.

My dialogism with other theories has helped me to look more closely into what was going on for women. Being critical in the context of post-intentional research means interrogating theories so that they do not obscure other ways of seeing during the analysis of phenomenological data. I sought to strike a balance among my interpretations, the voices of women themselves, and other philosophical conversations to craft stories in which we can sense, see, and almost be there with the participants (Vagle, 2014). Such an approach aimed

to enhance understanding about living within types of maternal bodies as women interacted with and connected with objects, things, places, and others in the world—specifically the ways in which women responded to the realities of maternal 'overweight' and 'obesity' in clinical encounters, as well as in their everyday lives. Vagle (2014) alluded to there being no goal to find the common themes of being towards such states of being and how to define them in post-intentional phenomenological work. Rather, the goal is to see how being towards these states is manifested (tentatively) in all sorts of ways, "the idea being that opening up these tentative intentional meanings provide a richer, deeper consideration for others to take up" (Freeman & Vagle, 2013, p. 730).

Component 5: Craft a text that engages the productions and provocations of the post-intentional phenomenon in context(s), around a social issue.

At the beginning of this inquiry I drew on an early iteration of post-intentional phenomenology (Vagle, 2014) which focused on the concept of tentative manifestations of the phenomenon. The phrasing of the term tentative manifestations reminds us that the researcher's authoritative voice is minimised and attention is deliberately focused on situating phenomenological work as contextual, partial, and incomplete (Soule & Freeman, 2019). In accordance with the methodology, the continuous deferral of final interpretation of the phenomenon is important. In this way, the crafted texts presented in following chapters are considered partial and incomplete. Through Vagle's (2019) evolving understandings, his later iteration of post-intentional phenomenology introduced a marked shift which repositioned the methodology to explicitly focus on social change. Productions and provocations then became central (Vagle, 2018) in the crafting of post-phenomenological texts. Vagle described a provocation as a catalyst (e.g., something within the phenomenological material that ignites something about the phenomenon; or a policy issue that appears to be strongly shaping the phenomenon). Alternatively, a production alludes to the multiple and ongoing ways the phenomenon is being shaped over time (Vagle, 2018). Figure 2 shows the conceptual framework for the crafting of the stories.

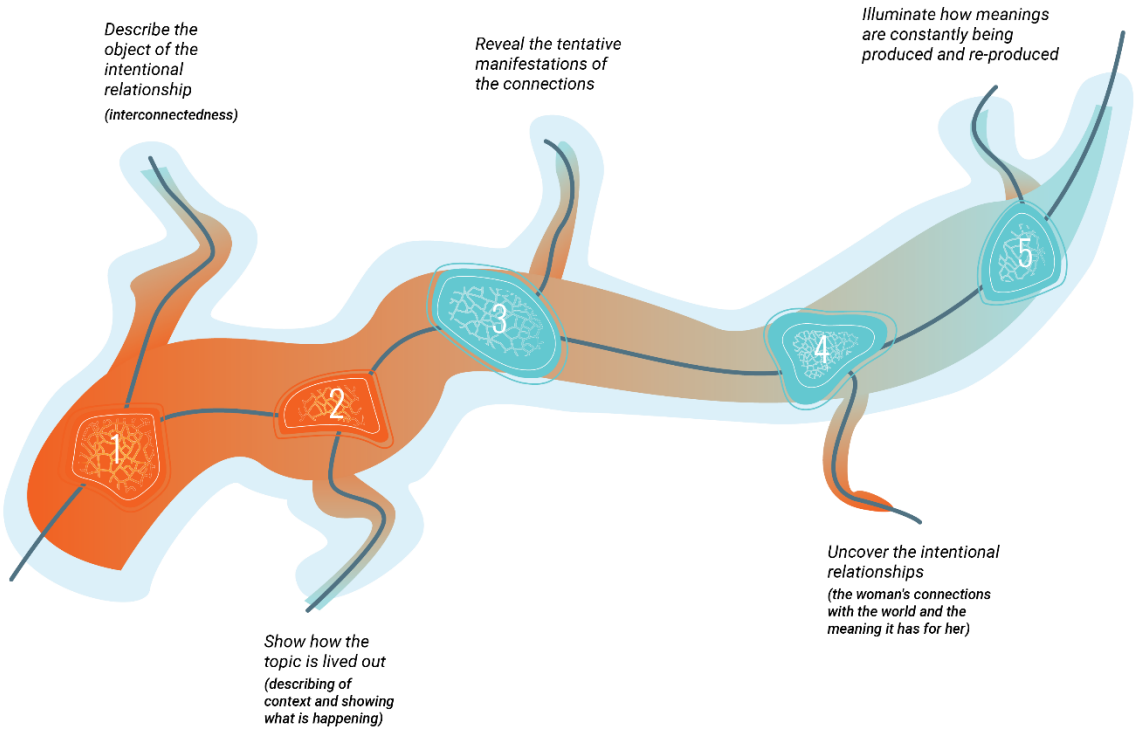


Figure 2. Conceptual framework for the crafting of the stories

Texts were crafted that attempted to capture the tentative manifestations of the phenomenon in its multiple, partial, and varied medical and social contexts. Vagle's later theorising also created an opportunity to illuminate productions and provocations of the phenomena in different contexts. Thus, the whole-part-whole analysis method focused on paying attention to glimpses of productions and provocations, to consider how the body of evidence represented in this thesis might inform social change.

Where the phenomena revealed itself in social contexts, stories were crafted and interspersed with narratives based on clinical contexts. Thus, data were represented in the form of individual crafted stories; interspersed with constructs and concepts from relevant literature and excerpts from my post-reflexion journal. Poetry, as an additional textual form, was included to evoke new possibilities, showing the important productions and provocations at work.

Chapter Summary

Clinically defined maternal 'overweight' and 'obesity' is a phenomenon that is a controversial and topical issue due to competing binaries on maternal 'obesity'. A post-intentional phenomenology offers a focus on being labelled high-risk because of weight and how it relates to gender and cultural positioning rather than the political aspects which are reinforcing high

BMI pregnancy as a type of embodiment that is incompatible with health. I chose to craft through-ness phenomenological research to explore intentionalities and how they take shape in complicated contexts, retaining the phenomenological commitment to understanding experiences as lived. Young's, Leder's, and Antonovsky's theories established the basis for the internal dialogism that exists within Vagle's (2018) post-intentional approach. Putting Vagle's post-intentional approach into dialogue with more disruptive theories accounts for the complexity of pregnancy as both a physiological and a psychological experience; and reflects the political forces at play. Understanding women's experiences from dual perspectives facilitates our understanding of the universal and differentiated aspects of diverse maternal bodies; thereby, providing a nuanced picture of the interplay between maternal 'overweight' and 'obesity' and the socio-cultural, historical, and political conditions within which women live. I showed that post-intentional phenomenology is capable of being used toward political ends. Vagle's five-component methodological process was summarised to foreground the next chapter which explains the methods that facilitated the research process.

CHAPTER FOUR: METHODS

This chapter presents the methods of research utilised to uncover the experiences of being labelled as 'overweight' and 'obese' in pregnancy. It begins with an overview of the research engagement and consultation, before outlining the ethical considerations. Then, the selection of participants to this research is discussed along with an overview of participants. Strategies related to the protection of participants' personal information and anonymity in this study are outlined. My approach to gathering phenomenological material is outlined. Next, guided by Vagle's (2018, 2014) whole-part-whole analysis method, a description of the approach taken to analyse the data and develop crafted stories is presented. Finally, and in accordance with Vagle's approach, I devised a flexible, yet trustworthy, process for gathering phenomenological material and interpreting the data. Practical strategies to enhance trustworthiness are described to legitimise the body of evidence produced from this research.

Engagement and Consultation

An engagement and consultation process was conducted prior to gaining ethical approval. As the research intent was to involve Māori and Pacific peoples, an information brief (Appendix A) was prepared to support engagement and consultation with people likely to be interested in or impacted by this research. Acknowledging the importance of te Tiriti o Waitangi as the foundation for the relationship with Tangata Whenua in Aotearoa New Zealand, I placed great value on respecting the status of Tangata Whenua as indigenous peoples. Therefore, an initial step involved research consultation with Te Ātiawa/Taranaki ki Te Upoko o Te Ika; iwi centred mainly in the Hutt Valley and Wellington city. Once iwi approval was obtained, consultation was held with stakeholders from a range of institutions and organisations identified in the plan. A consultation outcomes report was prepared on completion of this process and responses to consultation documented. Outcomes included a letter of support from the Director of Māori Health (Appendix B), the Director of Pacific Health (Appendix C), and approval by the Maternity Quality Committee at one DHB to implement the study.

Another outcome of consultation involved establishing a research advisory group to ensure a mechanism for cultural and clinical advice to inform the study. The group comprised clinical representatives from maternity services including Māori and Pacific practitioners and tikanga Māori specialists, as well as a consumer advisor. Terms of reference were established for the group (Appendix D). The purpose of the group was to ensure the research was conducted in a way which reflected the principles in te Tiriti. The group contributed to the development of the research through critical review of the research proposal, sharing knowledge on the maternity

systems and processes, and advising on approaches to data collection with Māori and Pacific participants. A codesign workshop was held with the group which produced ideas for research questions, effectively generating consumer perspectives. Furthermore, advice was provided on all recruitment material, including participant information sheets and consent forms.

Ethical Considerations

The Auckland University of Technology Ethics Committee (AUTEC) were engaged at the conception of the study to ensure the privacy, safety, health, social, and cultural sensitivities of participants were adequately considered. Further to AUTEC guidance, a scope of review was submitted to the Health and Disability Ethics Committee (HDEC) to determine whether the study proposal required HDEC approval. Once confirmation was provided that the study was outside HDEC scope of review, the study was submitted to AUTEC for institutional review and approved (Appendix E) with the condition that the locality organisation agreed the study met established quality and risk standards. A locality assessment (Appendix F) was completed by the DHB and constituted a high-level collaborative agreement between AUT and the DHB, providing authority to approach clinical and public health services. My approach at the service level involved participation in individual and multidisciplinary team meetings. Such engagement opportunities enabled me to provide study information and distribute an information pack containing evidence of ethical approval, locality assessment, study introduction letters for maternity services providers, participant information sheets, and consent forms. Clinical and public health teams were informed of what participation for women would entail, including the format and nature of involvement in the research interview. This comprehensive approach was designed to promote the research and enable the teams to make an informed decision about supporting the research. The research proposition was verbally approved by Te Ātiawa.

Selection of the Participants

I sought advisory group support to identify recruitment methods to involve participants with diverse experiences. My trust-based relationships with Māori and Pacific advisors contributed to establishing authenticity, which refers to approaches used in the design phase of research that lead to a showing of a range of realities in participants' lives (Lincoln & Guba, 1985; Polit & Beck, 2018). My intention was to have a variety of participants that would enable me to capture different experiences and achieve a depth of understanding about maternal women's diverse body experiences in a variety of social contexts. Thus, women labelled as clinically 'overweight' or 'obese' in pregnancy were sought. A variety of recruitment approaches was implemented. First, maternity services, Pacific health services, and Whānau Ora collectives, in

the locality area, were invited to support the recruitment of women. Additionally, clinicians were involved as recruiters and were invited to identify pregnant women to participate in the study. Information packs containing study introduction letters for maternity services providers (Appendix G), participant information sheets (Appendix H), participant consent forms (Appendix I) and recruitment posters (Appendix J) were provided to over 40 lead maternity carers. Simultaneously, approval was requested from the DHB to place marketing material in hospital and community settings. Material was posted on maternity and childbirth, and early parenting education and support agencies' websites and social media platforms. It was intended that this marketing material would also encourage consumers of maternity services to self-refer. The requirement for participants to be registered to receive maternity care at the DHB was applicable to all recruitment approaches.

All participants self-referred to the study; none of the recruitment was done directly by the researcher. As per ethical guidelines for observational studies, incentives were introduced to increase response rates (Ministry of Health, 2012). Accordingly, a $50 grocery, department store, or petrol gift card was offered to each participant as reimbursement for their time and effort. Participants were followed up with an introductory email asking them to confirm if they wished to proceed. All individuals responded to this initial communication and agreed to be interviewed. Consent forms were completed at the time of the interview, following a face-to-face discussion about the nature of the study. In summary, the recruitment plan was implemented as intended. No data were collected on the number of participants approached, how many, and who declined to consent or their reasons for declining, as that was outside the scope of ethical approval.

Recruitment strategies led to a higher response rate than anticipated. Although recruitment ceased after three months, some participants who had received information packs at the beginning of the recruitment phase self-referred later in their pregnancies or following the birth. I was open to keep going, as it was thought at this point that these participants' unique contexts would generate important insights. Accordingly, 16 eligible participants consented to participate in the study during the 26-week recruitment period. While a single interview was intended with each of the women, I modified the data collection process to create an opportunity to conduct follow-up interviews. Where women's stories created an opportunity to understand the phenomena more fully, I chose to linger a little longer, dwelling more completely within the data to uncover the dynamic nature of the phenomena in its changing contexts. Therefore, in accordance with the research methodology, a decision was made to invite a small number of women (n=3) to participate in a follow-up interview to reveal how

meanings might shift and change in and over time, through changing contexts (Vagle, 2014). A rich and diverse group of participants was achieved, and a decision was made to cease data collection following 19 interviews as I was not gaining any new insights and data sufficiency was deemed to have occurred.

My original research intention was to use a multi-method approach involving individual interviews and group interviews across two phases. It was intended that 6-10 single individual interviews would be conducted in phase one of the study. In the second phase, a sample of 15-20 pregnant women and new mothers were to be recruited to participate in a series of group interviews to explore themes arising from initial interviews, as well as the impact of contemporary discourses and health promotion messages designed to improve nutrition and physical activity during pregnancy. Analysis was conducted in an iterative cycle (Sargeant, 2012) and upon reviewing the material gathered in phase one, it was clear the further interviews anticipated in phase two were not required, as more than enough phenomenological material had been gathered. Thus, I decided not to proceed further with data collection. Creating space for phenomena to reveal itself led to a deeper phenomenological exploration of women's lived experiences; representing, "…an extreme form of care that savours the situations described in a slow, meditative way and attends to, even magnifies, all the details" (Wertz, 2005, p. 172).

Overview of the Participants

The study took place in the greater Wellington region. The research was conducted in a naturalistic setting and participants were invited to specify the setting of choice for the interviews. Of the 16 participating women, 10 chose their home setting. Three selected to be interviewed at their workplace and the remaining three in a clinical setting. Participants included English speaking women aged 16 years and older who were labelled as clinically 'overweight' or 'obese', primigravida, multigravida, and women of diverse ages and ethnicities. Many women were living with significant socioeconomic deprivation. Data were ascertained using the NZDep2013 Index of Deprivation (J. Atkinson, Salmond, & Crampton, 2014), an area-based measure of socioeconomic deprivation for people in small areas of Aotearoa New Zealand.

Most women were pregnant at the time of their interview (n=14). Non-pregnant women (n=2) experienced 'overweight' or gestational weight gain in their previous pregnancy. Women used a variety of words and phrases to describe themselves such as: being a big lass, coming from big stock, bootylicious, fat, large, overweight, and obese. Some women identified with the clinical terms 'overweight' and 'obese' and described their bodies in clinically defined ways.

Finding the language to use for this research has been technically and emotionally complicated. I felt empowered to use the words that reflected the personal experiences of the women, and therefore the words and phrases that individual women used to describe their bodies and experiences were reflected in the crafted stories. The characteristics of the women are summarised in Table 2.

Table 2. Participant characteristics

Age	
20-24 years	1
25-29 years	3
30-34 years	5
35+ years	7
Ethnicity	
NZ European	6
NZ Māori	3
Cook Island Māori	1
Samoan	2
Tongan	1
Niuean	1
British	1
Chinese	1
Deprivation Quintile	
1-3 (least deprived)	4
4-5 (most deprived)	12
Parity	
Primipara	4
Parous	12
Pre-pregnancy BMI[3]	
20-24 kg/m^2	1
25-35 kg/m^2	3
35+ kg/m^2	4
Unknown	8

[3] BMI data were recorded where it was known. Māori and Pacific women were less likely to know their pre-pregnancy BMI than other women in the study. All five Pacific women had no or little knowledge of BMI related terminology.

Women received specialist obstetric care (n=10) for medical and obstetric related conditions such as: rhesus disease, twin pregnancy, Graves' disease, and multiple sclerosis. The remaining women (n=6) received midwife-led care. The women attended many different services during pregnancy including midwifery care, specialist endocrinology, physiotherapy, specialist maternal mental health, and dietetic services.

Protection of the Participants

Respect for participants' vulnerabilities was carefully considered. At the outset of this research I have been aware that discussion could generate an emotional response due to the likelihood that, "many phenomena within specific cultural and social context are sensitive" (McCosker, Barnard, & Gerber, 2001, p. 272). Therefore, specific measures were taken to ensure the safety needs of participants. Protection of women's emotional and mental wellbeing was a priority and an agreement with Wellington Women's Health Collective counselling service was established (Appendix K), whereby women could contact the service if required. Contact details of this service were provided so that participants could get in touch directly. Participant confidentiality was critical due to the study being focused in a single locality and the small number of individuals participating. I took a variety of steps to maintain confidentiality. For example, in reproducing participants' verbatim responses, I removed potentially identifiable information and nuances of speech that could identify them from any preliminary interpretation of the data presented and written material within this thesis. A further measure to protect the women participating in this study involved me working closely with my supervisors using a reflect and review approach. During the data gathering stage, I committed to transcribing each interview within three days and providing my supervisors with a copy of the interview transcript, observations, and self-critique of my interviewing skills. Sharing the transcripts and debriefing with my supervisors on any ethical tensions that arose and my strategies for managing these, I relied on them to reflect with me. In doing so, a safe environment was assured for women through the process of continual review of my capabilities as a phenomenological researcher.

Biographical and descriptive data were gathered during the interviews providing a backdrop to uncover key facets of experience and reveal the nuanced and varied aspects of their personal stories. To protect the participants, potentially identifiable aspects of women's unique positionality and their real-world contexts are not included in this thesis. The data, such as transcripts, consent forms, demographic data, and analytical notes, were kept in a secured computer programme. The digital recordings and hard copies were stored securely in a locked filing cabinet, to which only I had access. Assurances were provided to participants that, after

analysis, the data would be stored securely on AUT premises, not on the private computer of the primary researcher, along with the consent forms. Furthermore, women were advised that a pseudonym would be used on all the tapes, transcripts, and reports to protect their identity.

Gathering the Phenomenological Material

Prior to data collection, I used a codesign approach with the advisory group to develop potential phenomenological questions that would help answer the research objectives. Following which, a minimal number of broad, data-generating questions underwent a process of cultural and peer review with a sample of Pacific Navigators and Māori Public Health Advisors with strong community and cultural knowledges. Next, questions were pre-tested with a small sample of Māori and Pacific women who were not included in the study. This process of codesign and pretesting assisted with the development of a core set of culturally sensitive questions and prompts which were then adapted to suit the cultural needs and priorities of participants during the interviews. This process supported the development of a highly contextual topic guide (Appendix L), increasing the trustworthiness of the research.

Key areas associated with women's lived experiences of maternal 'overweight' and 'obesity' in clinical and social contexts were explored in the interview. Participants were invited to describe their experiences of being in larger maternal bodies, and to discuss the meaning of weight-focused advice in the context of their everyday lives and social and cultural practices. The interview was directed towards establishing women's experiences of pregnancy and their understandings of gestational weight gain. The first area of questioning was deliberately broad and then became more focused on women's experiences such as, being referred to secondary care because of a high BMI. The meaning that women attributed to health promotion messaging formed the second part of the question guide. The third area asked the participants to reflect on contextual factors such as whānau, family, cultural, and environmental influences on eating patterns during pregnancy. Finally, demographic data were collected to conclude the interview.

Throughout the data collection phase I continued to dialogue with my preunderstandings, to examine my assumptions of what seems 'normal' based on my own positionality in the research. For example, one of my preunderstandings focused on my assumptions surrounding the relevance of the BMI for pregnant women. In my post-reflexion journal, I recorded my preunderstandings relating to the BMI and its meaning for pregnant women. Before gathering data, I assumed that all women would be familiar with the term because the measure of the BMI for assessing risk is a well-established aspect of pregnancy care in Aotearoa New Zealand

(Knox et al., 2018). Furthermore, as women were informed the purpose of the research was to explore experiences of 'overweight' and 'obesity' in pregnancy my assumption was that women would be ready to discuss weight related issues. I created the interview question: "How did your midwife or doctor talk with you about your weight or BMI?" to explore women's experiences of being asked about their BMI. The following extract shows how I brought my preunderstandings to the fore throughout working with the data; and, subsequently, modified my approach to data collection to remain open to the range of realities:

> When the Pacific nurse referred Teuili, she told me Teuili was very shy. Because of my experience with some Pacific women, and the possible sensitivities about asking Pacific women about their weight, I asked the nurse for her advice on how to approach further discussions. The nurse indicated that it would be very difficult for women to disclose their weight in an interview and recommended that I consider the following way to rephrase the question: "Obviously, when you are pregnant you can gain weight and sometimes it can be challenging to return to your weight before you became pregnant, especially if you have more than one child. Can you tell me about your weight before you became pregnant? Did you struggle with weight problems"?
>
> Following a period of dwelling in the data, and dialoguing with others, I came to see that for some Pacific women weight may not be an issue per se. Rather, it was likely that weight was an issue in a western healthcare context. When I asked Teuili if she could tell me about her weight before she became pregnant, she appeared to brush off the question, saying, "no, no". I felt that Teuili found it intrusive being asked about her weight. Weight did not appear to hold meaning for her; whereas protecting her baby through moving her body held significance and constituted the main features of Teuili's storytelling. My aim was to be reflexive about how I was approaching the participants.

This post-reflexion extract shows that through mindful attunement to what participants connect and disconnect with (Vagle, 2018), I was able to refocus questions. Thus, I made a decision to move away from more biomedical framings of questions, instead capturing women's perspectives about what was important to them in relation to pregnancy health.

The tape-recorded sections of the interviews which focused on gathering lived experiences material ranged from 17 to 47 minutes in length. The whole interview took considerably longer, particularly as whakawhanaungatanga and other culturally appropriate ways to build relationships with the women were prioritised before the tape-recorder was used.

Transcription was undertaken personally, by me, as a way of familiarising myself with the data. Thus, transcribing became an interpretive act which conferred significant analytical benefits through repeated and careful listening (Bailey, 2008). The participants were advised of their right to check and modify the transcript; and transcripts were shared with participants where they requested a copy. The purpose of inviting participants to review the transcripts was to improve accuracy and validity of what had been recorded during the interview. Additionally, I encouraged the participants to extend the data, providing additional content, which is congruent with post-intentional phenomenological research.

Analysis of the Phenomenological Material

Whole-part-whole Method.

A whole-part-whole analysis method which involves analysis of focal meanings (i.e., moments) in relation to the whole (i.e., broader context) was utilised in this study (Vagle, 2014, 2018). Cautioning against an overly mechanistic approach to analysis, Vagle (2018) encouraged more fluid and creative analytical techniques. Given Vagle's evolving understandings of post-intentional phenomenology I was able to work across his earlier and later conceptualising as a guide to analyse the phenomenological material. While Vagle referred to 'parts', once analysis began the parts were not discrete; rather, they started to blend together.

The initial phase involved becoming attuned to the whole material gathering event and involved a holistic reading of the entire transcript. The goal at this point was to unravel the wholes of the phenomenological material. Vagle (2018) contended, "the most useful way to carry out this part of the process is to operationalise Deleuze and Guattari's (1987) philosophical idea - lines of flight" (p. 157), looking for two kinds of analytical noticings. Following this guidance involved me first looking for ways that knowledge explodes in unanticipated ways. Reviewing the transcripts, preliminary analyses, and my post-reflexive journal, I considered questions, such as: "What doesn't seem to fit? If I follow this 'mis-fit' notion, idea, insight, perspective, what might I learn about the phenomenon that is not yet think-able?" (Vagle, 2018, p. 157). The second noticing related to how to differentiate between the lines of flight operating on us and the phenomenon. Here, I used Vagle's suggested questions as I conducted readings of the data: "Where might I appear 'certain' of what something means? Where might I appear 'uncertain' of what something means? Where might I have extended to something creative and intriguing, but then backed off to something a bit more safe?" (p. 158).

Sometimes a single word or phrase, from a participant, was so powerful that it needed to be amplified, such as Pania's descriptive statement, "I felt like a robot". I conducted multiple line-

by-line readings, including careful notetaking and signposting the data that seemed to focus initial meanings (Vagle, 2014) and asking myself questions of the data, as well as putting my supervisors' understandings into play with my own initial interpretations. I highlighted the parts of the data that appeared to be complex or contradictory; I knew that I could not overlook the complexity but had to dwell for longer here (e.g., did the woman experience stigma in secondary care or did she fear a stigmatising encounter)?

Focusing on Intentionality.

I took a systematic approach to describe the object of the intentional relationships, show what was happening, and reveal the woman's experiences. In accordance with post-intentional phenomenology, it was important to describe both the experience and the multiple contexts– including macro contexts (i.e., social environment, ethnic group) and micro contexts (i.e., the meaning of being bedridden or the significance of the bed-as-object in secondary care). Analysis focused on uncovering the intentional relationships between the woman and others and subjects she encountered. I worked with the data in a systematic way, carefully revising and re-crafting each whole and part, continually putting them in dialogue with other chunks of texts from other participants in other data moments (Vagle, 2014) to see what the phenomenon might become.

I read each of the transcripts and reflection sheets in the same way, paying attention to where I might have missed opportunities to more deeply understand the phenomenon so that I could bring the insights forward to the next interview. In this way, I used a form of iteration, incorporating what I learned about the phenomenon at the beginning stage of the research into the next interviews. The insights generated through the use of iterative techniques enabled me to craft additional questions or reframe the ways I asked questions. For example, from listening to women describe how their experiences and understandings differed from one pregnancy to the next, or how their experiences were changing from early pregnancy to later pregnancy, I came to understand that a follow-up interview might be important to more clearly reveal how the phenomena is being and becoming through the multiple and diverse contexts of the women. Thus, the insights obtained through the use of iteration guided my decision to conduct follow-up interviews with some of the women.

Thinking with Theory.

The second part involved thinking with theory. In the design stage of the study, I made a choice to think with Young's (1990) feminist theory and ideas as I intuitively felt that a feminist lens would be important to this inquiry. Then, in the analysis stage, I decided that Young's theory alone would be insufficient to help me extend and open-up phenomena in important ways

(Vagle, 2018). Based on the complexity of the data, I made a specific choice to think with other theories to explain the data more fully, showing both meanings being uncovered, and, more importantly, how women responded in complex contexts. Introducing theories of distressed embodiment (Leder, 2004, 2016) and salutogenic understandings of wellbeing (Antonovsky, 1979) became pivotal for providing an explanatory framework through which to show the experiences of women. Part of what was valuable about this process is the showing of what women do, thereby elucidating the grey.

Post-reflexing.

Post-reflexing was a primary aspect of my analysis process. The system I created to enable post-reflexing saw me develop a written reflection sheet (Appendix M) for each participant, which I then formed into a journal as my post-reflexing deepened. Reflecting on the interview with Lily, for example, I recorded my observations and reconsidered my approach to asking questions. Throughout the interview I had a felt sense I had approached questions from more of a general qualitative approach rather than a phenomenological approach. The consistent use of this tool supported me to capture my broader observations following each interview and informed the analytical process. For every participant, I recorded my immediate reflections on the interview, making notes on initial thinking that may contribute to the phenomenological text. I recorded my assumptions about the data and engaged in self-review of my approach as an interviewer to hone my craft as I moved through the interviews. When my supervisors reviewed the transcripts, they would also record their own understandings of what the experiences were for the woman. In this way, journaling became a source of material for developing the crafted stories, and sometimes poetry. Using my reflection sheets, I worked across the transcripts and my reflections to pull out the parts that appeared to hold initial meanings. I continually referred to the reflection tools throughout this process to critically consider how my presuppositions might influence the analysis. This process of continual review and reflection enabled me to hone my interviewing craft as I proceeded to interview other women.

Crafting the Stories.

The final component of the analysis process involved crafting stories to uncover all the possible and multiple phenomena in women's stories; thereby, revealing the tentative manifestations of the intentional relationships. Arguing that "crafted stories can provide glimpses of phenomena that other forms of data analysis and presentation may leave hidden" (Crowther, Ironside, Spence, & Smythe, 2016, p. 826), the authors urged us to consider crafted stories as a trustworthy methodological tool for capturing lived experiences. Crowther et al.'s (2016)

practical framework was used “to reveal ways of being, thinking and acting in the world that shed light on what is known but covered over, or forgotten” (Crowther et al., 2016, p. 827). van Manen (2014) claimed the story can be crafted in fiction-based or real ways. In this study the crafted stories were closely informed by the data to represent women’s actual lived experiences. Given the importance of staying close to the data, I chose to craft individual stories rather than blending stories from several lived experiences. I began free writing the stories, writing around the significant interpretations that arose from the data and looking for the unnoticed and listening for the particulars of the experiences that were not based on repetition. I honoured each woman’s personal narrative, showing the ‘difference’ across women’s narratives and, in doing so, illuminating the diversity and complexity of women’s different contexts. Where the data reflected extremely rich and detailed human experiences, multiple stories were crafted for these participants. Women’s stories were interspersed throughout the chapters as, oftentimes, their stories related to more than one of the tentative manifestations produced through this inquiry. Twenty stories were crafted and included in the tentative manifestation chapters. Where phenomenological material was considered not relevant to the research question, it was included in Appendix N to acknowledge this participant’s personal story.

The following excerpt of data, from Pania’s story, provides an outline of the steps taken to uncover and analyse the tentative manifestations. The interpretive process based on the conceptual framework for the crafting of the stories in the previous chapter reveals how disconnection was produced in a mechanised caring context. The interpretive process as shown in Table 3 involved asking questions:

- What was happening here (i.e., how was the topic lived out)?
- What was the woman’s connection with the world and what meaning did this have for her?
- How did the connections manifest?

Table 3. Interpretative process - Pania’s experience of machinelike care

How the topic is lived out	Pania’s intentional relationships (interconnectedness)	Tentative manifestations of the connection(s)
These appointments didn’t benefit me. They are the ones who benefit; they must get money for having so many meetings with you. I didn’t get any reassurance. Pregnancy is a unique and scary thing because your body is going through so many changes. When I got weighed my midwife wrote down the weight. I stood there aghast	Reliving the same experience over and over again provoked a disconnection from her midwife, her connection with her midwife	Groundhog Day (Ramis, 1993) experience - the experience of feeling like a human robot manifested.

How the topic is lived out	Pania's intentional relationships (interconnectedness)	Tentative manifestations of the connection(s)
thinking, 'WOW, she never said anything'; then a million things started running through my mind. It would have been nice to have a conversation about what's going on with my body, instead I felt like just another pregnant person waiting-in-line. I just felt like a robot to be honest. I know exactly what is going to happen each time. She measures me, she puts the little device on to check the baby's heartbeat, then we get weighed. She asks, 'is everything alright'? I say, 'yes'. She says, 'any questions'? I say, 'no'. As I go out the door, she tells me, 'have a nice day'. I come back the next week and we do the same thing all over again. Maybe most women know what to ask, but if you don't know what to ask you don't ask. I wondered why it happens like this but then I think the midwife is the professional so this must be how it goes.	derailed by the demands of the system. A feeling of strangeness and being othered under the alienating gaze of her midwife. The dehumanised space inhibited connection between Pania and her midwife – the relationship lacked authenticity and caring.	Within this automated care context, her body became an object body – the manifestation of vulnerability became evident when Pania's emotional and bodily needs were not met. Disruptions and disconnections manifested when Pania experienced automated patterns of care – tensions arose when Pania's taken for granted assumptions of care as relational were not met.

In the above example, the interpretation process showed that where the care relationship is focused on processing the maternal body, connectedness is perhaps not always possible in procedural-driven care contexts.

The analysis framework was consistently applied to the crafting process, and thus I was able to move from description into uncovering the intentional relationships to reveal the phenomenon. In doing so, it shows the analytical steps from the raw data to claims made in the analysis which led to conclusions drawn. I consider my interpretations are warranted, as here, I relied on my supervisors to read the transcripts and review my interpretations of the intentional relationships and tentative manifestations; providing feedback that they shared my sense that the interpretation fits with the data.

Once the stories were crafted the next steps involved reviewing the texts to identify the tentative manifestations of the phenomenon. When the tentative manifestations appeared, I gave them titles. I considered the different ways to organise the texts to reflect the overall story of the thesis. My struggle with thinking about the shape I wanted to communicate was evident and I spent considerable time producing and re-producing the shape of the story. While appreciating that the putting together of the whole story would hardly be clean, a tension was still evident in this thesis as I sought to round things off in more complete ways. Yet, in post-

intentional phenomenological research, Vagle (2018) explained that this, “might look a bit more irregular, and a bit less neat and clean” (p. 160) than hermeneutic phenomenology. Thus, the reader may experience a sense of the analysis in the following chapters being partial and incomplete – even leaving the reader wondering why the findings were not tied together more. Living with this tension is part of the process of post-intentional ways of doing phenomenology; leaving room for others to dialogue with the texts, re-engaging the phenomenon to see what might become of it.

Challenges Encountered in Doing Post-intentional Phenomenology.

At times, the analysis felt overwhelming even though Vagle (2014, 2018) provided a gift to the literature through the detailed whole-part-whole guidance. Engaging with phenomenology for the first time I encountered difficulty in finding ways of working with the data. Based on my sense of comfort with generalised thematic analysis methods that I had used in earlier post-graduate research, I began the process by identifying a list of categories which I then merged to find a way to begin to represent the phenomenon. After developing 112 categories, I realised these categories were about the ‘what’. In other words, the categories represented the things women constructed and how the things appeared to women. I had focused on what the things represented for women, such as ‘what’ these women described and ‘what’ they saw as being represented by things and others. To make my analysis congruent with post-intentional phenomenology I reflected that I needed to make a shift that involved moving away from focusing on ‘what’ to reveal ‘how’ things were being and becoming for women. Noticing I had lost my way, I returned to Vagle’s post-intentional texts where I was reminded that the goal of post-intentional analysis was to examine how meanings come-to-be in relation to things and others. Being careful to enter a dialogue with the meanings, I sought to avoid describing the essence of these meanings. Vagle (2014) described theme identification as a tool to support analysis rather than the goal of analysis. Following this advice, I attempted to return to the whole-part-whole process but was soon overwhelmed again with the volume of phenomenological material and a need to find a way to make sense of the data.

A further challenge related to my urgency to more swiftly uncover the tentative manifestations; thus, my initial analysis focused on the whole, rather than moving between the whole-part-whole as suggested by Vagle (2014). Neglecting the parts meant it was difficult to uncover what was happening for the woman and look for the tentative manifestations. Post-reflexing with my supervisors I uncovered that I had not “spent enough time paddling in the shallows before wading into the deep” (J. McAra-Couper, personal communication, July 27, 2018). This factor contributed to my difficulty in staying close to the data. My initial tendency to “jump to the next level too quickly” (J. McAra-Couper, personal communication, July 27,

2018) could potentially have resulted in analyses which were not grounded in the data in a post-reflexive way. Returning to Vagle's core idea that phenomenology is a way of living, which suggests looking at what we usually look through (Sokolowski, 2000), I was prompted that to do phenomenology necessitates a need for presence, in other words:

> …to leave no stone unturned; to slow down in order to open up; to dwell with our surroundings amid the harried pace we may keep; to remain open; to know that there is 'never nothing' going on. (Vagle, 2018, p. xii)

The potential for incongruence, by not paddling in the shallow end of knowledge generation, was turned to an advantage and saw me resolve the incongruity through developing a more detailed approach to analysis which was needed to reveal the tentative manifestations and engage the productions and provocations of the post-intentional phenomena in different moments, situations, and contexts. Using Vagle's (2014, 2018) whole-part-whole approach to guide the analysis, I modified the approach to include specific analysis protocols when challenges were encountered in uncovering the interconnected meanings for women. One such example to enhance trustworthiness involved taking a shared approach to analysis with my supervisors. Independent of each other, my supervisors and I undertook analysis of one participant's story to test the process; after which, we conceded that the process constituted a robust and trustworthy approach to analysis and interpretation. Thereafter, this process was applied consistently to my crafting of each participant's story, with my supervisors acting in a review role to ensure my interpretation was not based on my own preferences and viewpoints but was grounded in the data.

Trustworthiness in this Study

Trustworthiness, or rigour, of qualitative research is crucial to integrity of the findings through processes that uphold valid interpretations of the data (Cope, 2014). Trustworthiness is necessary (Connelly, 2016) but there is no clear consensus regarding what constitutes trustworthiness (Leung, 2015); leading to several definitions and criteria for evaluating the concept (Carcary, 2009; Koch & Harrington, 1998; Korstjens & Moser, 2018; Rodham, Fox, & Doran, 2015). Various terms are used in parallel with trustworthiness, including 'validity' (Vagle, 2014, 2018) and 'relevance' (M. Freeman, deMarrais, Preissle, Roulston, & St. Pierre, 2007).

Since post-intentional phenomenology incorporates elements of post-structural thinking into traditional methods, there is perhaps an even greater need to demonstrate the trustworthiness of this flexible and fluid method. As, "the 'work' of post-intentional phenomenology takes place along the hyphen, the jagged edges of phenomenology and post-

structuralist ideas, where stories are in flux" (Vagle, 2018, p. 126), it is important to demonstrate the trustworthiness of the analysis presented. For Vagle (2018), discussion of validity is, "marked primarily by a consideration of the researcher's sustained engagement with the phenomenon and the participants who have experienced the phenomenon" (p. 72), requiring the researcher to be open to the changing nature of the phenomenon throughout all phases of the study.

The hallmark criteria outlined by Lincoln and Guba (1985)—credibility, dependability, confirmability, transferability, and authenticity—are considered anchors of trustworthiness (Connelly, 2016). Additional considerations exist, such as reflexivity (Korstjens & Moser, 2018), which are integral to quality of qualitative research. Practical strategies to enhance trustworthiness were selected to fit the post-intentional phenomenological design.

> To be judged valid, a phenomenological study must take into consideration methodological congruence (rigorous and appropriate procedures) and experiential concerns that provide insight in terms of plausibility and illumination about a specific phenomenon. (Pereira, 2012, p. 19)

In accordance with the philosophical-methodological understandings in this inquiry my approach was dialogic from the beginning. Vagle's (2014, 2018) notion of post-intentional phenomenology as dialectic enhanced trustworthiness of this study. First, to establish confirmability; that is, "…the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning" (Elo et al., 2014, p. 2), I dialogued with my supervisors to determine the potential for congruence in the data. This process was ongoing throughout the data gathering, analysis, and development of the tentative manifestation chapters. The primary method involved my supervisors and me working independently to review raw data and preliminary analyses through applying the conceptual framework for the crafting of the stories (Figure 2). Using this diverge-and-converge collaboration approach, we worked separately to produce individual interpretations before coming together to discuss emerging insights and potential lines of flight.

Second, peer-debriefing with cultural and clinical advisors was significant to this study. After initial interpretation of the data, I tested the worth of my analysis with the cultural and clinical advisors in the study. This helped me consider alternative ways of looking at the data to see how lines of flight could be amplified even further. I applied peer-debriefing as a technique to enable the co-creation of Māori and Pacific traditional knowledge. Peer debriefing involved working with cultural advisors to provide debrief and feedback on parts of the research process. This technique helped me become further aware of my views regarding the data,

enabling a more complete uncovering of my position in the research and how this positioning might come to bear on the various stages of the research process (Nguyễn & Su'O'Ng, 2008). I was seeking to understand Māori and Pacific peoples' perspectives on the data as I was mindful that misinterpreted data can not only undermine the quality of research but has the potential to demean the cultural identity of women and families in the study. As an outsider researcher, I had ethical and moral obligations to protect research participants and avoid unsafe practices. Given the stories revealed information about Māori and Pacific women's motivations, values, and behaviours, it was critical to incorporate techniques for collecting valid information to help ensure the sacredness of their stories and protect women's cultural identity and values.

I selected two peer debriefers with whom I had trust-based professional relationships. I provided them with early drafts of crafted phenomenological stories, together with an overview of the research methodology, to support them to comment on the data with a Māori and Pacific lens. Thus, the crafted stories were put in dialogue with peer debriefers' understanding of the phenomena, asking, "What are the interconnected meanings that come into being for the women as they engage with others and things in the world?" The debriefers were asked to provide oral and written commentary and agreed to share feedback on the meaningfulness of the stories, trustworthiness of the data, under-emphasised or superficially analysed points and over-emphasised moments in the data and potential biases or assumptions. A post-reflexion journal extract is provided in Appendix O.

Debriefing with clinical advisors, to discuss complex concepts related to clinical midwifery practice, was also important to maintaining trustworthiness. Sharing sections of my preliminary analyses with midwives to confirm my interpretation of some issues, particularly around aspects of clinical midwifery, I attempted to deepen my understanding of aspects related to contemporary midwifery practice. For example, from some of the women's narratives it was revealed that midwives were using social terms, such as 'voluptuous' to describe women. Through dialoguing with one clinical advisor, who was familiar with phenomenological methodologies, I came to understand that use of voluptuous language may have been provoked by midwifery protectionism and that many midwives use words other than 'overweight' with women.

A further strategy to maintain reflexivity involved me sharing the crafted stories with wider audiences. Dialoguing with wider audiences often called my earlier understanding of the topic into question, further strengthening the trustworthiness of findings. I presented the research methodology, methods, and preliminary findings to a variety of disciplinary groups and sought feedback on the relevance and meaning of the phenomenological material. Over the duration

of the study, I have contributed to conferences (Appendix P), including Counties Manukau, Obstetrics and Gynaecology Women's Health Day, a New Zealand College of Midwives (NZCOM) national conference, NZCOM regional meetings, an AUT Centre for Midwifery and Women's Health Symposia, a Victoria University of Wellington Research Day, as well as maternity forums involving clinicians and consumers, and multiple midwifery, dietetic and public health professional practice meetings. Towards the completion of the analysis phase, a voice actor was commissioned to narrate the women's stories which created a more powerful medium, enhancing the opportunities for audiences to engage and feedback on the data, while still honouring the women's stories. As stated by van Manen (2002) a sudden silence can occur when phenomenological texts are read aloud, as if listeners have been drawn into textual meaning and are struck with perplexity. Sharing the crafted stories at a maternity consultation forum appeared to have a similar effect:

> The audience was silent; they did not know what to say. Real life stories give meaning to an issue. Hearing this story made everyone in the room pause and think about the issue from the woman's perspective and how we can avoid this thing called 'fat shaming'. (N. Jackson, personal communication, December 2, 2018)

Nicky explained there was a sense of sadness and disappointment that midwifery could do better by these women. According to Nicky, the effect of my text gave meaning to the issue. The audience connected with the story at an emotional level; they responded with silence and deep reflection.

I also led small group discussions with midwives to share findings to inform the development of midwifery-led services. Each time I engaged others or presented findings, I analysed the feedback seeking ways to extend my interpretation of the phenomena, making the analysis more rigorous. Finally, I led an international collaborative writing project, involving my supervisors and a scholar at Robert Gordon University in Scotland. This project culminated in a peer reviewed publication (Knox et al., 2018) (Appendix Q). Such opportunities showed the importance of research on enabling practice in both midwifery and dietetics and added to the confirmability of the study through seeing me develop the analysis in a manner which was responsive to the circulating practice issues and policy contexts. The study's transferability was supported through providing a rich description of participants' characteristics (Connelly, 2016); and by being transparent about participants' social, cultural, and clinical contexts. Amankwaa (2016) contended transferability can be enhanced through approaches, such as these, that can resonate with others.

Following the publication of Benade's (2016) work, in which he applied Vagle's post-intentional phenomenological approach in the field of education research, I initiated a meeting with Associate Professor Leon Benade to discuss his experience of applying the methodology. At the same time, I presented the method applied in the current study and sought feedback to increase the likelihood of achieving methodological congruence, thereby enhancing dependability of this study.

Chapter Summary

This chapter has described the steps that were taken, guided by Vagle's (2014, 2018) philosophical underpinnings, to best uncover all the possible and multiple phenomena in women's stories. This chapter shows the challenges I encountered using post-intentional phenomenological analysis, as I strived to operationalise Vagle's philosophical concepts. Techniques for demonstrating trustworthiness were woven throughout this chapter. The next chapter will introduce the contextualised and tentative manifestations revealed through this investigation.

CHAPTER FIVE: INTRODUCTION TO THE TENTATIVE MANIFESTATIONS

Chapters six to eight, present the contextualised and tentative manifestations revealed through this study. The findings are presented in a way that reflects the methodological processes of post-intentional phenomenology and are thus referred to as tentative manifestations. The stories I have chosen to include in these chapters reflect one of the possible ways to craft post-intentional phenomenological texts. The post-intentional assumptions of the phenomenon taking shape and being produced and provoked reflects the way I have organised the text. I attempted to find a form that reflected the 'take shape' concept; and, in doing so, I wrote around and through the grey areas to amplify the explosive lines of flight (Vagle, 2018). Thus, the post-intentional texts are organised by the shape I wanted to communicate (Vagle, 2014, 2018).

The goal was to have the stories serve as difference narratives, rather than centering narratives (Vagle, 2015). During this process of crafting, my intention was not to capture the essence of the phenomena, but to craft in a way in which was congruent with post-intentional phenomenology. The ways in which I have chosen to present the data show my explicit commitment to allowing the phenomena to reveal itself within the women's unique contexts—the spaces, places, embodiments, situations, and moments, all of which were partial and fleeting in participants' lives. The micro-contexts and unique nuances are revealed in the individual crafted stories. Presenting the data as individual narratives enabled ways to engage the minutiae of the data to discover possible meanings (Finlay, 2014), in a fuller and more intensive way than interspersing women's narratives around central themes. Titles were given to the stories that reflected the content of the phenomenological text and guided the crafting. As far as possible, titles revealed something unexpected or inherently unique to the story. I developed the habit of thinking contextually during the writing process as I sought to illuminate the depth and complexity of women's lives.

Cheng (2019) reminded us that we often uncover a multitude of things that are more complex than we will ever really know:

> Just being alive means acknowledging the seen and at times having to trust in the unseen: what is visible is not always the full picture, and what is beneath the surface can speak volumes. (para. 1)

To understand the ways meanings came to be for women I played, "with and among philosophies/theories/ideas to see what might come of such playfulness" (Vagle, 2018, p. 124).

As discussed more fully in chapter three, I drew on theories of pregnant embodiment (I. M. Young, 1980, 1990), distressed embodiment (Leder, 2004, 2016), and salutogenic understandings of health (Antonovsky, 1979) to expose the edges where women found-themselves-intentionally in relations with the world (Vagle, 2018). These theories and ideas are woven throughout the tentative manifestations chapters to support the explanation of the findings and show the "multiple meanings already in motion" (Vagle, 2018, p. 34). Though it was important to situate the present study within theoretical discussions found in health promotion, midwifery, and critical feminist literature, I did not base initial descriptions and interpretations on pre-defined concepts and frameworks. Rather, I allowed the tentative manifestations to reveal themselves before conducting a full and comprehensive review of the literature.

Putting phenomenology into dialogue with the aforementioned theorists led to the stories taking on an unexpected, yet natural evolution. It was my intention to invite people in, bringing a need of knowing more, wanting "a calm understanding to be felt, despite what may never be known" (Cheng, 2019, para. 2); and, like Cheng (2019), my goal was "to find more possibility in the intangible and allow for it to come into its own" (para. 2). Thus, I approached all the stories with great intention. I did not design or plan the frameworks on which to hang the stories. It all happened in the moment of crafting. Sometimes, I had to re-read, read aloud, and re-write. Overall, this approach to crafting the stories added a playfulness and experimentation to the texts that could not be achieved from more structured approaches. Patience and openness during the writing process led to the phenomena revealing its own complexity (K. Dahlberg et al., 2008).

The terms 'productions' and 'provocations' influenced how I crafted the stories and became a central feature in helping me illuminate unique nuances about the phenomenon. The stories show the ways in which the phenomenon is shaped through time and continue to be produced and reproduced. When considering the data as a whole, three tentative manifestations were formed by several experiential manifestations found throughout the narratives. These were: *connectedness and comfort*, *disconnection and disruption*, and *disruption to being-in-disease*. The tentative manifestations presented in the following chapters capture the complexities of women's experiences, including concepts of embodiment during pregnancy and the competing narratives circulating in social and maternity care contexts.

Women's experiences of their maternal bodies were shaped, produced, and provoked by contexts in which the phenomena shifted and changed. Contextual factors exerted powerful forces which, in turn, shaped, produced, and provoked meaning for women. The crafted stories

uncovered a multiplicity of forces, of varying intensity, which called women towards moments, situations, and contexts in a given situation. The broader, or macro, context represented a significant shaper of the phenomenon and included negative ideologies surrounding large maternal bodies and dominant risk-focused narratives and decontextualised health policies. Powerful contextual factors influenced women's experiences and the meaning women attributed to being in diverse maternal bodies.

Findings from the current study are congruent with a salutogenic approach, which recognises wellbeing as located somewhere on a continuum, with health/ease and disease/dis-ease at opposite ends (Antonovsky, 1979). In contrast to Antonovsky's linear concept of continuum, Figure 3 conceptually represents the positive (H+) and negative (H-) influences at play in a variety of contexts in the system and in women's experiences of the system. In this figure, the dark blue line represents the fluid and morphing manner of the continuum, communicating how women's experiences of ease/dis-ease is not linear.

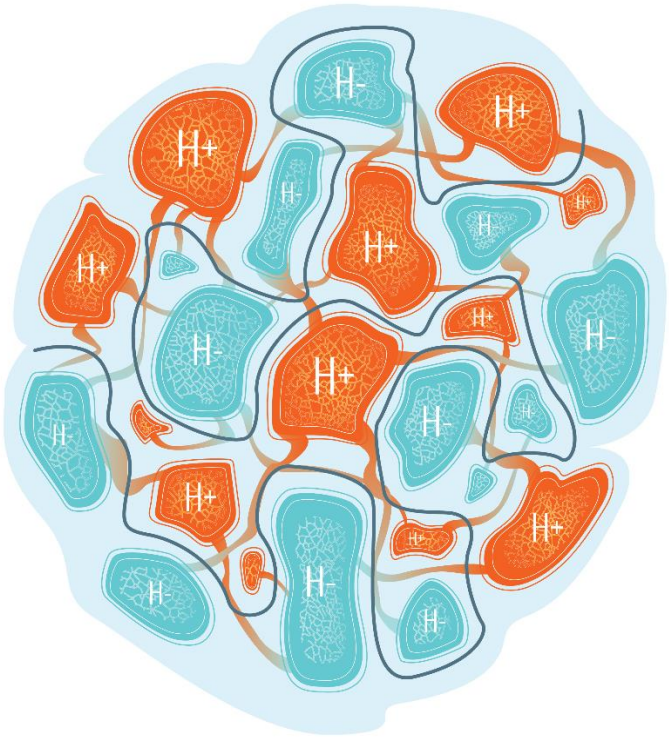


Figure 3. Post-structural continuum construct: Ease/dis-ease

Figure 3 reflects a post-structural notion, showing the endlessly deferred, continual influences on the phenomenon in response to contexts which provoke and produce women's responses. Rather than parallel movement across the continuum, from a post-structural perspective movement on the continuum is non-parallel as women move in and through contexts. Thus, experiences of ease/dis-ease are affected through multiple interacting levels. This re-

production of Antonovsky's continuum reflects what could be described as a post-structural model, suggesting that women's experiences of health and dis-ease were continuously forming and reforming. Furthermore, the assumptions and beliefs that underpin behaviour and structure of contemporary healthcare were revealed as influencing factors which shaped women's experiences. In some of the women's accounts, their perspectives can be seen to suddenly shift, or at least can be compared to an earlier, different perspective they held. The interplay of societal ideologies and maternity's watchful, yet critical, gaze, appeared to throw women into a deep, reflexive awareness about the meaning of being pregnant in clinically defined 'overweight' and 'obese' bodies.

The strong mechanistic worldview in maternity, with its dominant weight management policies and risk-focused health promotion constituted a powerful force. Some women appeared to resist maternity's mechanistic view of the body. These women actively and intentionally resisted, to varying degrees, societal ideologies and maternity's medicalisation of pregnancy. Amidst disruption, these women rejected the mechanistic view and asserted their agency to act against those forces (macro contexts, situations, and moments of influence) to shape their own health experiences. In these contexts, women felt a deeper sense of (un)disrupted integrity and experienced a strong sense of coherence (Antonovsky, 1996) which helped them activate resources to manage conflict. Seemingly rejecting medicine's view of the body, these women privileged cultural, social, and spiritual ways of being to mediate disruption. Finding meaning in harmonising relationships and contexts helped women connect intentionally and more meaningfully with self, others, and things in the world. These women experienced a deeper sense of control over their bodies through self-expression and self-determination; and for some, their resistance to dominant ideologies perhaps represented a move towards normalising types of bodies and experiences.

Some women seemed resistant to the biomedical paradigm, yet others appeared to understand their own lives within the context of the biomedical paradigm. These women's stories tell of a system of maternity care that increased disruption and disconnection. The biomedical model of care in maternity, which is focused on fixing, controlling and surveillance of the maternal body, pushed women towards dis-ease and distress-oriented ways of being. For these women, the 'expert' based biomedical paradigm framed health in negative ways. Young's (1990) account of women's experiences of pregnancy demonstrates that within biomedical contexts, women's maternal body experiences are merely peripheral; their perspectives are not given authority, neglecting the embodied knowledge and feelings of the woman. For women who moved from disruption to being-in-dis-ease, the related feelings of

being looked at with a fixed clinical gaze triggered feelings of helplessness, needing to thicken the skin, and a sudden sensation of being in a 'problem' body. The feeling of subjectivity and alienation frequently occurred in (un)caring secondary care contexts; ambiguities of the lived body were a common phenomenon. These women experienced less control, and their choices were constrained by medicalised ways of seeing the world. Thus, the expertise of maternity shaped many of the women's life events and experiences in negative ways.

CHAPTER SIX: CONNECTEDNESS AND COMFORT

A tentative manifestation of the interconnected meanings that came into being for ethnically diverse women was connectedness and comfort. The supports that women needed to achieve wellbeing aspirations—social relationships, cultural understandings, meaning in life, and humanised care—appeared to have salutary effects on women; provoking meaningful experiences of positive health in challenging situations and contexts. Health was not only biomedical; these women viewed their experiences through a salutary lens.

Salutary factors were driven by women to reframe distressing narratives and life events to achieve harmony and wellbeing. While, comfort and discomfort co-existed uneasily, some women were orientated towards salutogenic ways of seeing (Antonovsky, 1979). In other words, their salutogenic drive, their life force (Macdonald, 2005), led to more harmonising ways of experiencing the world; and, subsequently, a more easeful experience of being-in-the-world manifested. The ways in which connectivity between themselves, their experiences, and social histories (Downe & McCourt, 2008) manifested are described in this chapter. Women's personal narratives reflect the meaning of being cared for and connectedness with others, pointing to differential understandings of wellbeing. The stories reflect how salutary benefits manifested for women when they experienced authentic forms of caring and connectedness. Salutary contexts took on particular importance for women, helping restore their orientation to the world and make a more easeful transition to pregnancy and motherhood. The high-level tentative manifestations revealed, and the meanings uncovered for women in this chapter are illustrated in Appendix R.

The eight crafted stories in this chapter show how women utilised their environmental supports and cultural understandings of the body to find meaning in their experiences and help them manage disruption and disconnection to take a more positive approach to challenging pregnancy situations. Silivia's stories tell of a larger span of her life, as she reflected on a younger self. Silivia's first story uncovers her experience of finding a deep harmony and joy from being in a bootylicious body. Then, nostalgic connections related to food traditions and being with others are unravelled in two more stories by Silivia. Similarly, Nina's story speaks of comforting memories linked to place and the social aspects of food. Next, in La'ei's account, the experience of connectedness that emanated from spirituality and mothering is revealed. The experience of connectedness, through being cared for by others, is shown in the following two stories by Alisi and Pania. The final story illuminates Natasha's experience of connecting with weight-focused advice which led to meaningful change.

Silivia: Bootylicious Bodies

Silivia talks of her experience of bodily connectedness as she reflected on the natural, yet magical, experience of growing a baby. For Silivia, being pregnant in a large body brought happiness and contentment; transcendence in the physical and bodily context was evident. Wellbeing manifested for Silivia from her cultural values and acceptance of her body. Her noticing of Pacific female bodies brought harmony into near awareness. Silivia described pregnancy's transformation of the body; a body which aspired to beauty and producing love. Reluctant to use the word 'overweight' to describe the genetic characteristics of her people, Silivia introduced a linguistic strategy in which she foregrounded the sensuous, bootylicious qualities of large maternal bodies, turning away from contemporary portrayals of 'overweight':

> *Looking at the gene factor, being Pacific, there is overweightness, or shall we say bootylicious overweightness! In Pacific culture big is good. You know, big is beautiful especially when you are carrying your baby. Our Pacific pregnant women look so beautiful, they truly honestly do. From their skin to their hair, they look so au naturel because their body is doing its magic.*

Silivia's artistic expression of overweightness revealed her noticing of Pacific women's admiration for their bodies. Silivia also thought that being pregnant meant that women felt even more beautiful due to their growing bodies. This story calls us to share Silivia's deep held belief in the body's capacity to do what must be done. Young's (1990) writings on female body experience suggested:

> We often experience our bodies as a fragile encumbrance, rather than the media for the enactment of our aims. We feel as though we must have our attention directed upon our bodies to make sure they are doing what we wish them to do, rather than paying attention to what we want to do through our bodies. (pp. 146-147)

Silivia's experience did not arrive at the same point as Young's (1990) generalisation of western women, in that Silivia did not underestimate her female bodily capacity. Rather than being surprised at what the female body could accomplish, Silivia joyously related to the body as a magical and wondrous thing which is physically capable of accomplishing its task. Thus, the big, beautiful bodies of Pacific maternal women became the object of Silivia's philosophical reflection.

Silivia's story was devoid of concern for the body; rather, it spoke of the body as "trustworthy and in remaining intact through the ambiguities and ambivalences of human existence" (Trigg, 2017, p. 107). Silivia equated a large maternal body with a healthy body, which gave her a sense

of bodily certainty. Thus, finding comfort in her large maternal body helped her feel empowered as she aligned her body with a level of normalcy.

Silivia: Love Me, Feed Me

In this next story, pregnancy and birth is revealed as a time of increased happiness for Silivia. Recalling the meaning of the experience, Silivia dipped into a vast pool of memory in which notions of celebration, love, and closeness were summoned. At the time of birth, others were truly present for her, sharing her experience. Birth became a joyous moment when others offered themselves to be with Silivia:

> *When I was pregnant everyone was happy. Pregnancy is like a gift; your baby is the treasure and their gift to me was food. My family wanted to look after me. If you're really well liked in your family then you get everything! Because I was the one in my family who gets on with everybody I got everything. My room was filled with toys and food like you wouldn't believe! Every time people came, they brought food and presents. My mum would take bag-loads of presents home and come back again to fill up her car. And the food! You should have seen the food and the chocolate, mmm, so much chocolate! Bringing food is a respectful thing and it's sort of a comforter. I felt very special and really well loved then. It's a joyous time when we all get together. We're all talking, laughing, and eating.*

As Silivia illustrated, food created a sense of togetherness for her with others. It was tangible, visible, and sensory. Hence, food acted as a "sort of comforter" and a potent vehicle in which her relations with others were strengthened through the communal act of celebrating birth with food. Silivia relished the fact that she was well-liked, and her experience was of feeling loved, signifying how she was meaningfully connected to the world. Feeling loved was an existential experience of being acknowledged by others. Through being with others, she sensed a regard for her as a person. She was the focus of others' attention and being loved reminded her of feelings of pleasure and of feeling close to her family.

Silivia spoke of reciprocity in her lived relations with her family. She described her baby as a treasure; it was as though her baby was a gift to her family and her family reciprocated with gifts of food, which deeply emphasised their love for Silivia. A mood of social harmony unfolded in this context, and enhanced feelings of comfort manifested for Silivia when others brought gifts of food as a symbol of love. Salutary connectedness was more than feelings or physical sensations; for Silivia, being with others brought wellbeing into increased awareness. Silivia felt the completeness of being who she was. Through the presence of others, she experienced

security of relationships and saw the protective possibilities in relationships. Bottorff (1991) proposed comfort is our bridge to life, and it is through the experience of comfort that we become connected to the world:

> Our relationship with comfort is intentional; that is, our comfort is experienced in relation to our stance in the world. (p. 250)

The significance of the manifestation of connectedness and belonging for Silivia was that it gave meaning to Silivia's life; as, if she was strengthened through being with others, she was encouraged in her sense of self. Experiencing comfort reassured her of her connections with her family and a feeling of ease occurred when she reached a comfortable state of contentment. Silivia's story shows how cultural ways of being at the time of birth were a means to restoring and promoting health.

Silivia: Big Feeds in Aunties' House

Silivia was excited and joyous as she began her story of big feeds in her aunties' house. Reflecting on the big house re-awakened a sensual experience of being with others. Moreover, the sense of placeness stemming from the house was evident in Silivia's story. Her remarkable bond with this physical place was revealed; her experience of living in this place deeply felt. Silivia was connected emotionally and spiritually to the big house. The house brought meaning to her mind. She remembered its physical dimensions, the spirit of the place, and the nature of interdependent relationships within the house. As Myers (2016) wrote, "It is not simply that we are interconnected, but our very essence is uniquely shaped by the places we inhabit" (p. 3). For Silivia, the big house provided both physical comfort and security, and emotional meaning. It was, and remained still, a comforting space. Remembering the social activities that took place there reinforced her sense of belonging. Moreover, the values of her people were recognised and integrated within this place. Silivia described a positive sense of place, associating the big house with shared traditions, happiness, and togetherness:

> *When I was pregnant with Meilani and Airini, we all lived together. We had this big house which had three apartments. I was up the top with my daughter and my partner. Two of my aunties lived in the middle and on the bottom was my other cousin. All the grandchildren would come, you know, all the kids from my cousins that were pregnant. We'd do a big feed, and we'd all go to each other's houses. My aunties' house was the main one because they would be cooking donuts, pineapple pies, raukau and big pots of chop suey. We cooked food that was easy to make in bulk and spread it round to all the kids and us. It was yummy but also very fattening. With Pacific people, it's the cheap*

foods that are more dangerous to us, like the chocolates, the lollies, the biscuits. Overweightness may come from the cheaper foods because they are more affordable. I struggle with being overweight and I see the same struggle in some of my cousins who are really big and having their children. It's a personal journey for us. When we're at home by ourselves we know the struggles that we feel inside ourselves, but when we're together eating and laughing, we can forget about it for a moment.

The meaning of big feeds went beyond nostalgic delight; its symbolism was rooted in Silivia's family's tradition and values. Pineapple pies and raukau were transformed into gifts of nourishment and gestures of love. Hence the deliciously tasty raukau remained in Silivia's mind along with the comforting memory of extended family living. In her story, Silivia reminisced about the donuts and sweet pies cooked by her aunties. Later on, Silivia's perception of comfort changed when she described ambivalent feelings in relation to food. On one hand, food was a symbol of love and nurturance; on the other hand, food was characterised by risk. A painful recollection caused discomfort for Silivia when she found herself remembering how cheap food was her family's lived reality. During this moment, thinking of the cheap food seemed to bring an awareness of loss, and discomfort arose because of the harm of cheap food. It seemed that cheap food brought a threat to the integrity of herself and her family. Silivia experienced danger as a close reality, provoking melancholy as she reflected on the harms of chocolates, lollies, and biscuits.

Here, melancholy can be understood as a response to loss and for Silivia involved awareness that harmful food prevented her, and others, from living the life they wanted. She wondered what could have been. According to Heidegger, our experiences of being-in-the-world are filtered through moods. "Our entire existence within the world is shaped, coloured, experienced, and, in a sense, determined by our moods" (L. Freeman, 2014, p. 453). As such, mood cannot be understood apart from context. For Silivia then, her being-in-the-world existed against a backdrop of historical, social, and cultural meaning (L. Freeman, 2014). Silivia experienced the world through a lens of melancholy. Rather than being a debilitating mood, melancholy was something reflective or thoughtful (E. Brady & Haapala, 2003). In melancholy, perhaps she was reflecting on the mortality of her people. It was possible that the connotations of cheap food may have reminded her that her people were facing immediate danger because of overweightness. In danger, her being-in-the-world was disrupted, and she was confronted with the reality of loss for herself and her people. Being 'overweight' placed her in a situation of discomfort from which she wanted to escape or at least forget about the distress of the lived reality of 'overweight'. Perhaps, during these moments, she had lesser awareness of her personal journey, which then rendered a different experience. It was also possible that the

mental move to forget meant that she could protect herself from hopelessness rather than inviting a mood of despair into her lived realities. Silivia found herself being able to forget about her personal struggle with overweightness when she recalled those moments of comforting togetherness with others. Eating and laughing with others possibly invoked the notion of freedom for Silivia and being with others was a freeing experience of the mind. Finding comfort resulted in transcendence for Silivia, creating the space to regain energy and strength.

It is important to observe the fleeting meanings that circulate here, and how these were constructed and deconstructed during the telling of the story by Silivia. She spoke of comfort which occurred in food and the experience of wellbeing that was generated through being with others in the big house; yet, it was obvious that this easeful experience changed through a deeper telling and unravelling of the story as she reflected on the harms of cheap food and the deep influence of food environments which seemed to make it impossible for her and her family to make healthy change. In this way, the dichotomy of comfort and discomfort was apparent for Silivia, but it was her analytical noticing of unsupportive food environments that rendered her feeling vulnerable and ill-at-ease. Her story reveals the dynamic qualities of connectedness and comfort, and shows the changing shape of this tentative manifestation.

Nina: Fish ‘n Chips and Jelly Crystal Sandwiches

Nina’s story revealed aspects of home that held meaning for her as she experienced weight gain in pregnancy. For Nina, home was a contemplative space that evoked memories of the past. Her narrative reveals the inner tensions and paradoxes of home; a memory of place, of childhood space, loaded with intense recollections. Cues from Nina’s childhood place brought memories to her consciousness. She remembered her experience of togetherness and shared family times. Nina saw herself in the memory, as though she was an observer, watching as comforting memories linked to place and the traditional and social aspects of food from her childhood came to the fore:

> *I’ve always lived in Wainui and my family were on the poorer side of things. Our income wasn’t high, and it contributed to how we ate. We grew up on ‘old school’ meals that were big on meat but had few veggies. Veggies were expensive even back then. Cauliflower and broccoli were the ‘special’ veggies because they were real fancy. Dad even used fruit as a punishment food - when we complained about feeling hungry he’d say, “Have an apple”! We grew up with canned spaghetti Bolognese, which was high in sugar, or full-on Maggi noodles! Friday nights were the best because Friday was fish ‘n chips night. Every Friday was the same. Mum and dad would go get a movie from Video Ezy and we’d get the chips. We loved those chips. We started off with half a bag*

and once we got older we got a full bag to ourselves. I think back to the sandwiches that I was sent to school with. There was always three pieces of white bread and dad would cut three sandwiches in half. There would be one with tomato sauce, one with peanut butter and one with jam or jelly crystals. This lolly bread was SO delicious. It tasted good because it was pure sugar. He gave us pure sugar for lunch [laughter] - *it baffles me that that was even a possibility! I guess I didn't grow up with a good sense of nutrition because neither dad nor his mum had the knowledge. There are generations of us who don't know how to cook because we had no one to teach us anything. The place we grew up in played a huge part in how we behaved as adults. It's been really hard to make a diet change because this was something I had never factored into my life.*

Nina's story spoke of, "big home cooked hearty meals", "delicious lolly bread for lunch", and her family's "love of munchy food", revealing how memory is not confined to the body itself, but "it extends to the spaces and situations in which we find ourselves" (Fuchs, 2012, p. 13). Nina's food-related memories were implicit with metaphoric meaning; the smell and taste of food being strong evokers of nostalgia. In her mind, food was associated with experiences of people and place.

Nina's story elicited nostalgic feelings connected to childhood experiences. It was as though her telling of this story connected her more deeply to the past. Nina experienced a deep feeling of wellbeing when she recalled memories of the people she cared about and the place in which she grew up. Nina described two particularly nostalgic moments where food was a vehicle for her remembering. Her thoughts wandered back to what she described as "amazing times"; times marked by a sense of closeness to others. Remembering her upbringing, she considered the relationship with her father; fondly recalling her father's use of "fruit as a punishment food". Reflecting on the beauty of the past and the comforting times with her family on Friday nights, brought forth a vivid blend of feelings and perceptions. Food elicited involuntary memories for Nina, and these food-related experiences showed to be a bodily and emotional response involving mental imagery; the smell and taste of the chips bringing her back to her primary experiences. In another moment, she sensed again the overwhelming familiarity of family food traditions. Nina evoked positive memories about her dad preparing school lunches, causing her to romanticise about her childhood. Nina's second nostalgic moment related to her lunchboxes filled with jelly crystal sandwiches which were another symbol of her childhood. She associated happy moments, cherishing memories of comforting food, bringing feelings of pleasure and love for her family.

Zhou, Sedikides, Wildschut, and Ding-Guo (2008) described the restorative function of nostalgia as a psychological resource that protected and fostered positive mental health. Nostalgia "may facilitate continuity between past and present selves" (Sedikides, Wildschut, Arndt, & Routledge, 2008, p. 306) and, in doing so, lead to positive recollections of the past, enhancing meaning in the present. Telling this story seemed to help Nina put past experiences into the perspective of present life events. van Gennip, van den Hoven, and Markopoulos (2016), in their phenomenological study of remembered experience, noted that often, past experiences are remade and retold in relation to the self in the present day. For Nina, the present saw her explore the personal consequences of her childhood experiences. On one hand, she construed her memories as largely positive, such as the deliciousness of the lolly bread. Yet, though she remembered this as a positive experience, her perspective on that memory had since shifted as she reflected how the eating patterns of her childhood shaped her relationship with food in the present. Nina spoke of finding it difficult to make sense of lunches that were marked by so much sugar, feeling, "baffled that this was even a possibility". While nostalgia functioned to re-presence Nina with her childhood place, it confronted her with the impossibility of ever achieving her desired body in adulthood and making the changes to her diet. Her remembering of past events had a negative impact on comfort, steering her to a deeper understanding of overweightness and her struggle to manage gestational diabetes. Again, she recalled the social context of her memories; a bittersweet story of family eating that she later viewed through a more troubled lens because of her experiences with weight gain.

Home has been theorised as a special place, perhaps the most important place in our lives providing us with a sense of security and orientation in the world (Dovey, 1985). Not minimising the importance of phenomenologically grounded and idealised notions of home, such as Heidegger's phenomenology, contemporary post-structural theorisers (Blunt, 2005; Blunt & Varley, 2004; Easthope, 2004; Gibas, 2019) have produced an understanding of home which also takes into account the complexity; that is, the "inconsistencies, ambiguities, and contradictions inherent in home" (Gibas, 2019, p. 606), helping us see that home is both somewhere familiar and, potentially, threatening to future ways of being-in-the-world. In a similar way, Nina's story reveals the complexity of home—a stable space where she developed her love of munchy food *and* a space of turmoil which had wide implications for her adult eating patterns.

Having gestational diabetes mellitus in pregnancy seemed to motivate Nina to make a complete dietary change, as she did not want to re-live the same eating experiences in her adult years. Thus, despite her fond recalling of the past, Nina's nostalgic preference was for the present and of creating healthier eating patterns for her children which led to optimism for the

future. According to Leder (2004), happy memories can be a source of strength or comfort, reflecting a strategy of escape or reclamation. Thinking about what life is going to be for her baby, introduced hope and optimism. In the following passage, Nina's reimagining of the future introduces an element of freedom:

> *We had a birthday party last week. The table was covered in unhealthy food; deep-fried, high-sugar food. There was nothing for the children to eat that didn't have sugar. Even the grapes had milk chocolate buttons and cream stacked on top. When it's my daughter's birthday I'm going to make home-made healthy treats like monkey tail sandwiches with avocado and banana ice-popsicles.*

Reflecting on nostalgia's ambiguous position between past and present, Lems (2016) contended nostalgic experiences are "determined by an ambiguous interplay between self, time and place – by a constant switching back and forth in time and place and by a ceaseless re-negotiation of who we were, are and will become" (p. 435). It was plausible that, for Nina, the motivating potential of nostalgia may have boosted optimism and sparked inspiration to make a bodily change (Sedikides et al., 2008), eliciting a deeper sense of wellbeing from eating healthier food and the increased sense of control and decision making over her eating. For Nina, it seemed that traditional family eating patterns surrounding food acted as a catalyst for lifestyle change during pregnancy and to protect the health of her baby.

La'ei: Spiritual Wellbeing in Mothering

For La'ei, wellbeing in pregnancy was only possible when she had positive and balanced relationships between God, her people, and her environment. It was through wellness that she could meet her obligations to herself, her family, and others. La'ei talked of the meaning of mothering; her eyes glistening with tears of joy as she described the gratifying role of motherhood that gave meaning to her life. She cried as she reflected on finding comfort through mothering and the blessing that God had bestowed upon her. Crying seemed to be a way for La'ei to express her empathic connection to her children, stimulated by the beauty and appreciation of her family.

La'ei described the connection between healthy behaviours and protecting her baby. Looking after her body in pregnancy meant that her baby would be healthy during its life. She held a deep belief that being healthy in pregnancy would help her baby be strong in this world and "not struggle with other things". Her baby was a gift from God and His blessing inspired her to protect her baby, filling La'ei with a deep sense of wellbeing. For La'ei, love was the concept of giving, of nurturing her baby while he was inside her stomach. She spoke of how protecting baby began during pregnancy as she attempted to form an intimate attachment

with her baby in utero. The spiritual significance of a Higher Power was a comforting and transforming experience for La'ei:

> *I look forward to that baby coming because it is a blessing from God to my family. So that's why I want to make sure I stay healthy not only for me - the important thing to me is my baby. To be a mum is to make sure when the baby is born he or she is coming to this world 100% healthy and not struggle with some other thing. When I stay healthy I know that my baby is healthy. But if I'm doing the wrong stuff and I'm not focused on my baby then I'm not giving my love for that baby to grow up and be welcomed into this world. I know exactly how I can protect that baby. The first step starts inside your stomach. I do everything I can to get closer to my baby when inside my stomach. When I feel he's moving I call my kids, "Come, come, he's moving". Sometimes I sing and then massage my stomach. I want him to feel me. Sometimes I know he's moving and then I say hello. Then, I feel maybe his leg, or his arms stretch up. Soon I'm going to get him closer, closer to myself. I'm starting that kind of relationship with him inside my stomach before he comes out, so I can't wait. I remember the first time I had all my kids in my arms. I look at them all with the same feeling. I think, "how can I impress them"? I got six kids right now and this is my last pregnancy. The more babies I had, the more I knew exactly what I was gonna do.*

La'ei felt so much love for her children as she remembered holding each of them near when they were born. She was compelled to do the best by her children and put her trust in God, calling out to Him to help her. This expression of gratitude was essential to La'ei's experience of spirituality and religiosity which were important components for her sense of wellbeing and peace. With La'ei's decreasing fertility, the spiritual dimension gained prominence. La'ei's spirituality was enriched through pregnancy and she described how her faith became more meaningful as awaited the birth of her last child. Her embodied knowing from each of her pregnancies helped her as she created a deep emotional connection with this baby. Sensing her baby's attempts to communicate with her, La'ei created an opportunity for her family to become close to her baby.

La'ei's lived experience description captured something of her worldview that then informed her health and wellbeing, and motivation for change during pregnancy. The following extract illuminates how La'ei learned how to make healthy change through the visits to her doctor. A deep experience of comfort manifested for La'ei during this moment with her doctor:

> *When the doctor advises me to do something to help me help the baby, I try to do it. It's going to help me not only in this time, but in the long future. Some other women*

don't follow the advice because they are lazy. The doctor gives them information and they go home but they never do it. Maybe they don't care. But for myself, I'm always active. If I've been to the doctor and he suggests I do exercise to help my pregnancy because I've got a little bit of weight, I love to do it. I'm taking care of myself in this pregnancy because I have diabetes for the first time. He said, 'Just be careful and take care of your diet'. So that's why I don't want to miss the appointment because I know it's helping me to change, and I take comfort from it. I love my kids and my husband, and I want to live a long life. Maybe it's because the love got put inside my heart to love and take care of that baby.

It was possible that this caring situation represented an exemplar form of culturally congruent care, which held deep meaning and enabled La'ei to express self-determination. La'ei was motivated to take up the advice because she intuitively knew it would help her to take care of her baby. This salutary context constituted a motivating influence on her decision making as she contemplated and prepared to change. Her doctor's care held meaning for La'ei which enhanced meaningfulness of health promotion, and resulted in transcendence in a psychospiritual context. Receiving health advice gave La'ei a sense of controlling her destiny and realising her potential as a woman and mother. Thus, for this woman, care extended beyond the physical dimension and enhanced her involvement in health-seeking behaviour.

Alisi: Being Cared For

In a similar way, Alisi's story told of a caring situation in which enhanced feelings of wellbeing and safeness manifested. In this story, wellbeing was created from being cared for by her midwife. Alisi's experience was characterised by the extremes of closeness and distance as she reflected on her earlier experience of birthing in Tonga. Describing her mood towards her caregivers in Tongan and Aotearoa New Zealand maternity care systems, she recalled moments of distance with her past experience in Tonga and noticed moments of closeness and comfort in the present:

This is my first baby here in New Zealand. In Tonga I was having a baby before, but he passed away inside of me. In Tonga there is no midwife. When I have a problem the nurse and doctor there will say they will be fast in coming, but they will take their time and do other work. It's very different from here because I can tell it's very important for the midwife to know if something goes wrong. I feel like I'm important for them here. The first time I was talking with my midwife she was showing me the books and helping me know how to have the healthy food. I am happy having a baby here. I like it because

when the midwife comes I can see it's important for her to do her work and look after me.

Alisi was exposed to a critical event in her previous pregnancy. She recalled her experience of losing a baby, sharing that her symptoms were not taken seriously by the doctor and nurse. Her Tongan experience was characterised by tension and broken connections, where she described feeling insignificant or peripheral. She talked of feeling unimportant, marginalised, or otherwise silenced during her encounter in the Tongan healthcare environment. While maternity care professionals offered Alisi reassurances that, "they will be fast in coming", Alisi recounted how, "they will take their time and do other work" before reaching her. This example illustrated how her experience of feeling something was wrong with her baby was discredited, leaving her feeling cast aside and unimportant. Being ignored, Alisi felt her credibility, and possibly even her intelligibility, was brought into question. She was left with the feeling that her caregivers were disconnected from the lived realities of her life situation. Her existence was not acknowledged, and she felt disconnected from her caregivers when she was not heard, as though her body and her baby did not matter.

In contrast to her past experience, which was permeated by a mood of being unseen, a ubiquitous feature of her story in the present is the experience of empathy. Moments of closeness happened when Alisi experienced 'being with' her midwife in the Aotearoa New Zealand maternity system. A positive image of care was revealed in her narrative, which was described in terms of feeling closeness with her midwife. The encounter with her midwife became something more than just a health care appointment; it brought new meaning to her life, revealing that 'being seen' and feeling comfort was an important part of being-in-the-world. The feeling of closeness was created by her midwife who actively involved Alisi in decisions about healthy eating. Noticing her midwife's attentiveness, she felt her midwife had an intimate understanding of her needs. Closeness with her midwife created a new dimension of wellbeing for Alisi as she knew her midwife was there for her and, in this knowing, she experienced meaningfulness. Alisi's lifeworld was shared with her midwife; it became a gratifying connection of understanding and the freedom to express herself. Feeling she was able to open-up without being silenced or misunderstood was almost overwhelming for her.

Being cared for by her midwife brought about a sense of safety and, similar to La'ei, being cared for gave her a sense of controlling her future through producing safe outcomes for her baby. Her relationship with her midwife promoted comfort and facilitated relief. According to Kolcaba (1991), the caring situation is indeed transpersonal and has the potential to bring about transcendence through expanding individual capacity. Alisi and her midwife utilised the

concept of salutary factors, which promoted coping. These interactions with her midwife led to growth and change; feeling important produced wellness and was possibly even a healing experience for Alisi.

Pania: Loneliness to Belongingness

In a similar way to Alisi, Pania told her story of belongingness, as she navigated pregnancy's lonely road. Crisis was a manageable challenge for Pania. In her first pregnancy, her living situation was fraught with negativities. She spoke of limited financial resources, food insecurity, and frustration as affecting her emotional resilience. Reflecting on these challenges, Pania admitted that, "pregnancy can be a lonely road sometimes". She experienced intractable loneliness in her first pregnancy, a loneliness perhaps originating from her awareness of loss; her lack of access to intimate relationships and environmental supports. Pania associated the experience of loneliness with negative feelings which made her feel painfully insular. It was as though she was concealed from the world, staying home, sleeping, and doing nothing. Yet, she longed for more than she had managed to attain, desiring love and closeness in her connections with others. Kirova (2002) wrote:

> In loneliness we discover what other people mean to us. We discover the meaning of being loved. Perhaps the true being of loneliness is that it becomes an experience changing the person experiencing it. Perhaps loneliness is our way of becoming human perhaps because in the experience of loneliness we realise not only our longing to be "with" the Other, but to be "for" the Other. (p. 164)

Though Pania felt frustrated by her previous pregnancy's unexpected lows and vexations, and recalled experiencing the world in negative terms, in this current pregnancy her experience of detachment and disconnectedness from others were soothed by living with Anaru:

> *Being pregnant can be a lonely road sometimes. When I was living on my own I didn't pay attention to what I ate. I didn't have much so just ate whatever I had. I didn't see many people. I felt stressed and was at home, doing nothing - just sleeping all the time. But now I'm living here with Anaru I feel quite lucky. We eat well here. Anaru always has good bread and he's strict on the fizzies. I stopped having Cocoa Pops and white bread and started having smoothies and fresh juices. It wasn't all plain sailing cause at first, I would go to eat those kind of things, but he would say, "no have this instead", and to save arguments I would do it. I've had the benefit of living with him and I notice the difference between my two pregnancies. Now I'm eating better, and I feel better. Even my attitude has changed. I'm closer to my kids; I've got more patience than I used to have. I've been helping my cousin who was due to have her baby a few weeks after*

I had Ariki. She struggles with weight and asked me to help her. She thinks of salads as just lettuce and tomato and that's not appetising for her. I told her I Googled different kind of salads we can make and so we got together and made kumara and couscous salads. She still has them now and has made dramatic changes to her diet - not just her diet but the whole family's diet. It was great helping her and seeing her happy. The best support comes from whānau. They are the people that you love, and you trust.

Appreciative of her nurturing relationship with Anaru, Pania described how she felt, "quite lucky". 'Lucky' is a descriptive label that reveals how being invited to live with Anaru was a chance happening. It seemed to Pania that this fortunate situation was brought by chance rather than through her actions; and luck was significant for Pania as it filled her world with depth and meaning. In luck, she experienced acceptance and love with Anaru. This connection had an impact on Pania's wellbeing and, in particular, on her emotional life which was altered by staying with him. A more easeful experience of being-in-the-world had begun to manifest for Pania.

Pania felt fortunate to be living in a supportive environment where healthy eating was regarded as an unspoken set of behaviours. Anaru's support was a source of resilience that enabled Pania to enhance her understanding of the relationship between nutrition and wellbeing. At Anaru's place, she found herself in need of his concern and longed to be accepted by him, even compromising by eating the food he suggested. Pania spoke of the negative and positive aspects of whānau living. Though Pania did not feel she had a choice, she felt Anaru's approach was beneficial in helping her improve her nutrition. On another level, as Pania made sense of her new living context, she felt the changes to her diet positively impacted on her health. She even pondered if there was an association between improved nutrition and reduced anxiety.

Through whānau connectedness, Pania experienced a deeper sense of manageability. She described positive changes in how she related to others and felt an increase in her appreciation of life. Pania had an awareness of, and gratitude for, the possibilities that living with Anaru brought. These were primarily expressed as developing increased patience with her children. For Pania, showing her children patience brought her closer to them. Persisting, even thriving, amid disruption increased Pania's regenerative capacity for giving. New knowledge and understandings on wellbeing grew from her relationship with Anaru, who was a strong influence in shaping her experience and enhancing her sense of control over her wellbeing.

Later, Pania found herself in a situation where her cousin asked her to share her nutrition advice. Extending aroha to other women, Pania's experience was of becoming both a learner and a teacher of wellness. Self-reflection, a sense of agency, and commitment to whānau connections was protective for Pania. Drawing on her heightened sense of agency and its associated possibilities, she felt a sense of cohesiveness to others that strengthened her desire to have meaningful relationships by being a part of, and having influence, on her whānau. Feeling valuable to somebody, being important to others as a person, was essential in providing purpose in her life. It was also possible that Pania's earlier experience of loneliness was a motivating force which presented new possibilities for action. Pania's experience shows how whānau connectedness increased her sense of comfort from being-in-the-world and enabled her to make a lifestyle change during pregnancy. Whānau support helped Pania to mobilise her own inner resources and motivation to restore healing in this pregnancy. Thus, the experience of personal involvement in health-seeking manifested for Pania; the sense of wellbeing that whānau's protective cocoon provided was inextricably linked with wellbeing in this pregnancy.

From within Alisi and Pania's stories, it seems that closeness and comfort associated with others eased the transition to pregnancy. For both of these women, connectedness with others enabled them to manage painful feelings of adversity in previous pregnancies, evoking a positive mood of resilience.

Natasha: Health-Within-Illness

Natasha's story revealed how her life, lived-in and lived-through a particular body and lifeworld context, was disrupted; her lived experience of multiple sclerosis bringing her to the edge of vulnerability. While multiple sclerosis represented diminished bodily and emotional control pre-pregnancy, Natasha's maternal body experiences provoked more hopeful perceptions of body and self:

> *Nine years ago, I was a size 12 and now I'm a size 22. Being a gym bunny, I ate whatever I liked because I was working it off. I was in control and liked the size I was then. When I got multiple sclerosis I was on big, heavy, drugs that made my body swell. Being bedridden for three months I watched the weight pile on. When anybody came to see me they never brought me healthy foods. They were like, "Oh you must be suffering, have a pizza". I'd enjoy that pizza, but I'd be stuck in bed watching my body grow-and-grow. They thought they were doing good because it put a smile on my face but, at the same time, I was disappointed in them. I ate it because what else could I do? I couldn't get up and make a sandwich. I felt really depressed but swallowed my feelings. Being big and pregnant is my reality now and I'm worried about being big more than I ever*

was before. I was told not to gain any more than 7kg. She [obstetrician] *said a smaller person might put on 30kg but a bigger person shouldn't put on any more than 7kg. I don't know what damage it does but obviously it does something, otherwise why do they put you on the scales. I remember feeling hurt and I'm thinking, "How dare she say that"! Her advice was harsh but sometimes you need that harshness, especially from strangers. But if it wasn't for her advice I don't know where I'd be right now. At first I thought this is my chance to eat and eat, but I've wanted a baby for such a long time. These nine months were about being able to produce a healthy, active and safe baby - not to produce 'another me'. I've only gained 5kg in my whole pregnancy. I'm so super proud of myself, I can't stop smiling. In nine months, I CAN change!*

Natasha reflected on a former self; a self who had control of her body, a self who found it easier to achieve health, free from illness. Her sense of identity and relations with others was threatened as she felt vulnerable and very much dependent on care and nourishment from others. She was grateful for their help and, at the same time, doubted their integrity. She felt hurt that others did not understand the harm of bad food and its consequences for a large body. When others brought her food, which was incongruent with Natasha's desired way of managing her increasing weight, it produced negative eating patterns. Recalling the enabling behaviour of her family, Natasha had a sense that others offered her little chance of regaining control of her body and feelings of depression began to emerge. Swallowing her feelings, Natasha navigated the 'helpfulness' of others to regain a sense of wellness. It was experienced as an ambivalent situation as Natasha was conscious of her ever-changing body and her need to navigate a return to health-within-illness (Moch, 1998).

Natasha's story reflects the generation of meanings and their various possibilities, and the process of making and re-making of her experience of being "told not to gain". Natasha recalled being advised not to gain more than 7kg. At first, the advice provoked annoyance for Natasha as the advice did not make sense to her. She felt it was impossible to adhere to weight gain recommendations, particularly as she was early in her pregnancy. Natasha explained it was easy to put on weight. Knowing that she could only gain a little weight led to her being more focused on nutrition.

Prior to pregnancy, Natasha did not consider that being 'overweight' would be problematic. Conversely, she felt it would be more advantageous for the baby because her baby would have "more room to grow". While she knew overeating might harm the baby she did not understand the harm caused by excessive weight gain. Seeking more understanding, Natasha asked her doctors to "dumb down" the advice. Later she was made aware that, "the bigger you are the

higher the chance of the baby being bigger". Natasha described adhering to the weight-focused advice because she did not want to harm her baby and came to see that weight monitoring was important for keeping the baby safe.

A different reality later unfolded for Natasha in which the doctor's interaction seemed to change her perceptions. Between my first and second interview with Natasha, I noticed her evolving and changing understandings of the meaning of being "told not to gain". She made sense of her relationship with her doctor and felt intuitively that this interaction helped her redevelop her self-agency in response to weight gain. Weight-focused advice had a prescribed effect, helping Natasha heal. She reappraised the earlier negative advice to later harness the advice, nurturing it and finding something beneficial from it to have a positive effect on her bodily and emotional wellbeing. Hope was a dynamic and increasingly present feeling as Natasha reflected on how her interactions with her doctor had a deep effect upon Natasha as a mother. Realising that she was making changes to help her baby have a different embodied life to hers increased meaningfulness in her life. van Manen (2016) discussed the concept of relationality, saying: "As we meet the other we are able to develop a conversational relation which allows us to transcend ourselves" (p. 105).

Natasha cogently explained how, "pregnancy was a big plus" as it reduced her pain from a seven or eight, on most days, down to a four or five. Thus, a shift occurred, seeing Natasha move away from a bodily focus on multiple sclerosis to a re-conceptualisation of health through connecting with a deeper purpose. Pregnancy became a healing and existentially transformative experience bringing an enhanced emotional state as well as unexpected joy. She consciously thought about how her lifestyle may affect her baby's future health and planning for her baby's safe passage into this world characterised the pregnancy. She focused on fulfilling her commitment to mothering and protecting her baby from the ills of her own life.

Natasha wanted to live a purposeful life. In a sense, she was exploring her purpose in life as she talked of her aspirations for her baby. She felt a meaningful connection to her baby and her baby invoked a sense of awe and wonder. Pregnancy brought forth changes in her relationship with self; her inner yearning was to become a mother, to love and protect her child. In a pregnant body, she existed both for herself and for the baby. The meaning of life is to be able to exist for another person (Eriksson, 1992), and providing the best health through one's own body and person is a way to this ministering (Bondas & Eriksson, 2001).

Natasha's experience was initially one of disruption and then one of healing. According to Vagle (2014), intentional meanings shift and change in and over time, through ever changing contexts. In this sense, meanings are salient, partial, fleeting, temporary and unstable and are

at best “glimpses of possibilities” (Vagle, 2014, p. 41). The idea of healing related to the restoration of a sense of personal wellbeing and dignity (Toombs, 1995), despite the physical manifestations of illness. For Natasha, healing related to the preservation of personal not bodily wholeness (Jonas & Crawford, 2004; McDonough-Means, Kreitzer, & Bell, 2004), enhancing her experience of wellbeing and living a productive life. There was a realisation that the advice was given with the goal of improving overall health. Coping with recurrent symptoms and social situations related to the multiple sclerosis was facilitated by maintaining control and a sense of hope. Healing meant that Natasha accommodated the advice in a way that enabled her to have a greater sense of wellbeing in pregnancy—bringing about an experience of health-within-illness (Moch, 1998). Her determination, attitude, and life context played a large role in her healing experience. There was deep joy to show the beginning of a major change in Natasha’s life, as though she was able to forget about her suffering of multiple sclerosis. Thus, her unborn baby had evolving significance in her life. In her telling of the story, pride manifested, and Natasha described feeling “so super proud”. Natasha felt good and worthy in relation to her weight, because it was through this achievement that she was able to have a “safe, healthy and active baby”. The meaning of this was an unmasking of deep pleasure which impacted her sense of self. In *Being and Nothingness*, Sartre (1943/2003) suggested that pride had ontological significance and brings the capacity to reveal myself *to myself* through ‘the look’ of the other, awakening self-reflective awareness. This experience taught Natasha something new that she could not have known otherwise.

I identified and resonated with the personally meaningful accounts shared by Natasha. In the following post-reflexion journal entry, recorded after my interview with Natasha, I recounted my moment of connection with Natasha. I share my lived experience of managing transference in sensitive research, offering an existential analysis of my experience of transference:

> I was stirred by this story, though unprepared for the personal meaning this story had for me. While on one level, I was aware that the practice of phenomenology would necessitate a dwelling and lingering in the lives of others, my taken-for-granted assumption was that I would remain unaffected by the stories of participants. As Natasha’s story deepened, I found myself deeply touched by her narrative. Remembering my tears forming as she described that difficult moment of diagnosis, I empathically connected with Natasha, even seeing myself mirrored in her; my body soon becoming responsive to her situation. I recognised how I seemed fascinated with her multiple sclerosis and how it might be manifesting in my world. Intoxicated by her tale, I seemed to dwell in Natasha’s story, obsessing about it, becoming more curious

> about her multiple sclerosis, the hidden illness. I watched her closely and saw the way she moved her body with difficulty, noticing how she stretched and yawned. Mentally, she struggled to recall her obstetrician's advice, even laughing as she described how memory loss was one of the greatest joys of multiple sclerosis. She had me hooked, I was intrigued, but I catch myself dwelling longer than is comfortable for me and her. I find comfort in Finlay's (2014) advice for novice researchers when she cautioned us to avoid becoming transfixed in individual's life story, and so miss the phenomenon.

van Manen (2007) reminded us that a phenomenological attitude sees us being open to our connection with others:

> Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations—and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect. (p. 12)

Chapter Summary

The salutogenic aspects of women's unique individual, social, cultural, and spiritual contexts are uncovered in this chapter. Salutary connectedness can be considered a metaphor for how women interacted with, and were shaped by, health promoting situations and contexts. A common theme was the importance of relationships to wellbeing. Women sought harmonious relationships and connections with others to restore order to their world. The women in this chapter experienced salutary factors in a variety of contexts and situations. Connectedness was something positive and good, anchoring these women to familiar meanings and ways of being-in-the-world. Women experienced critical events and situations which were overwhelming and provoked a strong orientation to generate wellness in a multitude of ways. The experience of feeling strengthened was achieved through meaningful connections with others, and from experiencing a deep connection to cultural understandings and embodied knowledge. Thus, women experienced a deep sense of ease with their decision-making and behaviours. These findings allude to the importance of acknowledging social and cultural factors, including authentic approaches to caring, which produce and provoke positive health. These influences go far beyond medical understandings of maternal wellbeing. The next chapter discusses the tentative manifestation of disconnection and disruption.

CHAPTER SEVEN: DISCONNECTION AND DISRUPTION

A further tentative manifestation revealed was disconnection and disruption. Women's relationships and connections with others in a variety of situations and contexts had an important influence on how women viewed their bodies. Social contexts exerted disruptive influences on women, seemingly bringing women into increased awareness of their body's capability. Maternity care contexts also provoked disconnection and disruption, where medicalised care processes and pathological medical narratives unsettled women's socio-cultural understandings about their bodies and health. Thus, women experienced intensely disruptive bodily, emotional, and social transitions to pregnancy.

Throughout these transitions, a mood of being-in-flux was evident for women whose stories are included in this chapter. The uncertainty and ambiguity that women experienced relating to body weight made pregnancy a difficult and liminal transition. Weight gain for these women was like a 'biographical shift' from a normalised view of the body to one that may lead to uncertainty disrupted ways of seeing the world (Bury, 1982). These collective stories show how women engaged with the world as they navigated disruptive clinical, social, and cultural forces. The attempt to normalise bodies and situations, in the face of disconnection and disruption, was uncovered. The high-level tentative manifestations and the meanings uncovered for women in this chapter are shown in Appendix S.

Six crafted stories are included in this chapter; each reveals how disruption and disconnection manifested in multiple and diverse contexts for the women in this research. The first story uncovers Ruth's experience of fat embodiment and the disruptive experience of bodily pain. The next two stories illuminate the disrupted bodily and emotional transitions for Lily and Emma who experienced feelings of being-in-flux during pregnancy. The fourth story unravels Cheree's experience of negative transitioning, as she adjusted to a new temporary reality of being in a large body; this story uncovers aspects related to her acceptance of a temporary identity as an 'overweight' pregnant woman. Then, Pania's story of machinelike care is described, revealing how disconnection was produced in a mechanised caring context. The final story shows the disruptive impacts for Nive through a sense of caughtness when moving between two different cultural worlds.

Ruth: Being Fat

For some, fat is a transitory identity; though for Ruth, fat was a fixed and marginalised identity. For as long as Ruth could remember, she was the fat girl. Having lived in a fat body since her

childhood, Ruth described herself as being a "product of her environment" and coming from "big stock". While she gestured to accepting her body, her embodied experience was of intense suffering. Ruth experienced inner tension, fluctuating between bodily acceptance and resistance. She read her body as impaired and unchangeable, describing the disabling and disruptive experience of being fat:

> *I've lived with it. I accept I'm fat. This is who I am now. Mum's fat and my nana was fat. My nanny used to tell me it was alright because we came from big stock. We couldn't leave the table until we finished everything on our plate. It's not all about the fat gene! We're a product of our environment so it's not an easy road. I've done it many times, but the weight comes back no matter what. So, this is it. These are the cards I've been dealt; yet being this big is crippling. Being pregnant and being on crutches just adds to the pressure of what you can and can't do. I'm seeing maternal mental health because I'm just down. I'm not coping with the fact that I can't do anything. I can't be a mother to my son, and it feels like I'm failing. There's that guilt inside, if I had been slimmer before I got pregnant I wouldn't be where I am now. It's more obvious now that I should have prepared better before pregnancy. I had all the best intentions, but they fell a little bit flat. I'm trying not to show too much. I think about my kids and I don't want them to go through me dying early. That's the reality for big people—our fate is sealed.*

Describing the genealogy of her fat family tree, Ruth felt genetically programmed to eat too many calories. Her way of knowing the world revealed that fatness was not solely under individual control. Yet, at the same time, she appeared to blame herself. While she acknowledged the role of genetics in body size, she accepted she was fat because of her choices. Anguish manifested for Ruth when she talked of having no control over her future. She had tried to fight the odds of getting bigger with diet and exercise, but this had only led to regaining lost weight. Her story spoke of her future as having some determinism to it.

Salient themes were revealed in Ruth's first-person account of disrupted transition to pregnancy: feelings of shame and self-blame, inescapability from her circumstances, and failure as a mother. The sense of self-blame and helplessness was tangible and revealed within her lived experience of being in a fat maternal body. During a reflective moment, Ruth described how feelings of inadequacy surfaced when she was unable to step up and do more. Almost every aspect of her life seemed affected—from her aspirations to everyday activities of caring for her child.

According to Ratcliffe (2015), a person's experience of mental ill-health involves a change in how one relates to others, attributable to a disturbance of world. Ratcliffe argued that a

person's sense of reality and belonging is not completely lost in depression but, "it is profoundly altered, in that the person does not feel fully 'part of the world' and everything seems somehow different" (p. 19). Suffering was a lens through which Ruth interpreted her experiences. Bodily pain and distress welled from within causing her everyday world to become devoid of significance. Leder (2016) described distress as, "being stretched apart from our customary lives, where the body becomes a distrusted other" (p. 1), reminding us about the acute vulnerability of the embodied life. Ruth's pain was enduring—an ever-present challenge—which was more than a bodily discomfort. It entangled her in a complex and ambivalent relationship with her body.

Ruth's story is characterised by the emergence of a disability as she found herself noticing a connection between her fatness and disability. Ruth constructed a narrative around disablement; one which destabilised her world and influenced her connections and relations with others. In doing so, she assembled a selective account of herself. The pressure of being on crutches intensified the disabling experience of being big and Ruth alluded to how her body impaired her movement. Her use of the term 'crippling' shows us that she saw her body as being functionally limited. She read her body as impaired, which to her signified that her body was physically different to others. Perhaps she was seeking a more enabling means of being-in-the-world. Focusing on the phenomenon of mobility, Todres and Galvin (2012) argued that mobility "is centrally characterised by both literal and existential possibility; that is, mobility involves all the ways we move both physically and experientially to connect ourselves to motivated lived possibilities" (p. 56).

Whether disability was a valid label or a metaphor for Ruth to make sense of the world, her phrase conveyed certain lived aspects of her experience. Behind Ruth's self-defining as a disabled woman, was the view that her body was impaired, impacted, and at risk of ill-health. As she considered the consequences of her body size, Ruth pathologised her situation, saying that "early death is a reality for big people". Perhaps she adopted contemporary western pathological medical discourses that serve to (re)produce risk narratives about the fat female body (S. Murray, 2008). For Ruth, fatalistic acceptance was deeply connected with her understanding of physical science and she described her intuitive knowing of the link between 'obesity' and ill-health. Suffering led Ruth to a new realisation about what really mattered to her and she reflected that her children were the thread that connected her to the world. Appearing empathetic, Ruth was aware of the consequences of her fatness for her children; yet, it seemed that she was separated from the world, watching the world but having little means of participating due to her emotional and bodily state. Ruth's story shows how

traditional family and cultural narratives concerning body weight provoked her beliefs and understandings. She believed that her body was a barrier to experiencing love and connectedness with others. Her deep sense of shame in her body saw her hide from the world, staying silent. Her experience of fat embodiment was intensified as she transitioned to motherhood. Pregnancy brought a deeper experience of bodily disruption for Ruth; her increasing weight intensifying her experience of being in an dis-abled body. Reading her body as impaired, she moved through the world in an altered way, her body being an obstacle to connecting with self and others.

Lily: An Unfamiliar Body

Lily's story revealed insights into her lived experience of waiting. She experienced intense intrapersonal discord as she waited for her pregnancy to end. Lily's discordant experience was provoked by her desire to return to a more familiar, capable body. Lily experienced disruption during time's slow passage, as though the movement of time was inconsistent with her needs and desires. Her altered mode of being involved bodily changes, variations in mood, and worries; her changing body evoking feelings of bigness, heaviness, and stretching:

> *This pregnancy is just so uninspiring. It's my second baby so maybe it's not going to be as exciting as the first one. My first one was a breeze, but this time it's so different. I'm unable to focus on anything other than getting to the end - having it all over. But instead, it goes on and on. I haven't enjoyed it as much this time around as my first time. I feel a lot bigger all over. I'm carrying bigger than what I did with my first baby and I really don't like being this big. My body's struggling to keep up. My skin is a lot tighter and my legs are a lot heavier. I went to put on a pair of pants today and they didn't fit. Yesterday they fitted and today they don't. I can't believe how much weight I'm putting on. I'm eating really well and exercising but I still can't stop the scales from rising. Because of my pelvic pain I've been laid-up on the couch for the last seven months. I've literally done nothing! I'm usually quite conscious of being fit and healthy. I weighed more at the start this time so maybe this has had an effect on how my body is coping? I get quite depressed about it. My focus is on the end. I'm looking forward to having this baby out and getting active, then I'll be back to where I was. But then I think about how much work I'm going to have to put in; how much time it will take to get my body back to how it was. I always thought I'd have three children, but this might be my last. I don't know if I can do this again.*

As time stretched, Lily became increasingly conscious of the physicality of her body. When her body swelled from rapid weight gain in the first trimester of her pregnancy she was no longer

able to do the ordinary activities she associated with her non-pregnant body. Feelings of control, present in her former body, now became manifest as a mood of restlessness and boredom. Lily's experience of pelvic pain meant that she found herself in a situation where she felt it was impossible to maintain a healthy lifestyle and ensure her weight gain was within 'normal' limits. Leder (1984) showed how pain can make the world shrink to here and now; similarly, for Lily, her world was restricted to her house and lying on the couch. Succumbing to a low mood, she noticed how her former habits and routines were breaking down, pointing to a new form of existence and way of engaging with herself and others.

Feelings of powerlessness and a lack of ability to act and change the situation dominated Lily's story. She described her body as, "struggling to keep up", as if her body were an unwilling other; one which could not keep pace with herself and her expectations. Moving her pregnant body entailed an unfamiliar awareness of effort and feeling of resistance which never left her. Aware of her body's massiveness, Lily caught herself noticing a contrast in her body's movement through this and her previous pregnancy. The joyous experience of her first pregnancy was in sharp comparison to the heaviness and burden she carried through this disruptive transition to pregnancy. Lily was unable to express herself through her body in the way in which she used to. Previously, she was confident and trusted her physical body, but in this pregnancy she was uncertain and hesitant in her physical engagement with other things.

Women can experience their bodies as burdensome, rather than a medium for doing things through their body (I. M. Young, 1980). Lily described a distance towards her body; yet, at the same time, seemed to be completely swept up by pain. Pain preoccupied her, loosening her connections with her former active and capable body. Her world appeared to her as fundamentally changed. Living in a large, painful body meant that Lily's relation with herself was disrupted; the possibility of creating new life after this pregnancy was no longer in reach as Lily questioned her body's capabilities. Perceiving her pregnant body as under-performing, she became uncertain of her body's future capability.

Young (1980) suggested that feminine bodily existence was an inhibited intentionality. Young's point was that having an inhibited intentionality makes a difference in how people think of themselves. Lily, similarly, seemed to experience split subjectivity as her body changed. Pregnancy symptoms made her aware of her body and she no longer saw her body's future performance possibilities. Though Lily's changing embodiment altered her experience of being-in-the-world, limiting her aspirations, she was motivated by the prospect of returning to her former body. She planned to "get back to where she was". While she eagerly anticipated

weight loss after birth, she also experienced trepidation about the time it may take to engender a more liberated and capable body.

Increasing weight gain and bodily pain was a disruptive and limiting experience for Lily. She experienced her weight gain as unstoppable despite following the healthy weight guidance in pregnancy. Resultingly, she viewed her body as a burden; as something separate to her. She wanted to get back to her old-self and, in doing so, shed the self that was now.

Emma: A Body-In-Flux

According to MacKenzie (2001), our corporeal condition is not static and changes to our corporeal condition have the potential to change who and what we are. Emma's lived experience of pregnancy was of negotiating a changing pregnant corporeality. Emma's increasing size disrupted her experience of pregnant embodiment, changing her relationship to her body. Transitioning to a pregnant body was a distressing experience which provoked the need to regain control:

> *My BMI is around 25. My midwife said gaining up to 12 kilos is the ideal. But I'd already gone above that in the first 12 weeks. I'm disappointed that I've gained so much so quickly. I've been active and eating well so I didn't expect such a dramatic weight gain. I thought I would be able to control it, but the scales kept going up and up. But the thing is, I don't feel unhealthy! I've got my diabetes test soon, but I don't expect to have an issue here. My Graves* [disease] *is under control and I haven't been tired. You know, I've got energy. I feel fine, I feel good - I really do. I didn't want to have this 'weight thing' in my head the whole time so I dealt with it by not going on the scales. For my own personal wellbeing I prefer not to know what the scales say. It's been my choice to stop monitoring it. If I continue to feel OK that's good enough for me. I don't need numbers to tell me how much I'm gaining because I can see my body changing. Weight gain is natural. I'm growing another person.*

For Emma, pregnancy was not a wondrous and magical time she expected it to be. Instead, it became a transitionary period where she had to abandon her business-as-usual body. Emma seemed to believe that her pregnancy was imperfect as she could not control her weight gain. She was surprised at the sudden increase in weight, despite her uptake of health promotion advice. Shocked and disappointed at her increasing weight, Emma felt unprepared for the emotional havoc pregnancy was having on her. While pregnancy had not impacted her ability to be active, she was getting bigger.

In a similar way to Lily's story, Emma's story spoke of disenchantment with pregnancy as it brought disharmony that she had not experienced before. At the beginning of her story, Emma revealed how her sense of harmony was ruptured as she experienced discontent with her body. In her non-pregnant body, Emma seemed sure and unshakable, but now a new mood of disappointment became evident as she adapted to her changing embodiment. While Emma did not deny the reality of her changing embodiment, saying, "weight gain is natural", initially she found it difficult to accept bodily changes. It was as though Emma self-objectified, which produced an initial negative attitude towards her weight gain. Emma was aware of this negative adaption and sought to attune to her body once again. Later in her account, Emma talked of trusting her body and she placed her emotional wellbeing above bodily aesthetics. In her transition to acceptance of weight gain, Emma placed meaning on feeling healthy, rather than looking a healthy weight.

Young (1990) said, pregnancy was "the most paradigmatic of such experience of being thrown into awareness of one's body" (p. 165). In her theory of embodiment, Young provided an account of the relations between bodies and selves, helping us understand how the integrity of Emma's body was undermined in pregnancy. Describing how pregnancy puts the boundaries of the body-in-flux, Young reflected:

> My automatic body habits become dislodged; the continuity between my customary body and my body at this moment is broken. In pregnancy my prepregnant body image does not entirely leave my movements and expectations, yet it is with the pregnant body that I must move. (p. 163)

Young (1990) argued that a woman's encounter with obstetric medicine can often be an alienating experience when maternity care professionals' perspectives are disconnected from those of the woman. In accordance with Young's theory, Emma's experience of going above normal weight gain limits may lead to alienation, because excessive weight gain tends to be defined as a disorder in maternity. It was as though Emma's midwife did not share her goal (to feel well regardless of how big she was becoming). Emma resisted reliance on objective measurements of health; instead, trusting her body to navigate the complexities of her changing embodiment, placing focus on subjective bodily feelings. In this sense, Emma sought release from the disruption that the scales brought, and to maintain wellness Emma resisted maternity's advice to monitor her weight. Young considered that instruments, such as scales, transfer control from the woman experiencing pregnancy to maternity providers, leading to a devaluing of the woman's experience.

The dominant biomedical model of health assumes that the normal healthy body is unchanging (I. M. Young, 1990); yet, Emma's story calls us to remember that it is normal for bodies to change, as in pregnancy we are "growing another person". In this part of the telling of her story, Emma rejected the pathological lens through which maternity negatively critiqued her body. She found herself reflecting on the baby growing inside her; it was as though this reasoning helped Emma accept that she would wait until after her baby was born to lose weight:

> *I've got to accept that it is what it is, and I'll get it off once the baby's come. In pregnancy it's more acceptable to eat what you like. People are more forgiving, and they won't judge you on your lifestyle or what you are putting into your body. But, if you are not pregnant, WOW! There's such a drive to be the perfect size 10. Women go, "Should you be having that pie"? Someone told me how big I looked. Women are so 'judgy' with each other and it just seems so normal to judge and compare our bodies with one another, both when we are pregnant and not pregnant. The mindset for females is to focus on getting back to our pre-pregnancy weight before we have our next one.*

Here, Emma reflects on the continuous surveillance of the female body, noting how the body was placed centre stage by other women (Grosz, 1994). Nash (2013), in her works on pregnant embodiment, provided support for Emma's lived experience, saying western women have to reconcile the tension between 'feeding the fetus' with their own nutritional needs and maintaining a socially and clinically acceptable 'healthy' maternal body that was not 'fat'. Though Emma had a sense of wellbeing, perhaps this was somewhat disrupted by her midwife's focus on measuring weight in pregnancy. To be in control of her body following pregnancy was a way in which Emma could return to a more comfortable state. This yearning to return to her former embodiment was motivated by her need to return to her pre-pregnancy identity. Emma perhaps feared a loss of identity, of never getting back to her normal shape.

Emma's story illustrates the ways in which the phenomenon of being in a changing maternal body is both shaped by contexts and situations and is being constantly re-produced. Consequently, Emma's account reveals how maternity's pre-occupation with surveillance and measurement of the pregnant body disrupted her understanding of normality. Her experience of disenchantment with her maternal body changed when she rejected maternity's objective measures of maternal health.

Cheree: "I'm Not Myself"

In imagining why pregnancy was so hard for her body, Cheree reflexively engaged with possibilities, becoming curious. Exploring what was going on, the phenomena of aging and

displacement entered her awareness. In the giving up of her home and moving to a new place, Cheree experienced feelings of disorientation. She was displaced from her home, her whānau, and her past; the loneliness of being in a different town and being in an unfamiliar body became more apparent.

Cheree's pregnancy was unexpected. Describing the disrupted transition to this pregnancy, she shared:

> *Pregnancy was a surprise. I was told that it would be difficult to have another baby with my weight. This is the biggest I've ever been, and it's been one of the hardest pregnancies. I'm not sure why it's so hard on me this time - it might be my age or the move away from my whānau down here - I'm not sure. I know I'm not myself. I'm not who I was two years ago. Before, I was always out at the gym and socialising. I was never a sit-down person. I need to get out there again and be a bit more motivated for all of us. I expect more from myself and I need to do more but I'm not capable of doing much at the moment. I miss doing things together with my whānau, things like taking our dog for a walk but that's all stopped. They keep telling me to do something, that I must do something! So, I know I need to make a life change. It's really important for me personally, and I don't want my kids being overweight. I'm not confident, but I need to make a change for me and my kids.*

Cheree's experience of displacement related to her sense of belongingness in the world. She described feeling, "not myself – I'm not who I was two years ago". She felt different somehow, other than who she was. Ratcliffe (2012) contended that feeling 'not oneself' is "inextricable from our sense of reality; alterations in the sense of belonging are frequently coupled with the complaint that things, people or the world as a whole seem unreal" (p. 24).

Weight gain produced a change in how Cheree engaged with, and acted in, the world. Her body was no longer in harmony with the world around her. Allen-Collinson and Pavey (2014) contended that,

> …the physical body enters the consciousness as a cumbersome obstruction, an immovable hurdle that prevents connection and physically engagement with the world in ways that were previously taken for granted. (p. 801)

Cheree's sense of manageability and control over her body in her previous pregnancies was now difficult to access. Her weight gain led to a slowing down of life which meant having fewer connections with others. Cheree was not able to utilise her environmental supports, to attain wellbeing. Cheree's experience of emotional and physical displacement is perhaps comparable

with physical illness. Like the experiences of others with illness embodiment, Cheree's body became an obstacle to connecting with others. In *'Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine*', Svenaeus (2011) used the philosophy of Heidegger to establish a phenomenology of illness that worked to understand illness, or 'unhealth', as a rupture in the meaningful organisation, temporality, and narrative of one's life. In illness, Svenaeus argued the "body shows up as an alien being (being me, yet not me) and this obstruction attunes the entire being-in-the-world of the ill person in an unhomelike way" (p. 337). Similarly, Cheree's transition from a homelike to an unhomelike being-in-the-world fundamentally changed the way she experienced the world. The meanings she ascribed to things and to herself were radically altered, and not in a positive way.

The felt intensity of Cheree's emotional and physical experience of displacement and 'unhealth' led her to make a life change to remedy her perceived failure. Her need was to get back to the way things were. Cheree wanted to both make a personal change and influence her children's lives. While change was important to Cheree, she was not confident that she would be able to make the life changes. Committed to protecting her children from future consequences of 'overweight' and ill-health, she was seeking resolution. Her need to make a firm decision to make a life change, her resolution was to rebuild her homelike being-in the-world (Svenaeus, 2000).

For Cheree, 'not being herself' in a larger body constituted a profound disturbance in her experience of self, others, and the world, and exposes us to a more deeply understood experience of human vulnerability. Her story conveys the disruption of belonging that is ordinarily taken for granted.

Pania: Machinelike Care

In Pania's story of machinelike care, she described a series of disruptive moments where she was seen as "just another pregnant person waiting in line". Pania's experience of mechanised care reveals how her midwife's actions provoked disconnection. Here, she described being on the periphery of caring processes:

> *These appointments didn't benefit me. They are the ones who benefit; they must get money for having so many meetings with you. I didn't get any reassurance. Pregnancy is a unique and scary thing because your body is going through so many changes. When I got weighed my midwife wrote down the weight. I stood there aghast thinking, 'WOW, she never said anything'; then a million things started running through my mind. It would have been nice to have a conversation about what's going on with my body, instead I felt like just another pregnant person waiting-in-line. I just felt like a robot to*

be honest. I know exactly what is going to happen each time. She measures me, she puts the little device on to check the baby's heartbeat, then we get weighed. She asks, 'is everything alright'? I say, 'yes'. She says, 'any questions'? I say, 'no'. As I go out the door, she tells me, 'have a nice day'. I come back the next week and we do the same thing all over again. Maybe most women know what to ask, but if you don't know what to ask you don't ask. I wondered why it happens like this but then I think the midwife is the professional so this must be how it goes.

A series of tedious care processes occurred in exactly the same way from one appointment to the next. In these mechanised moments, Pania relived the same experience over and over again. Pania described a Groundhog Day (Ramis, 1993) experience; every appointment began to look alike, even the midwife's dialogue appeared to change little. The routinised and machinelike nature of care provoked the experience of feeling like a human robot. The most likely interpretation of Pania's phrase, "I just felt like a robot", is in terms of 'it is *as if*' the world is unreal (Radovic & Radovic, 2002). An amount of strangeness was present in these encounters, as though her appointments had taken an unexpected twist and somehow she was an outsider to care—on the periphery of the caring encounter. In this context, she was made into an 'other', an object under the alienating gaze of her midwife. She interprets her situation of being an object body and she watches her body being watched (Leder, 2016). Care focused on the things to do, rather than being a space for connection.

Similar to the findings from H. Dahlberg and Berg (2019), who described the lived experience of health care for pregnant women with diabetes mellitus, Pania's need was to be acknowledged as an individual woman with unique ways of being-in-the-world. Seeking a humanistic connection with her midwife, Pania desired a deeper, more authentic form of care which acknowledged her embodied experience as opposed to care practices underpinned by processes. She wanted to be met as a person as she was at that moment, instead of only following the care processes. To be met in this way, and have unique life histories seen and understood, was a prerequisite for feeling cared for (H. Dahlberg & Berg, 2019). Instead, for Pania, the clinic was something akin to a dehumanised space. To understand this experience, I turn to the work of Leder (2016) who explained how "the living patient, embedded within a world of involvement and grappling with modes of suffering and concern is reconceived on the model of a mechanical device" (p. 73). According to Leder, modern medicine's efficacy can also cause it to seem dehumanised as it abstracts progressively away from the social context, lived experience, and healing touch.

The midwife, being preoccupied with conducting a series of tests in a time-bound context, does not truly encounter the woman in the room. This compromised connection intensified Pania's experience of depersonalisation and, in the absence of empathy and connection, she experienced a bodily felt and obvious emotional separation from her midwife. Despite Benner's (1994) contention that the nature of the reality of the lifeworld between practitioners and clients holds shared meanings; no such shared meanings were revealed within Pania's interactions. Instead, there was a loss of status and a deeply felt awareness of needing to comply with the routines of antenatal screening. In her midwife's focusing on routines, it was as though the body was not even seen, taking objectification to a whole new level.

The expression of vulnerability was also seen in Pania's story, where she spoke of, "a million things were running through my mind". The manifestation of vulnerability implies a strong need for care and caring; yet, Pania perceived caring as an activity, not as an emotional encounter. For Pania, this relationship lacked authenticity; it lacked caring and is contrary to 'other-regarding' and engaged presence care heralded by Kennedy, Shannon, Chuahorm, and Kravetz (2004).

Pania's experience of machinelike care serves as a metaphor for a form of marginalisation in maternity care. Pania uses the metaphor of the robot, which uncovers her marginalised status in the clinic. Though metaphorical, the robot helps us understand that Pania is like something else; she is seen as an 'othered' being. Pania watched her midwife work with maximum productivity in a machinelike way. In the processing of Pania's maternal body, little interaction was required. Her midwife's actions, whether or not intended, provoked a feeling or being like a thing or a machine. This experience is articulated in terms of feeling like an object. Being, "just another pregnant person waiting in line" emphasises her lack of embodied presence. In feeling like a robot, she experienced being glazed over and not really being there. Pania felt reduced emotionality which can be framed as intrapersonal disruption, even a distance from the world. She expected pregnancy would be the thread of connectedness that allows her to be seen as an individual, rather than a cog in the machine.

The routine focused pregnancy care context exacerbated Pania's experience of marginalisation as her midwife's over-reliance on devices, tests, and routines triggered alienation and disconnection. Aspects of Pania's personal identity were stripped away in the bureaucratic machinelike maternity system. Noticing that the emotional constituent of care was missing, Pania's experience of care assumed an almost entirely technical meaning, and in this clinical context technical aspects dominated, indeed overruled, emotional aspects (Kleinman & van Der Geest, 2009, p. 159).

Feelings of confusion, from a sense of not knowing what was going on, were evident in Pania's story. These events seemingly disrupted her understanding of midwifery care and, in her attempts at meaning-making, Pania questioned the political context in which maternity care was delivered. Becoming resentful, this experience provoked a deep curiosity for Pania. She could not seem to make sense of what was happening. In attempting to reconcile why things were the way they seemed, Pania legitimately considered how remuneration strategies might be at play to "benefit them". Becoming critical, Pania began to question health care ethics. The meaning was that Pania experienced care as not genuine. While antenatal care was seemingly good, it was as though it was not really so. Appearing not to fully trust the motivations of the maternity care system, Pania possibly experienced her interactions with her midwife as something specious, her appointments as illusionary, even deeply flawed. Giving us a glimpse of the power imbalance in this practitioner-client relationship, Pania conceded that "the midwife is the professional so this must be how it goes". At the clinic, she became subject to the clinic's rules and processes; her connection with her midwife derailed by the demands of the system.

Pania's narrative is meaningful because it communicates the meaning of caring from a woman's perspective. Her story points to the focus on technical aspects being the core focus of caring in biomedical maternity contexts. Pania's understanding of midwifery care was that it should have been uniquely nurturing; yet, her narrative illuminates how her experience of care and caring was interrupted by the bureaucratic structures. Pania's reality of the on-the-ground midwifery care was uncertain and fragile as she came to question the way things were.

This journal entry was written after the crafting of Pania's phenomenological text. Like other phenomenological researchers (Smythe, 1998; C. M. Young, 2011), I use poetry here as a medium for reflection on the phenomenological material gathered in this study. In this instance, post-reflexing happened after the gathering of data, thus becoming phenomenological material during analysis (Vagle, 2018). Analysis of my post-reflexions produced a poem, unpacking my reflexive thinking and my assumptions about the ways in which I see the phenomenon being shaped, produced, and provoked. In Pania's story, it struck me that reliable routines took dominance over person-centred care. The poem reveals that without humanised approaches to caring, the world appears less understandable, uncovering how the mechanistic worldview in maternity has the potential for producing disruption and disconnection:

Pania and the Machine

The system performs like a well-rehearsed routine,

shaping my world, my view of me.
With rigid doctrines.
Too much machine,
too little care.

Nothing ever happens, nothing happens at all.
The needle returns to the start of the song.
And we all sing along like before.
And we'll all be lonely tonight and lonely tomorrow (Currie, 1989).

See me, hear me, care for me.
It's a sad truth,
I just want to feel loved.
Humanise the machine.
Too much machine,
too little soul.

Nothing ever happens, nothing happens at all.
The needle returns to the start of the song.
And we all sing along like before.
And we'll all be lonely tonight and lonely tomorrow.

Frayed is the thread that connects you and me.
Invisible, silent, the thread can't hold us,
Frayed is the thread,
which can't keep us safe.
It had loosened itself and gone.

Nothing ever happens, nothing happens at all.
The needle returns to the start of the song.
And we all sing along like before.
And we'll all be lonely tonight and lonely tomorrow.

My body is processed like a machine,
not visible to you.
The machine moves forward at pace,
but who benefits?
It's Groundhog Day, day after day.
Each time I left,
I knew.

Nothing ever happens, nothing happens at all.
The needle returns to the start of the song.
And we all sing along like before.
And we'll all be lonely tonight and lonely tomorrow.

Every word, every move, every action the same.
The gears whirl and whiz,
with *Groundhog Day*-esque predictability.
What might-have-been if we connected?
It never-was.

Nothing ever happens, nothing happens at all.

The needle returns to the start of the song.
And we all sing along like before.
And we'll all be lonely tonight and lonely tomorrow.

Vagle (2019) reminded us that a variety of textual forms, such as poetry, can make sure "the text engages the post-intentional phenomenon as a social apparatus, and helps readers join the researcher in the important productions and provocations at work" (p. 11). The chorus in the song, "*Nothing Ever Happens*", (Currie, 1989, track 10) speaks to the misplaced values in maternity care and serves to deepen our understanding to the social change which is possible for the maternity system. Carefully uncovering what is happening in the in-between, the chorus indent calls into question the approach to caring for women, uncovering taken-for-granted aspects of care such as automated patterns of care. Pania wanted her midwife to be there for her, not the system, yet it seemed that her midwife was also 'caught in the system'. Reflecting the disconnection between the caregiver and the woman being cared for, these lyrics prompt us to return to seeing care as a relational phenomenon, as something beyond mechanical.

My interest in humanising caring stems from an assumption that caring is a means through which maternity care can be conceptualised as a means toward equitable change. Maternity care founded on the premise of production-like maternity care causes harm, provoking a deep rupture for women. Similarly, findings from Doering's (2020) study showed that women struggled with seeking and making a connection in assembly line care contexts. A different set of premises is needed, one which shows a shift from (un)caring contexts to a more carefulness of approach. Constraints in institutionalised care contexts can seriously undermine the midwifery-woman relationship presenting a challenge to midwifery professionalism. Task-oriented protocols create emotional distance between midwives and women; meaning the midwife/woman relationship is focused on processing the maternal body. Connectedness is perhaps not always possible in procedural driven care contexts.

Nive: Caught Between Old and New

Nive lived her embodied life in a complex social and cultural world. For Nive, cultural inclinations were deeply embedded, and she felt and acted in ways that were largely culturally determined. In her story, Nive showed how she switched between different cultural frameworks for understanding the world. On one hand, she instinctively connected with her Niuean culture and the influence of traditional Islander values, sharing that, "big is normal for Islander women". On the other hand, Nive felt some commitment to modernity and western culture's beauty ideals:

It's really hard with my culture because it's accepted to be big. Big is normal for Islander women. Being Islander, you're allowed to eat and eat and eat. It's fixed in our heads. Old-school Pacific women don't worry about their weight. Many older women are fine with putting on extra weight and staying that way after baby comes. Men don't look negatively at their partners when they get bigger and bigger, and my husband says, "yeah, eat for the baby". But here is different and people are more likely to say you are overeating. Young Islander mums have an issue with being big. It's a trend for them to be pregnant and still look good. My daughter is 17 and she's already worried about her weight. She looked at my body and said, "Oh my gosh mum you're so big, I'm never, gonna get pregnant"! I'm feeling caught in this in-between space. I feel like saying, "somebody help me… help me watch what I eat", because I like to look good and feel good. I've never been this big before and don't feel myself, yet I'm too lazy minded to do anything about it. I haven't talked to my midwife about my weight because I don't focus on myself when I go to the clinic. Because of my antibodies, all I need to hear is that baby's OK. My weight issues are minor in comparison.

The cultural worlds embodied by Nive seemed disconnected. Her story reveals the compelling 'caughtness' of being simultaneously Niuean and European. Eating according to baby's needs was culturally significant for Nive as a Niuean woman. She spoke of the cultural permission to, "eat and eat and eat"; yet, being allowed to eat whatever she liked generated a personal struggle in her daily life as she became increasingly dissatisfied with her body. Nive seemed unable, or possibly refused, to shed "Islander values"; yet, felt conflicted by these apparent freedoms. Existing uneasily between worlds, the competing cultural norms generated a felt sense of ambivalence for Nive.

Nive took Polynesian concepts as real and factual things. In her narrative, Nive was not reflecting that the Islander way of being-in-the-world was good or bad; she was simply conscious of it. Western concepts of dieting in pregnancy were, perhaps, simply incompatible with being an Islander woman and external to who she truly was. Discord showed in Nive's story as she attempted to reconcile the multiple selves created for her living between two cultures. Her story revealed western culture's influence on young Islander women's body image experiences and the generational differences in relation to body acceptance. Nive described the old and new-school cultures as being thrown together, caught up alongside each other, complexly intertwined. She might never quite hold old ways, yet may not fully inhabit contemporary ways of thinking. Hearing her daughter's views on her maternal body seemed to pull Nive out of the past and into the present. This pull was experienced by Nive as powerful and disruptive. Her daughter's reaction distressed her and at the same time provoked new

understandings for Nive. This situation seemed capable of disrupting old meanings, and even potentially overwriting them. Here, the concept of caughtness is not about feeling stuck but implies a freedom of movement. Nive felt caught, yet could still find herself free to question, or perhaps simply wonder about, her future embodiment. Nive adopted an objectifying gaze upon herself, monitoring her own body. It seemed that she could not decide how she felt about her body and experienced ambivalence towards her body, being neither accepting nor rejecting of her physical self.

Despite weight management being important to Nive, she described weight gain as a minor issue. As a Pacific woman, she attached meaning to focusing on her baby. She did not ask her midwife for weight-focused advice, as her primary concern was for her baby's wellbeing, the risks to her pregnancy taking priority. This illuminates the partiality and relative importance of Nive's neglected lived reality but her wider concern for her baby's health renders her weight gain experience silenced. The tension seemed almost impossible to resolve and Nive described 'not being herself' as a result of these disruptive impacts. Although this story of caughtness in thought may seem trivial, it is in fact crucial in terms of current concerns over the uptake of lifestyle advice in pregnancy. Nive's understandings of being-in-the-world were not fixed – she dynamically experienced a shifting, constant movement, as she tried to make sense of the significance of both worlds. Her story hints at the complexity of competing contexts in which women make decisions about their bodies. The co-existence of competing attitudes towards body size thus have important consequences for maternal health promotion approaches which must be tailored to the complex lifeworlds in which women exist.

Chapter Summary

These findings address the larger matter of outside forces and contexts on women's maternal body experiences. Adapting to being in changing bodies represented a complex transition where women experienced intense disruption and disconnection from others. Women experienced the impacts of disruption and disconnection in their lives differently, according to their individual situations. Contexts intensified the disruptive impacts, increasing women's sense of being in unfamiliar and 'incapable' bodies. Maternity contexts exerted a destabilising and disruptive force which threw women into deep awareness about their bodies, challenging their taken-for-granted assumptions. For some women, disruption manifested from the embodied experience of weight gain and the increased physical and emotional pain which co-existed for them. Although women intuitively knew the transition to a large body was not forever, being able to make meaning of their altered reality was important to their emotional wellbeing and acceptance of this temporary state. However,

this experience revealed ongoing uncertainty and, as such, was never quite stable, given the unpredictability relating to managing their body weight.

Some women experienced uncertainty and ambiguity before finding a deeper experience of bodily agency. Others fluctuated between having a healthy body experience and a felt sense that they were transitioning to a body-at-risk. Some women alluded to maternity's preoccupation with being a 'healthy' weight rather than women's embodied understandings of body size and wellbeing. There are deleterious consequences for women who are unable to attain a deep sense of wellbeing and these findings confirm the importance of individualised, person-centred care that takes account of the complexity of women's lives. Ultimately, what is at stake are the multiple and complex influences on women's lives which go unnoticed in pregnancy care. An effect of disruption and disconnection was the deep manifestation of being-in-dis-ease, as discussed in the next chapter.

CHAPTER EIGHT: DISRUPTION TO BEING-IN-DIS-EASE

Disruption to being-in-dis-ease is a tentative manifestation which illuminates the ways that disruptive contexts, social and clinical, provoked dis-ease for women as they interacted with others. This chapter uncovers how the experiences of being in bodies labelled as clinically 'overweight' and 'obese' manifested in different ways and in different contexts. In secondary care contexts, women experienced discontinuous unity with their surroundings under the critical gaze of maternity care professionals. A variety of intentional relationships manifested and appeared as women came to see their bodies as 'problem bodies' embodying despair, shame, discomfort, distress, and dis-ease. Yet, the crafted stories show that despite being in disruptive contexts many women found ways to reconnect with their bodies and, in doing so, reclaimed body and self.

This chapter shows where women living through disruption and in-dis-ease used strategies of escape and reclamation or a fusion of both (Leder, 2004, 2016). The stories uncover how women sought ways to escape into the past or present. In contrast to escape being provoked, living in the present became an opportunity for reclamation or conscious decision-making. Some women found a way to turn the potentially disempowering medical gaze into a resource-oriented approach; that is, women found the resources to remake the chaotic, disordered and unpredictable structures of their world into something understandable and meaningful (Antonovsky, 1979). The high-level tentative manifestations and the meanings uncovered for women in this chapter are shown in Appendix T.

There are six crafted stories in this chapter which illuminate women's experiences in social situations and clinical contexts. The stories show where women used strategies of escape, reclamation, or blended integration (Leder, 2004, 2016), and the multifarious forms of these strategies. The first story reveals Ruth's experience of distress following an encounter with an 'other' on the train and the manifestation of shame which was revealed. In the second story, Ruth spoke of the secondary care which led to her feeling silenced. Ruth's strategy of escape is uncovered in both of her stories – she sought escape from her painful present. The next stories uncover Sam's and Christina's experiences of being looked at with a fixed clinical gaze and shows how the subjectivity of these gravid women is largely neglected by maternity with its pre-occupation with fetal surveillance and maternal judgement. Strategies of reclamation take different forms for both Sam and Christina. Finally, Julie's and Jennifer's accounts unravel how bodily uncertainty manifested when doctors saw the large maternal body as a 'body-at-risk'. Similar to Sam and Christina, these women used reclamation to turn their experiences of the

weight-focused advice into situations in which they exerted their personal power in ways which were meaningful to their unique situations and contexts.

Ruth: The 'Look' on the Train

Being in a fat body meant Ruth lived as an outsider, somehow on the edge, violating society's thinness norm. Ruth experienced the 'look' of the other on a crowded train when she travelled to work with her partner. At first, she found herself absorbed in a different world from the other, completely forgetting about her body. However, when she sensed his noticing of her, she immediately became aware of her body, because she was the one who was violating the space of the other and causing annoyance. Anxious anticipation and dis-ease manifested when the encounter on the train pulled Ruth away from her usual place in the world (Leder, 2016):

> *We were on a crowded train. We got bumped and pushed in the horde of people and I got jostled against another passenger. I saw him look at my body with annoyance. He got huffy and said, "Your bag is annoying me". I told him I was annoyed that he didn't give up his seat for a pregnant woman. That's when he said, "I just thought you were fat"! I've been fat FOREVER and I've spent my life laughing off fat jokes. It's easier if I beat them to the punch as it takes that sting out of it. But this hit home hard and hit my partner even harder. We take the car into work now because we just don't want to deal with that kind of situation. It's wrong to me to hide away from it but at the same time I don't have the emotional ability to deal with it.*

For Ruth, the presence of others brought suffering. She was consumed by acute awareness of her dis-eased body. Ruth's body shape concealed her pregnancy. Her need, in that moment, was for her pregnancy to be recognised. She wanted to be seen as pregnant as opposed to fat. She used the metaphorical phrase "hit home hard", revealing her need to have her pregnancy recognised.

Our bodies enable our connection with others through our association with place. "In turn, bodies are accessed and *read* as information sources by co-participants who actively interrogate the bodies of others in practice in order gain access to embodied knowledge" (Lloyd, 2010, p. 15). For Sartre, awareness of self can be disrupted through an other's value-laden look, which has disruptive potential:

> To be looked at, and to experience oneself becoming an object to someone else (and thus to oneself), makes the person aware of his or her whatness. This conscious whatness somehow brings about a certain vulnerability, and a profound sense of being in default of a personal defense or possible escape from the look. (Saevi, 2005, p. 166)

Sartre's view was that two people cannot look at each other in comfort and mutual recognition, rather the subject-object relationship takes the form of conflict. Ruth's world was drawn towards that of the passenger, which displaced her own relation to the world. Her feeling of being visible, of being seen, disrupted her thoughts, derailing her when she sensed his disapproving look. Though nothing had changed, an element of disruption was brought into Ruth's world, bringing other meanings. An all-enveloping mood of insignificance manifested for Ruth; her sense of belonging to the world seemed disconnected following the encounter. Lang (1985) said, "the home is incorporated and assimilated into the fabric of embodied existence; the home being our second body" (p. 201). The other's rejection of her body, and the space it was taking up, led Ruth to viewing her body less positively. The everyday activity, of being on the train, brought deep feelings of shame.

Ruth described the importance of being the first to pull a punch, a conscious and protective impulse to defend her existence. Ruth used the metaphor of boxing to show that getting her punch in first was driven by her need to avoid hurt, so that she remained in control of the distressing feelings. The sport of boxing provides the embodied actions underlying the linguistic concept of 'beating someone to the punch' (Gibbs, 2006). Obstacle and helping metaphors were revealed in Ruth's story. For example, her words "beat to the punch" revealed a transformational journey from 'fighting ring and contest' to 'positive interactions and healing', showing her need to restore balance in her relationship with self and others. Her metaphoric imagery takes us on an imaginative journey of taking out the scorpion's sting. She was desperate to attenuate the intensity of the other's remarks because the words stung so painfully. What mattered to Ruth was taking the pain out of her connection with others.

Ruth's metaphorical phrases showed us one thing as another, and, in doing so, extends the way we see her world. But what damage was caused by Ruth's use of violence metaphors? Battling metaphors may have hidden consequences for Ruth, producing feelings of guilt or failure if she is 'losing the battle' and imposing a sense of personal and social responsibility for managing her body. According to Lakoff and Johnson (1980) metaphors play a central role in defining our lived realities. For Ruth, metaphorical representation may have provided a cognitive shortcut for making sense of her relationship with her body in any context.

Ruth desired harmonious co-existence with others; yet, being under another's critical gaze disrupted Ruth's relation with herself and others. The look of the passenger disrupted her view of herself, separating her from the world. It took her by surprise not enabling her to have her usual defence mechanisms in place. So powerful was this experience of the look, was the need to make her body less visible, minimising her place in the world. It was as though through the

critical gaze of the other, her body was experienced as a limitation and she was unable to continue to travel by train. Ruth's decision to stop taking the train shows the depth of meaning this had for her. Reflecting on her changed life situation this encounter was beyond her manageability. She could not tolerate it. Dwelling on what she was no longer able to engage in, she made a deliberate choice to adjust her situation, as though her body was completely determining her new routine. Travelling to work now required conscious planning. In a critical way, her being-in-the world was transformed and she was forced to recognise her inherent vulnerability. Loss of control manifested as Ruth experienced a threat to her lived body and the fundamental unity between her body and herself was experienced as disrupted. The sense of inescapability and limitation of freedom is illuminated in Ruth's story. Using the strategy of escape, her body would become less visible to others.

Ruth: The Unsafeness of Secondary Care

In another story, Ruth spoke of how dis-ease and disruption surfaced again, this time in a clinical context. Ruth was transferred to secondary care because of a high pre-pregnancy BMI. Her story reveals the manifestation of unsafeness of being in secondary care:

> *I didn't want to be pregnant anymore. My mental health was deteriorating VERY rapidly, and I didn't feel safe. I wanted them to induce me early, but they wouldn't. I was being judged for wanting to get the baby out for no reason by my own. They kept telling me the baby was safer inside, but no one was listening to me. No one listens to the mum. My baby might be safe but I'm not. I felt like an incubator. It was absolutely heart-breaking for me. I had a really funny turn at work one day and came straight to the hospital. The midwife put the monitors on and said there's nothing baby related. She said baby was fine so there's nothing wrong. But there was something wrong with me. My heart was going off all over the place. I was in and out of consciousness and my heart rate dropped right down. There WAS something going on! They left me in a delivery suite. The consultant came in and he was very dismissive. He wouldn't even discuss options of induction. No one cares about the mum. I gave up trying because there's no point in asking for help if no one is going to help you. They are the people who are supposed to help you. The doctors. They're the ones. It could have gone the other way and meant I was quite alienated from my baby. Everyone was so focused on baby that there was the real possibility I would resent her after she was born. I might not have bonded with her.*

Ruth alluded to the many silencings that took place in secondary care that rendered her unable to communicate her feeling of being unsafe. She described her experiences of inadequate care

and lack of psychological support which impacted negatively on Ruth's body and mind responses to coping. Ruth felt the doctors' dismissive attitudes undermined the expected benefits of being in secondary care. For Ruth, the meaning of being looked after by secondary care related to frequent monitoring and the increased likelihood of being helped, but the doctors appeared not to be interested. Ruth expected the doctors were there to help her, commenting "they are the people who are supposed to help you".

Ruth wanted her concern of feeling unsafe verified; instead, her interactions were fraught with inattention and a lack of concern for her own wellbeing. Hannah (2014) contended that doctors are socialised into seeing illness and suffering in particular ways, which creates a distance between them and the lived experience of their patients. For Hannah, this meant "seeing people as bundles of symptoms, or data or diagnoses rather than as themselves" (p. 12) which leads to the emergence of Foucault's 'clinical gaze'. Ruth's body became the subject of the clinical gaze. It appeared her body became a site of concern for her unborn baby which intensified her experience of objectification. She felt she was birthing in a system that viewed her body as a vessel for carrying her unborn child.

Ruth compared her womb to an incubator. With the help of this objectifying terminology, she visualised her body as an incubator, perhaps revealing that she was distancing herself from her baby. It was as though the pregnancy was not occurring inside her body but in a separate body altogether. She described how her importance lessened and she felt she was not significant enough for the doctors to listen to her. In '*Pregnant embodiment*', Young (1990) considered that in pregnancy, because of shifting bodily boundaries between the woman's body and her baby, she experiences her body as herself and not herself. Young stated:

> *The integrity of my body is undermined in pregnancy not only by this externality of the inside, but also by the fact that the boundaries of my body are themselves in flux. In pregnancy, I literally do not have a firm sense of where my body ends and the world begins.* (p. 163)

The presence of her baby and the strong medical focus on her baby seemed to devalue the privileged relation she had to her baby and her own body. Ruth was trying for bodily integrity; yet her bodily integrity felt violated when her doctors refused to induce her labour. Ruth sought release from the emotional and bodily pain that pregnant embodiment brought. Her need was to return to a more easeful pre-pregnant body to minimise disruption in her life. She tried to be heard as a woman in a situation which made it almost impossible, as from a medical perspective there was no 'valid' reason to induce labour as her baby was safe. She expected to be helped but her experience was of extreme distress, vulnerability, and disconnection from

those who were there to help. Ruth felt her decision-making was questioned, her values judged, her femininity doubted.

In the manifestation of unsafeness, she felt silenced and separate from her surroundings which brought about a profound experience of 'unhomelike' being-in-the-world (Svenaeus, 2011). This silencing increased her sense of dis-ease, leaving her cut-off from the help she had hoped for.

> The experience of feeling listened to is intrinsically linked to quality of life and evolving patterns of living and being with others in co-creating meanings, rhythms, and choices informed by hopes and aspirations. (Kagan, 2008, p. 59)

Feeling unheard created tension in the relationship with her doctors and she spoke of how hurt surfaced in response to a system which placed the woman's needs secondary to those of her baby. Being heard is intrinsic to relationships and Ruth spoke about her hopes that the doctors could help her. Feeling silenced, for Ruth, meant that others did not understand the significance of her body returning to a pre-pregnancy state. There was no connectedness with her doctors, nor did Ruth think the doctors had a shared sense of responsibility for her wellbeing. Her doctors failed to engage with her entire being. Ruth wanted to express herself and feel listened to in this dialogical process with her caregivers. She sought non-judgmental recognition within which she would feel valued and loved. Instead, her experience of not feeling listened to in this care context was shattering.

Ruth's story illuminates the way she sought affirmation and reveals her hopes for a significant affiliation with her caregivers. To be heard and believed was crucial for Ruth's sense of self and her connectedness with others.

> If our voices are essential aspects of our humanity, to be rendered voiceless is to be dehumanised or excluded from one's humanity. And the history of silence is central to women's history. (Solnit, 2017, p. 18)

Wendell (1996) claimed that the power of the biomedical model is such that a person's subjective descriptions of her bodily experience need the confirmation of medical descriptions to be accepted as accurate and truthful. The words, "baby is fine, there's nothing wrong" invalidated Ruth's lived bodily experience. According to Wendell, "being told that there is nothing wrong with you regardless of how acute or debilitating a condition may be can completely undermine a person's confidence in her lived experience and relationship to reality" (p. 123). Ruth sought empathy and looked to her caregivers to connect with her

emotionally; even to step into her emotional world and walk alongside her. Ruth's doctors failed to communicate that they understood the meaning of her lived experience.

Another silencing took place during the monitoring of Ruth's pregnancy which heightened her sense of dis-ease in secondary care. A feeling of shame manifested when Ruth made the decision not to be weighed during pregnancy as she did not want to hear about numbers. Ruth told her midwife about her decision not to be weighed. Her midwife responded with empathy, making Ruth's expression of shame a little easier. However, when Ruth transitioned from midwifery care to secondary care, her experience changed. She asked not to be weighed but the doctors insisted on it, as weighing her body would help them monitor her baby's health.

During this experience, Ruth resisted shame, moving away from it, withdrawing, and staying silent with her doctors when they asked her to stand on the scales. She gazed at the ceiling, dutifully doing as she was instructed, retreating into herself:

> *The doctor insisted on weighing me. I wasn't happy about it, but they have to do their job, so I stood there looking at the ceiling* [laughs]*. I didn't want to know how much weight I had put on. I knew I was big. I knew I was not healthy, and I didn't need the numbers as well to add to the stigma of it.*

Ruth recounted her experience of being told to stand on the scales, in an objectifying manner. In this story, she noticed the medical narratives which are designed to "rein in the 'fat' body and scrutinise its being-in-the-world" (S. Murray, 2008, p. 213). She was seen as a fat pregnant 'object' body that needed to be measured and managed, rather than as a woman who chose not to be weighed. This (un)caring response confirmed to Ruth that the medical system was focused on the needs of the baby. Ruth wanted the ability to speak up, to participate. Perhaps, though, she felt that speaking up might have been considered as speaking out-of-turn, or possibly she was worried about criticism.

Both accounts revealed Ruth's deep sense of being-in-dis-ease. The unsafeness of being in secondary care manifested for Ruth when her concerns were not heard. The needs of the system were the dominating focus of care, when what mattered most to Ruth was the right to participation in her care.

Sam: Being Steamrolled

Sam identified as an "overweight lass". She had been 'overweight' for all her life and was acutely aware of her body weight in her pregnancy. Sam was told to gain no more than 9kg, recalling weight-focused advice being the focus of conversations in secondary care. Weight was discussed at every appointment and Sam almost ignored the message because of how much it

was talked about. Reflecting on her experience of secondary care, she described situations in which she and her partner felt steamrolled:

> *I've always been an overweight lass, so I'm used to being talked to about my weight. I just shut-off, and when I got pregnant it was the same. They told me I shouldn't gain more than 9kg and went on about it at every visit. They always weigh me, but I never look down at the numbers. Because I'm a big girl I know what the scales are gonna say… "one at a time please* [laughter]*!" Nobody likes to stand on the scales, not even skinny people. Everybody has got some kind of complex about the numbers. BMI doesn't make complete sense to me. I know it's about how tall I am and how heavy I am, but it doesn't really mean anything to me. I want them to talk about me and my babies, but they never do. It's all about the numbers on the scales. When I came to my first appointment, I had barely taken a seat when they mentioned my weight, saying I was going to need a C-section. I was talked at, they didn't stop for breath, I was not involved at all. My partner was there too. He didn't stand up for me; we were both steamrolled. After that we decided we are going to take control and I won't leave the chair until I'm 100% satisfied I understand what they mean. These are our babies! My midwife, in contrast, was amazing. She gave me the weight chart early on and she said, "I'm going to make sure your babies are healthy - I'm not going to make you hop on the scales all the time". The thing is, I'm confident about who I am. I don't have a problem with my weight because I'm the one who controls what I eat. So, if I wasn't happy with who I am I would have changed it by now. I love my body and I'm not embarrassed about being big.*

For Sam, this was an appointment about her pregnancy and her and her babies' health; but, for her caregivers, it was primarily about her weight and the need for her to have a Caesarean section. These two factors seemed to put her caregivers 'in charge' of what happened to Sam and her babies. Sam felt talked at and had a sense she was no longer in control of what happened to her and her babies. Sam's noticing of dominant medical values initially led to Sam anxiously and compulsively weighing her body. Revealing her fleeting pre-occupation with weight early in pregnancy she said, "I'd hop on the scales every morning to see how much weight I'd put on".

Sam and her partner were treated as though they were not involved in the decisions of her pregnancy. It appeared to Sam that secondary care values-based rules were focused on risk. Upon seeking an explanation for weight gain recommendations, Sam came to understand that the advice to limit weight gain was due to high pre-pregnancy BMI, the risk of diabetes for the

babies, and medical concern for her bodily recovery. Sam understood the advice, even identifying with the 'problem of overweight'. Yet, there was a sense that, for her, achieving health was much broader than medicalised re-produced concepts of risk. For Sam, it seemed that the BMI-focused advice lacked relevance and failed to align with her core needs and aspirations for health.

Sam also talked of the disharmony between her midwife and doctors in secondary care. For her, self-efficacy was easier to achieve in midwifery care as opposed to secondary care. Revealing the inter-professional dissonance, she compared midwifery care with obstetric care. Sam felt her midwife understood the consequences of BMI-focused messaging on women, which enhanced Sam's trusting connection with her midwife. Portraying her midwife as "a bigger lass", Sam sensed her midwife identified with Sam's experience of being 'overweight'. She described her midwife's noticing of 'something in her face', which facilitated a deeper advocacy experience for Sam. There was a connecting with her midwife upon the realisation that her midwife connected with her on different aspects. Whereas Sam was connected to doctors through numbers, her relationship with her midwife was on different aspects: aspects unrelated to just numbers.

Sam's experience, at first, was of wavering and hesitation as she negotiated her perceived maternity's pathologising obsession with weight gain. The experience of steamrolling was confusing and anxiety provoking. Disappointment and irritation manifested and showed themselves in resistant moments as Sam became increasingly disconnected from her caregivers. Sam 'shut-off' from her doctors, isolating herself from the chaos happening around her. This shut-off, and maybe even a splitting from her doctors, may be interpreted as a deep rejection of the dominance of weight-focused practices and dimensions of medicine.

Yet, later, her experience changed to one of detachment as she came to disregard weight monitoring because it lacked meaning for her. These discordant relationships were unpleasant for Sam as it appeared that her doctors were not emotionally attuned to her needs. Sam even rejected the medical notion that her body was at risk. Her disavowal of medicine's focus on weight showed that Sam turned away from medicine's obsession with fixing and controlling large maternal bodies. Not feeling respected or involved in decisions about her babies triggered resistance for Sam. This experience had meaning for her at a deeper level. For Sam, meanings came-to-be in various ways, in those in-between spaces, where she found herself in relations with her caregivers. Maternity's dominant values and practices produced tension for Sam. As she came to see her interactions as (un)caring she distanced herself from her doctors.

The following post-reflexion journal entry after my interview with Sam reveals more of women's disconnection from numbers, uncovering medicine's fascination with fat bodies and associated surveillance tactics, designed to reorient fat bodies to fit in with medicine's dominant values:

> Before we finished, I asked Sam if there was anything else that she thought I might have asked her about. With a sudden change of tone and new tenderness in her voice she said she was so pleased I hadn't asked her about numbers. She switched her voice to a different tone, as though she was performing, and her voice was a prop. "Because I'm a big girl", she said, "I know what the scales are going to say - one at a time please". She erupted into laughter, inviting me to join her. She seemed to wear her voice as a costume, perhaps in attempt to help me – her audience on this occasion – accept the reality of her message. Even though she was laughing, I detected a sadness in her voice; it was the same sadness I've heard in other women's voices. Perhaps sadness is shrouded in shame because being weighed is really a nightmarish situation for women. I became aware that women wear masks of comedy in maternity, using humour as a form of cognitive re-appraisal. Comedy was present in so many stories, especially narratives depicting uncomfortable, alien, environments which *push* feminine knowledge with the social and moral discourses on fatness and *pull* women toward medicine's pathologising discourses. Experiences of being pregnant in large bodies are diverse but a common lived experience is fat as deviant, abject, and pathological.

The phenomena continue to reveal its complexity in my post-reflexive journaling during the gathering and analysing of women's experiences.

Following this rupture in the harmony between Sam and her doctors, her perception altered, and she realised that she had to take control. In these in-between spaces and moments, Sam experienced a reclaiming of control and enhanced sense of self; a recovering of self-belief and trusting in her body was unspoken. This restored way of seeing the world gave Sam an enhanced sense of wellbeing as she reclaimed control over her body and sought an active role in caring for her babies. Sam's relationship with her partner helped her to maintain power by sharing her experience with him; involving him as advocate in an environment where she had to negotiate relationships and reclaim control. Sharing meant that she received confirmation from her partner and when the concerns of their experience were confirmed, she felt strengthened. No longer anxious, Sam's mood became one of humour and tolerance as she surrendered to the irresistible force of secondary care.

Later on, in a different context, Sam found herself in a further situation where a sonographer believed she was within her rights not to share information about Sam and her babies with Sam. Sam's experience reflected an interaction with a sonographer who did not seem responsive to her need for knowledge. Sam resented knowledge being withheld or controlled. The sonographer refused to show Sam the chart she was filling out and told her that to see the chart she would have to ask her doctor. Re-living her encounter with the sonographer, Sam spoke of her experience of relational turbulence:

> *When I was having a scan, the situation steamrolled again. I asked to see the chart, but I was told to ask my doctor. Remembering my last experience, I was not leaving that bed until I got it. My partner was worried I would have a tête-à-tête with her* [sonographer] *but I wasn't hopping off that bed until I saw it. I want to see, and I want to understand. I'm the mother.*

The sonographer, for some reason, saw the doctor as having the right to decide who should see information about Sam and her babies. Sam found herself having to pause and not hop off the bed until she had the information. Sam's experience led her to believe that doctors, and others in secondary care, had a different opinion, so she had to ensure she and her babies were getting the best care. This story reveals the strategy of reclamation, showing how Sam reclaims the living present as "a scene for fulfilling and purposive action" (Leder, 2016, p. 169) through having the courage to confront others in uncomfortable situations. Responding to relational turbulence, Sam navigated the power differential in these relationships by accessing self-trust and self-efficacy. Maintaining power was a core priority for Sam; it was her main concern. Her goal was respectful and equitable relationships with the secondary care team. Sam had a sense of power that she expressed as a bodily and mental strength to have the right to access information on her pregnancy.

Sam's stories collectively present an interesting insight in the world of pregnancy. When there are issues such as weight, it would appear that once things are not straightforward there is almost a transfer of who is in charge of what will happen. In an age of informed choice and consent, it appears that when there are complications of pregnancy, choice and consent may not readily live with the woman. This, then, leads the woman to have to act, such as not 'not leaving the chair' or 'not leaving the bed' until she is given information and understands. For Sam, not leaving the chair or the bed was an active reclaiming. It was as though she experienced the bed and chair as something solid, as objects which provided the space for a reclaiming action, helping orient her towards her purpose of protecting her body and her babies within. The furniture perhaps signified support, assisting Sam to regain control of her appointments,

easing her sense of distress. Ahmed (2008) examined the concept of being orientated, exploring what it meant for bodies to be situated in space and time. Ahmed suggested that bodies take shape as they move through the world directing themselves toward or away from objects and others:

> If we know where we are, when we turn this way or that, then we are oriented. We have our bearings. We know what to do to get to this place or to that. To be oriented is also to be oriented toward certain objects, those that help us find our way. These are the objects we recognize, such that when we face them, we know which way we are facing. They gather on the ground and also create a ground on which we can gather. (p. 1)

Sam's experience was more than a feeling of disorientation or displacement in secondary care. Sam's use of metaphors, such as "being steamrolled" and "feeling railroaded", revealed a deep dis-ease associated with secondary care which gave a sense of her feeling simultaneously flattened and yanked in a different direction. It was only through the constricted spatiality of the clinic that she came to see her lived body as a deviant body. However, her inner knowing reminded her of the beauty of her body; this memory brought her joy: "I'd like to get photos taken in my pregnancy and I'd like those photos to be flattering and sexy, showing others how beautiful pregnancy can be". Sam had a strong sense of self which enabled her to negotiate the power differential in the relationships she encountered.

Becoming aware of the power relationships (Lupton, 2012) in secondary care, Sam felt that no one was listening to her embodied knowing. It seemed to her that her unique understandings of her body were neither accepted nor valued in secondary care and her doctors' reluctance to listen created tension in the relationship. Sam could not embrace authoritative, medical knowledge without seeking to understand the meaning of such knowledge. Alternatively, Sam valued the worth of personal knowing related to her pregnancy. She came to the phenomenon with prior knowledge about her body. She did not deny her knowing as it relates to her body but used her inner knowing as a basis for learning and decision-making. Sam trusted her intuition regarding her cognitive and bodily abilities to nurture her babies; she had an undeniable attachment to her babies. Sam was orientated towards a shared sense of power, an equal relationality. She was serious about being treated as a moral equal. Her stories uncovered the significance of her lived body being concretely grounded and present for her. The objects seemingly anchored her, as though provoking her need to find meaning and re-connect with herself. Her analytical nature was a resource that she used as a way to stop the steamroller tactics; helping her make meaning of the challenging experiences.

Sam's account illuminates how the particulars of finding oneself in distress become nuanced and shifts. Being-in-dis-ease in one moment was different to the next and Sam's lived experiences were marked by difference and ruptures. For Sam, it would seem that the BMI-focused approach in maternity was harmful and unproductive. The BMI narrative in maternity has a high values component and her doctors' values were in dispute with Sam's preunderstandings of a healthy pregnancy. Importantly, her story shows how acts of reclaiming saw Sam re-mark the boundary for equitable relationships; helping her regain a sense of authority over her body.

Christina: Maternity Care – Cure or Dis-ease?

The strategy of blended integration (Leder, 2004, 2016) is implicit in this next story. Initially Christina resisted weight-focused advice and felt 'tied' because of restrictive guidance. Later, she described a purposive letting-go of some of her traditional eating patterns to adapt to western eating as she found herself realising that losing weight would mean a healthier pregnancy. Christina adopted a strategy of reclamation when her spatiality became constricted in the alienating context of secondary care, illuminating how she re-harmonised her world, through positively affirming and thereby reclaiming aspects of dietary advice that might otherwise seem alien to her.

Pregnant embodiment heightened Christina's sense of disruption and dis-ease about bodyweight and appearance. Before pregnancy, Christina was unconcerned about her bodily appearance. In her former, un-gravid, body she identified as healthy, but in pregnancy she struggled with the conflicting positions of 'normal weight and healthy' and 'overweight and diabetic'. Christina sought to understand the meaning of 'overweight', as she attempted to unravel her new 'overweight' identity:

> *I didn't expect that I will get diabetes because this is for fat people. It's a little bit of a worry for me. My family is all in China and I told them I had diabetes. They were surprised, just like me. My family was so surprised they asked a doctor in China for advice. Chinese doctors would not suggest I take medicine for diabetes. They say my blood glucose is standard and can go up to 11 and they think this level is not harmful. But here my levels can't exceed 6.7 and they told me Metformin is good. But I am very uncomfortable about taking medicine. I worry about the side effect on the baby's function. I kept asking for reassurance, but the doctor told me medicine is safe, so I have to listen to him. I don't tell him about Chinese standards because he is the professional. This is my first baby and I have no experience, so I will take professional advice. My family say follow here's advice as they think that I will be taken care of. But*

I'm surprised. I still look thin. I feel good. I still look alright, don't I? I don't expect that my size is not good. I don't even buy a pregnancy dress. I would think I'm not fat, but the midwife tells me not to take too much food because of overweight.

Christina noticed the differing approaches to treating diabetes and described the tensions arising from competing management approaches. Feelings of unease persisted when Christina began using Metformin in the last trimester of her pregnancy. Reflecting on the eastern approach to medicine, she explained how pregnant women are discouraged from taking medication whilst pregnant. Christina transitioned between two belief systems and held several viewpoints simultaneously, though the different approaches brought about an uneasy dilemma. Christina's help-seeking was driven by motivational factors such as dealing with fear and uncertainty, understanding the nature of the condition, and the approach to diagnosis and treatment of diabetes. Furthermore, her strong motivation to protect her baby was manifesting. She shared how cultural connections were significant in her life and helped her navigate the challenges of receiving care in a western healthcare system. Her meaningful connections with her family had a powerful impact on how she viewed herself and helped Christina engender trust in western advice, thus easing her anxiety.

Adhering to traditional values, Christina trusted her family's recommendation that she should listen to the advice from her caregivers. In this situation, deciding not to tell her doctor about the differences she noticed between China and New Zealand, being cooperative rather than confrontational, held meaning for her. Instead of uncovering her doctor's treatment rationale further, Christina's priority was to preserve harmony in health care interactions. Christina placed her trust in professional advice, but perhaps she felt obligated to follow the advice because this was her first baby. Pregnancy was a new experience for her, and it was as though she felt she had little real knowledge nor the privileged position of having experienced pregnancy before. Thus, for Christina, embodied knowledge paled in comparison to that of her doctor: she had to listen to him.

Feelings of dis-ease and anxiety manifested again when Christina's midwife advised her not to overeat during pregnancy because she was concerned about her increasing weight. As Christina did not look 'overweight', she was initially reluctant to accept that her weight was problematic, resisting the messages about 'overweight'. She intuitively felt her body weight was normal until she encountered maternity's watchful and critical gaze. When Christina was advised to not overeat, she experienced a critical, unanticipated moment. Her experience of body image and wellbeing was rendered in-flux as she shifted from a familiar to an unfamiliar embodiment. A feeling of surprise and unexpectedness manifested for Christina. In this in-

between space, her beliefs and ways of seeing the world became disrupted, as she considered the possibility that her gravid body was 'overweight' and unhealthy. In the philosophical literature, Dastur (2000) suggested that surprise happens when the event that occurs is an "impossible possible" (p. 183). Surprise was a sense-making process for Christina. How she felt in her pregnant body shifted when Christina's relationship with her midwife brought notions of risk and uncertainty.

Yet, later, she spoke of how distress turned to delight when she lost weight. Enthusiastic, motivated, and optimistic intensities were circulating through Christina's language, were embodied, and were lived, which, in turn, evoked motivation for change. Christina internalised the messages regarding her weight. Sharing her experience with calorie restriction, she said:

> *I've made some big changes. I've been on a very strict diet. I follow the dietitian's advice every day and I lost at least 2kg. At first, I feel a bit tied because of the regulations as I need to check the energy and sugars before I eat anything. But now I command myself to follow this advice for the rest of my life. I care very much about what I eat. My partner is healthy now because we eat the same thing. He's lost weight too.*

In feeling surprise, Christina shifted her view of the familiar. As Christina narrated her story, it facilitated an unfolding process. She reflected on how the experience expanded her horizon, changing the moment and shedding a different light on the familiar. Thus, elements of reclamation and escape are shown in Christina's story. Where her spatiality had been constricted in the secondary care clinic, her story tells of her doing what is possible to re-harmonise her world.

We are reminded that we always inhabit the world with others and, as such, space is a shared construction, deeply influenced by those around us (Leder, 2004). Christina's story shows how her dietitian, a sympathetic other, assisted with the process of reclamation. An experience of 'togetherness' was produced through Christina's relationship with her dietitian which radically expanded her lived space, enabling her to reclaim the present as a scene for decision-making.

The next two stories show how Julie and Jennifer adopted strategies of reclamation. Their reclamation strategies took different responses when navigating experiences of medical paternalism in secondary care to claim control and give meaning and richness to their experience. These stories show how reclaiming embodied wholeness (Leder, 2004) was challenging in the face of the disciplinary gaze.

Julie: Knowing Her Body Best

Julie described feelings of shock at uncovering her pregnancy. Recalling her previous complicated pregnancies, she spoke softly as she recalled the challenges of being pregnant:

> *I was shocked, absolutely gutted, when I heard about this pregnancy. It was very, very difficult. Both my previous pregnancies were very different but equally challenging. It's been five years since I was last pregnant and now my body has to re-learn everything. I was huge before I got pregnant. My BMI was almost 50. My specialists are concerned I will put myself at risk if I gain too much weight. They said it's going to be risky for me. They know the stats, but I know my body... I know my body best. I trust my body but it's as though they don't. I would know if something is not right. I just felt dictated to in this conversation. I'm getting really distressed about the numbers. It's psychologically damaging to focus on BMI because physiologically our bodies are designed to change. Don't focus on numbers, focus on anything else. I've talked with a lot of second- and third-time mums; they all think numbers don't mean anything.*

Doubt enveloped Julie as she prepared for the birth of her baby. Sensing her doctors' disregard for her embodied knowing, her initial experience was one of doubt and uncertainty. Julie's former confidence in her body was displaced as doubt manifested with intrusive intensities, modifying her experience and provoking detachment from her caregivers. Julie felt her doctors did not involve her in discussions about the birth, nor did they trust her intuitive knowing that her body was capable of birthing normally.

Trusting her body, Julie, at first, relied on deep-rooted embodied knowledge from her previous pregnancies; her body providing this inner knowing. Julie attempted to make decisions about this pregnancy and birth, but her bodily knowing seemed to be overlooked and lacked authority in the conversations with her caregivers. In this maternity context, Julie sensed that medical knowledge assumed priority and, for her, being in secondary care disrupted her autonomy and experience of embodiment. Concurring, Bernstein (2011) described bodily doubt as a disruptive force which can challenge our taken for granted assumptions about the world and, as such, expose feelings of reality which are vulnerability, existential uncertainty, and dependency on others. These insights resonate with Carel (2013) who alluded to bodily doubt as "radically modifying our experience in three ways: loss of continuity, loss of transparency, and loss of faith in one's body" (p. 178). For Carel, bodily doubt constitutes a disruptive internal force which dynamically alters our veer of normality.

Julie felt that her doctors' intentions were in opposition to her bodily need for control. Distrust prompted Julie to take steps to reduce her vulnerability and draw from her embodied

knowledge to engage in a process of re-learning. She shared her account about trusting her body, saying, "I know my body… I know my body best". Through interpreting the feelings in her body, she became aware that her body would intuitively remember what it felt like to be pregnant and birth. Embodied knowledge is derived from a woman's perception of her body and its natural processes (Browner & Press, 1996). The notion of embodied knowledge is derived from Merleau-Ponty (1962), who referred to it as a 'knowledge bred of familiarity'. Thus, embodied knowledge is a type of knowledge where the body knows how to act; the knowledge seems to be imprinted in one's body. Cheyney (2008) argued women's connection with their embodied ways of knowing can "implicitly challenge the (over)reliance on technology and hypervaluation of scientific ways of knowing that they believe characterise more medical approaches to childbirth" (p. 259). It seemed that Julie's doctors did not take her judgements about her bodily experiences seriously. She felt that her doctors prioritised scientific, statistical knowledge as the only legitimate form of knowing. It was as though medicine would only allow her body to birth normally if the science supported it. Numbers had dominance in her conversations and, for Julie, such language-discordant conversations lacked relevance and meaning. Julie found medical language disempowering and spoke of her distress at hearing about numbers. Julie's account uncovers how maternity's focus on the BMI in pregnancy is ill-placed. Describing the BMI tool as unhelpful, she said, "physiologically our bodies are designed to change".

A mood of insignificance manifested when Julie's doctors seemingly overlooked what was important to her. In the following narrative, Julie spoke again of the conflicting clinical perspectives held by her specialist team. Her story shows the opposing views to management of weight-related risk:

> *The doctors are keeping on top of my weight which means I don't have to. I'm waiting on them to decide whether a C-section is necessary, and my weight is a factor in their decision making as being over 120 kilos adds greater risk. My doctors can't agree though. One of them said, "let's just hold off and play it by ear"; whereas another said, "with your weight, yes, it's going to be risky and a section will be safer for the baby". But the doctor who is reluctant to book me for a C-section is the same doctor who can't even find his heartbeat on ultrasound, so I have very little faith in her.*

Julie surrendered control to her doctors and described a letting go of responsibility for her body. On one hand, she wanted to hand over control to her doctor for monitoring her weight; on the other hand, she did not want to relinquish decision-making about her birth. Through the act of handing over her body to her doctors, Julie's embodied experience was of drifting

apart from the world, from her caregivers. The body is no longer the taken-for-granted seat of our powers but a distrusted other (Leder, 2016). Julie felt intense pressure to accept the type of birth deemed safest for her baby; the statistics appeared to mark out a path which was clearly safer. It was as though she was expected to look at her body through the lens of risk. Perhaps there was inevitability about relinquishing control in secondary care as Julie considered holding her own risk would only add to her already sizeable responsibility for her body.

Following the interaction with her doctors, trust was severed, and a deeper sense of being disconnected manifested. Julie critically evaluated her doctor's recommendation that a C-section was safer. In doing so, she questioned the capabilities of her doctor, as it was the same doctor who could not find her baby's heartbeat on ultrasound. In Julie's view, this doctor was not a reliable knowledge source and she concluded that the doctor did not have enough integrity to decide about her pregnancy. Here, her distrust of this doctor evoked a competitive orientation as she considered the priorities of scientific versus embodied knowing. Julie's comment about 'knowing her body best' is an example of reclamation as to protect her body from negative judgement she positively affirmed and thereby reclaimed autonomy, through her reliance on her embodied ways of knowing. Shared decision-making engenders some responsibility for those decisions made and this is particularly important when a pregnancy is already complicated by a challenging history and current risks. Yet, as Julie's story unfolded, it appeared that she felt challenged by her lack of involvement in medical discussions. Her doctors took over decision-making, being directive rather than offering choice, essentially limiting her reproductive autonomy in undesirable ways. Attempting to negotiate increased control, in a medicalised and fetocentric context, provoked feelings of discomfort and disillusionment for Julie.

Julie's experience was of recurring risk-focused conversations with her obstetric specialists, conversations that increased her understanding of her doctors' concerns. Pregnant women labelled high-risk are more likely to experience negative feelings related to childbirth (Berg, Lundgren, & Lindmark, 2003). Although these pregnant women require specialist care, they need to participate in the care process (Berg, 2005). Kukla et al. (2009) argued the importance of giving women access to births that are both safe and expressive of their autonomy. Julie's maternal embodied experiences supported her to challenge the authoritative knowledge of her doctors (Browner & Press, 1996), using strategies in which she sought other women's experiences which enabled her to exert agency in her birthing decisions. Drawing from other's embodied knowledge in social networks enabled her to access to legitimate alternative forms

of knowledge (Cheyney, 2008); in doing so, re-humanising the lifeworld through a strategy of reclamation (Leder, 2016).

Jennifer: Thickening Her Skin

Jennifer's story is of bodily uncertainty when she was transferred to secondary care. Feelings of doubt took on a particular inflection when Jennifer came to realise that she was not having a 'normal' pregnancy:

> *I've always been bigger but this time I'm at my heaviest. I thought everything was ticking along quite nicely; thought I was having a normal pregnancy. I knew that I was looking after myself to benefit my baby. So far, my baby is OK, but it seems that I'm not as healthy as I should be. My midwife told me she had no choice but to transfer me to secondary care. So now, because I'm a bit heavier, I'm having to be checked on with other people as well. It's upsetting to think that I've been through three other pregnancies at a similar weight where everything's been OK, and I've been left alone. It feels like they are invading on my space. Was this because I'm bigger than I was in my other pregnancies? I'm guessing that's the reason. I felt hurt when I realised, I was being set apart from other women - normal women having normal pregnancies. My midwife told me it's not a nice place. She said to put a thick skin on as they will say things I don't want to hear, "they might think you're not looking after yourself". I got so worked-up and frightened before the appointment. It was like going to jail almost. I felt plunged into the unknown, like I was falling into the mysterious territory of secondary care. I was really unsure what it meant to go there. I thought they would tell me I've been silly and that I shouldn't have done this to myself. I steadied myself, anticipating a stern telling-off in the corner. I wondered if the staff knew why I was there. I'm sure they didn't, but I had a feeling that maybe this clinic was only for overweight women. Did they just see me as an overweight person? Would they only see me as I am now, the weight being a blemish on my character? But it was nothing like I expected. Really it wasn't! The doctor made it clear I had to solve the problem of my big body. I told him my goal weight and he thought I was being very reasonable. When I heard my BMI being compared to an average person, I knew I had to do something. I knew I can't keep doing this to myself. Somehow, I didn't know I was that big. How did I even let it get like this? Now I'm making the right decisions the weight isn't creeping on as much as I thought it would! I'm glad I was told to be smart and clever.*

Jennifer's BMI was more than 40kg/m^2 at her first antenatal appointment. It was through the experience of being pregnant that she came to realise the meaning of a high BMI and the

implications of this measurement for her health. Jennifer described her experience of "all the goings-on" and the increased surveillance throughout antenatal care because she started this pregnancy a little heavier. Jennifer's experience of lived space in maternity was changed by being a little more 'overweight' than her previous pregnancies. Schumacher (2010) noted we are not usually conscious of lived space; however, it is the space that affects our feelings. The space in which Jennifer found herself affected how she felt about her body, a sense of threat and intrusion manifested when the sacredness of pregnancy was not protected. The celebration and joy of pregnancy she expected was taken away and replaced with the burden of increased contact with multiple caregivers. For Jennifer, being passed on to secondary care came with an element of sickness and dis-ease.

The discord in this story points to conflict and resentment at the involvement of multiple caregivers in her pregnancy, leading to Jennifer feeling overwhelmed by the others involved in her care. At the beginning of her pregnancy, she intuitively felt healthy, saying, "I knew that I was looking after myself to benefit my baby". Yet, through her experience of lived space in maternity, she came to see that she was not a person who was having a healthy pregnancy: "So far my baby is OK, but it seems that I'm not as healthy as I should be". Jennifer talked of how her pregnancy was ticking along, making the positive sense explicit, adding "quite nicely" to emphasise her sense of comfort with her body. Being transferred to secondary care was almost comparable with being sent to jail, emphasising the constraints on her freedoms and the giving-up of independence. Suddenly her thoughts became tangled, her body tense, her senses on alert. In her story, she reflected experiences of disbelief, powerlessness, and uncertainty, struggling with the reality of being unhealthy. Being sent to secondary care felt extraordinary, seemingly shattering her worldview.

Jennifer experienced negative emotions related to her transfer of care and she expressed feeling separated and alienated from other women, recalling how much disappointment she felt from being pulled-away from healthy pregnant women of a normal weight. This is confirmed by I. M. Young (1990), who alluded to the tendency of medical conceptualisation to treat pregnancy as a disease producing alienation for the pregnant woman. It is possible that the midwife's depiction of the clinic provoked how alienation manifested for Jennifer, heightening Jennifer's concerns that secondary care was an unsafe place.

Jennifer found the surveillance of her body disturbing. The intimate space of her body was invaded by unexpected others, putting her in a protective position, as though protecting the space immediately around would protect her body from hurt. She appeared to initially adopt a defensive position, wondering at others' intentions. Jennifer was told to thicken her skin – it

was as though Jennifer felt the world with thin skin which would not protect her there. She came to see that a thicker skin or defensive layer would help her withstand the criticism and insults that would likely come. Listening to her midwife's advice, Jennifer's skin thickened in this shared space as though it was a way of projecting a particular version of herself—a stronger and more invulnerable self—to the world. In Jennifer's account, the medical discourse of obesity resonated with her. Her body was the object of the critical gaze under which Jennifer accepted her deviant identity and the risky status of her body. Under this gaze, her body softened, conforming, as she became open to new ways of being and found herself aligning with the perspectives of her doctor and midwife; her experience becoming one of positive interaction.

The poem that follows illuminates how thickening the skin can keep the outside out, capturing my own reflections about Jennifer's experience of lived space in secondary care. It reflects how Jennifer used the strategies of escape, then reclamation (Leder, 2004, 2016), to harmonise her world. In doing so, the complexity associated with elucidating the grey and the showing of the endlessly deferred possibilities is uncovered (Vagle, 2014, 2018). The goal of post-intentional phenomenological analysis is to elucidate the productions, provocations, and shapes rather than trying to centre meaning. Jennifer's story shows that meanings are not fixed nor stable; rather they are continually being re-shaped. In this way, "…the intentional 'findings' of phenomenological research are de-centred as multiple, produced, provoked, partial and endlessly deferred" (Vagle, 2018, p. 132).

<u>Keeping the outside out</u>

She says, thicken up your skin.
How I need to grow it tough,
to keep the outside out.
They need to keep checking on me.

Breathe.
Keep the outside out.

She says, I will hear things I don't want to hear.
How my skin wraps around me tighter and tighter,
in this not-nice place.
They think I'm not looking after me.

Breathe.
Keep the outside out.

She says, it's not personal.
How I sit there, keeping the outside out.
Miles away I say, this is my goal.
They think I'm being reasonable.

Breathe.
Let the outside in.

She doesn't know how it got this way.
How the weight creep is now not so much,
now I'm making the right decisions.
They are happy. I am happy,
with me.

Let the outside in.

Recently, women's experiences of hospitalisation in pregnancy have been likened to being in carceral spaces (Lomax, 2019). In this study, being under intense scrutiny in secondary care contexts provoked an experience of feeling like prisoners through having little control in confinement. Similarly, Jennifer's story shows concepts of 'doing time', revealing how secondary care resembled a form of a carceral space. van Manen (2016) described the existential lived space as the space we exist in, or which encapsulates us, affecting how we feel and act in the world. In the lived space of secondary care, Jennifer was unable to move freely through space without feeling controlled, observed, and watched.

In his phenomenological analysis of how "imprisonment constricts, disrupts, and fragments lived time and space, and one's experience of embodiment", Leder (2016, p. 9) showed how individuals construct strategies of response. While the lived space in secondary care provoked the need to hide or escape, Jennifer's response changed when it was nothing like she expected. It was possible that her reasonability, that is, her responsiveness to solving the problem of her big body, seemed to protect Jennifer in this space. Being-in-dis-ease, Jennifer committed to working with others through sharing her goal weight, essentially retaining some freedom and responsibility that Leder (2016) referred to the "ability to respond" (p. 9). It was possible that her response reflected reclamation as she worked with her caregivers in a positive way, harmonising her world. Jennifer, perhaps, started by reclaiming the present, asserting bodily authority through making a decision to manage her weight. Happy, that in the present she was discovering the joy of being able to stop the weight, "creeping on as much". Jennifer found a way to turn the medical gaze, which was potentially alienating and disempowering, into a source of personal power.

Jennifer thickened her skin to keep the outside out yet later let the outside in. This story elucidates the grey (Vagle, 2014, 2018), revealing the possibilities of what is happening in the in-between. It provides a further example of how some women are not passive but active agents – retaining freedom to respond creatively in restrictive maternity care contexts. One of the possible things that may be happening here, is what Leder (2016) described as "a careful

division and manipulation of space, time and movement creates docile bodies of its inhabitants, minimising their resistance while maximising their utility" (165). It is as though Jennifer had been conditioned to take on the advice; yet, she experienced this as her own triumph, even glad that she had attained more self-mastery (Leder, 2016).

From within Julie's and Jennifer's stories, it appeared that their sense of certainty and confidence in their bodies was disrupted in secondary care contexts. Another dimension in these women's stories was that they felt their bodies could not do what they were required to do, such that a low-intervention pregnancy and birth was entirely out with their bodily competence. I show that women's interactions with secondary care, in many instances, diminished bodily certainty. These women's bodies were, at times, exposed and rendered passive and compliant, as explicitly described by Jennifer. Yet, concurrently, these women moved to a place of positive acceptance and change.

Chapter Summary

In this chapter, women shared stories of complex experiences often filled with ambiguity and paradox. Findings reveal what it is to be in a distressed body. Though women had a heightened awareness of their bodies, in many cases they no longer felt at home in their bodies. For some women, the maternity system produced disruption, moving women towards being-in-disease. In this state, there was a search for legitimacy which implied a re-evaluation of the relationship between their identity and sense of self. Being under watchful surveillance appeared to displace women, pulling them apart from others and self. Furthermore, these accounts draw attention to the increased and extensive medicalisation and pathologising of maternal bodies. Contemporary maternity contexts have the power to distinguish between healthy and pathological maternal bodies, negatively impacting women's experience of wellbeing. Thus, the experience of women concerning the 'overweight' maternal body as ill and needing to be managed, can shed new light on taken-for-granted aspects of maternity care. This chapter showed how women, living through disruption and in-dis-ease, used strategies of escape and reclamation or a fusion of both. A synthesis of the tentative manifestations is provided in the next chapter.

CHAPTER NINE: SYNTHESIS OF THE TENTATIVE MANIFESTATIONS

Putting phenomenology into play, or interplay, with politically oriented theories and methodologies (Vagle, 2014, 2018) created an opening for me to think differently about women's strategies of response in clinical and social contexts. This inquiry has been shaped by I. M. Young's (1980, 1990) theorising on pregnant embodiment, Antonovsky's (1979) model of salutogenesis, and Leder's (2016) insights on distressed embodiment. As I moved through this inquiry, I later turned to Leder's carceral theorising, namely the strategies of escape, reclamation, and blended integration, to understand what was happening for women who experienced maternity care and health promotion in biomedical contexts. The findings articulate the meaning of being in diverse maternal bodies in complex contexts, in a way that have not previously been explored. The dialogic possibilities (Vagle, 2014, 2018) expose 'the grey' of the women's lived experiences, revealing the complexities involved for maternity care professionals in meeting women's holistic health needs. While it may be perceived as surprising that theories from prison phenomenology have come to bear in this study, it illuminates how some women experienced aspects of maternity care as something akin to structural oppression and dehumanising treatment often experienced in the prison lifeworld, and points to how restrictive care contexts provoked and produced a variety of strategies which enabled women to re-harmonise a disordered world.

There are connections between the tentative manifestation chapters as this study makes visible the stories and experiences of the women, in all of their diversity. While the chapters were structured to reflect the tentative manifestations uncovered, the crafted stories often related to more than one theme. Glimpses of disruption, disconnection, comfort, and connectedness are evident in each of the tentative manifestation chapters, illuminating how women's experiences of ease and dis-ease were not fixed but continually on the move as they interacted with others in clinical and social contexts.

The stories uncovered how women accessed resources from multiple levels which anchored women to familiar meanings and ways of being-in-the-world. Salutary rich contexts and situations helped women connect intentionally and more meaningfully with self, others, and things in the world. When women experienced empathetic care, they considered this a salutary factor, or that it had salutary benefits. The experience of feeling strengthened was achieved through meaning connections with others, and from experiencing a deep connection to cultural understandings and embodied knowledge. Thus, women experienced a sense of ease with their decision-making and behaviours. These women achieved more control over their

bodies through self-expression and self-determination. It appeared that, for these women, their resistance to dominant ideologies was possibly linked to a desire to change the focus on maternity's rejection of large bodies to narratives towards acceptance of diverse bodies. Their stories perhaps demonstrate how women were seeking more harmonising experiences and embodied ways of seeing the world, pointing to the use of reclamation strategies by women. Person-centred care, which engaged with women's emotional and value systems, enabled women to create health. Further, relational richness with maternity health professionals was revealed as being a critical enabler of wellbeing in maternity contexts, demonstrating the importance of quality of relationships to wellbeing. The counter narratives produced by women took on particular importance, helping restore their orientation to the world.

Many women's stories pointed to disruptive care experiences. In (un)caring contexts, women came to see their bodies as 'problem' and 'risky' bodies. Pregnancy care was pre-occupied with surveillance of bodies and was exclusively focused on women's clinical features, rather than social features and influences on health (including poverty, childhood experience, and environments) which present risk factors for ill health. The risk-focused approaches and ideals in secondary care contexts appeared to encourage conformity to the medicalised care processes. In these contexts, maternal health promotion was received by women in a climate of risk. Under maternity's critical gaze, these women appeared to take-up the risk-narratives surrounding body weight and health. For women who experienced medicalised care processes and pathological medical discourses, interactions with caregivers were experienced as detrimental to their autonomy and expression of choice. In these situations, women described being minimalised in their own care. Dis-ease and distress manifested for these women and they used strategies of escape to cope with their disordered worlds.

Some women fluctuated between having a healthy body experience and a felt sense that they were transitioning to a 'body-at-risk'. These women experienced uncertainty and ambiguity before finding a deeper experience of bodily agency. Amidst disruption, these women appeared to reject medicine's view of the body, instead privileging feminine, cultural, and spiritual ways of being. Women were active at producing a change in disempowering narratives to regain order and achieve harmony and wellness. These women's stories pointed to an active resistance to the deficits-focused health promotion model in maternity. Disconnecting from BMI-focused advice, women were reoriented towards a health promoting paradigm and used reclamation strategies to normalise diverse maternal bodies and situations. Women did not appear to consider their bodies were at risk. Rather, these women appeared to privilege their

bodies in their unique social contexts, valuing the influence of salutary factors which helped them re-connect with their values and beliefs.

Women sought care which promoted empowerment and wellbeing; desiring control over how their bodies were weighed, measured, and managed. Care which respected feminine bodily knowledge, experiences, and dynamic ways of being-in-and-moving-through the world was essential to achieving wellbeing. Women in this study sought harmonising interactions and empathetic care which reflected their values, social contexts, and clinical needs. Though women were being cared for in medicalised maternity contexts, women sought normalising care experiences and described the importance of caring interactions which validated their embodied knowledge and shared women's celebration of transitioning to motherhood. Women hoped for possibilities for understanding and empathetic care, in which autonomy, decision-making, and choice remains with the woman. For women, health was not only biomedical: wellness was not framed by biomedical understandings of health.

Findings identify the need for maternity carers to understand how women's experiences of pregnancy differ from caregivers' understanding of health. Women's stories expand our understanding of factors which produce and provoke salutary connectedness and its associated experience of feeling renewed and empowered for women, which go far beyond medical and public health understandings of 'healthy' bodies and 'healthy' lifestyle change. Furthermore, findings call into question the use of pathogenesis to frame maternity services and challenge the relevance and effectiveness of deficits-based health promotion models. These chapters (6-8) draw attention to the extensive medicalisation and pathologising of maternal bodies and provide the basis for a critique of health promotion and the policy agenda which need to personalise maternity care and avoid problematising this group of women.

The discussion chapter, which follows, shows that exploring women's experiences through post-intentional phenomenological approaches has provided rich interpretation with a post-intentional emphasis. Recommendations are outlined that consider the implications of health policy and health promotion practice based on women's embodied experience as not fixed, but as fluid and always in motion.

CHAPTER TEN: DISCUSSION

This chapter draws together the preceding work of the thesis to formulate a response to the research question and aims which were outlined in chapter one. This important research reveals a new understanding of maternal health promotion, grounded in women's experiences, that is reflective of more inspiring, holistic approaches to health promotion practice. The discussion is framed around the most prominent threads from the findings; in particular, two contexts are highlighted: health policy and maternal health promotion practice. Each strand is discussed, revealing how these powerful contexts produced and provoked diverse women's disrupted experiences of being labelled as clinically 'overweight' and 'obese' in pregnancy. The chapter offers recommendations for policy, advocacy, practice, education, research, and service provision which hold promise for shifting the conditions that secure the current model of service provision in place. Finally, a summary of the thesis contribution to knowledge is provided.

The Research Problem this Study Answered

In this study, of women's maternal body experiences, the primary post-intentional research question was: What are the experiences of ethnically diverse maternal women labelled as 'overweight' and 'obese'? The secondary research questions focused on how the various contextual aspects of the study, such as political, cultural and care contexts; gender; and women's individual social, cultural, and personal factors, produced and provoked the phenomenon. These subsidiary questions became the lens through which the data were considered, enabling a much deeper exploration of the appropriateness of service provision and maternal health promotion.

At the beginning of this study, my preunderstandings were grounded in medicalised understandings of health, which influenced my early methodological decisions. A turning point came when I embraced a more intentional move towards post-intentional phenomenology. Vagle's (2014, 2018) post-intentional phenomenological theory influenced me to go beyond individual lived experiences and lift my focus to the politicised nature of individualised health policy and contemporary maternal health promotion. The spaces and places where care was delivered, as well as the broader political public health context, were integral to this lived-experiences study.

Women's narratives helped me more deeply understand the philosophical complexities related to public health messaging and the resulting impact on furthering the moralisation of women's

lifestyles. As discussed in the tentative manifestations chapters, preliminary analysis revealed that multiple world views existed; yet, a single dominant western worldview prevails in maternity. Thus, this study became less about the messaging and more on women's experiences of the packaging of messages in the maternity care context, and the meaning for women in the context of their social and cultural lives. Given my decision to delve deeper into exploring the phenomenon from a social contexts perspective, I then had to move further away from biomedical framings of the research questions to explore salutary influences on health—shifting from deficits-focused thinking to strengths-based concepts. I recognised this as a more powerful guide to research because it was informed by women's influences and possibly unspoken urgings. Thus, in becoming increasingly concerned about the appropriateness of public health approaches from a moral and ethical standpoint, I did not want to fuel further moralisation of this approach to health promotion. I was concerned about the tensions created for the individual liberty of women within a biomedical care context.

Illuminating the Findings Within the Literature

The majority of the literature appears to be underpinned by a biomedical focus and findings in this study support the dominant themes that were identified in previous research; namely, medical problematising of higher weight maternal bodies, navigating weight-related conversations and maternal anxieties, and negative impacts on mental wellbeing. Much of the research highlighted in the literature review (chapter two), relates to medical problematising of large maternal bodies and points to how women feel unprepared for weight being framed as a pregnancy health issue (Parker, 2017). I single out Parker's (2017) study because,

> 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. (Parker, 2017, p. 28)

Similar to Parker's findings, in the present study women's stories revealed that weight-focused conversations lacked meaning and relevance for them. This finding is consistent with that of Jones and Jomeen (2017), who found that many women with larger maternal bodies appeared to be dissatisfied with weight management approaches. These authors reported a lack of transparency concerning weight and that women were acutely aware of the problematisation of their pregnant bodies, leaving women feeling dissatisfied and disenfranchised.

Furthermore, findings from the present study showed that the majority of women emphasised the challenges of managing gestational weight given physiological changes. This finding supports the work of other studies, including Jarvie (2017), which found that weight

recommendations are unrealistic and create stress for women. Women were concerned about being perceived as irresponsible, deficient mothers. Many women did not make changes to food, shopping, cooking, and eating habits despite receiving current government guidance on healthy eating in pregnancy. Women were cognisant of the challenges surrounding weight management in pregnancy, particularly given the strong influences of culture and contexts.

Findings in the present study are not consistent with those of Lavender and Smith (2016) or J. Spencer and Mcintosh (2016) who contended that women are receptive to lifestyle change interventions and that increased nutritional knowledge acquired during pregnancy enabled women to change behaviour. The current findings show that while some women made a lifestyle change, where experiences of empathetic care and togetherness with others was evident, it was clear that behaviour change was not always a valid goal. Of more significance is the fact that paternalistic approaches to promoting 'healthy' weight gain revealed disruptive impacts for women. An issue that was not addressed in these studies was the influence of contexts (i.e., historical, childhood, social, cultural). Employing a post-intentional study design offered a broader scope than other studies, given its specific focus on uncovering how contexts produce and provoke women's experiences. The inclusion of ethnically diverse women in the present study enabled a deeper uncovering of cultural contextual influences.

While past studies have examined the challenges related to behaviour change, none, to my knowledge, have considered women's experiences and understandings of health-creating factors. The literature makes little to no reference to salutogenesis as a source of inspiration for maternal health promotion approaches. What is clear from the majority of studies regarding women and maternal body weight is that they are situated within a model which seeks to link to a pathogenic focus. Research into women's experiences of being in 'problem' bodies rarely explores this issue through a salutary lens. The findings from the present investigation are significant in at least two major respects. First, the findings show that maternity is exercising authority over what are the concepts of health and the ideal pregnant body weights for women of all cultures. In doing so, maternity practice represents paternalistic**,** disciplinary control over gravid bodies. Second, the current model of maternal health promotion is focused strongly on pathogenesis and it is concerning that there is minimal evidence of the application of salutogenesis in maternity settings. Present study findings add to current understandings and go some way to uncover the cultural and social needs of maternal women and how a culturally responsive maternity care pathway can be re-envisioned. In summary, these research findings support some of what has already been published while extending the discussion towards producing policy change in public health. It

is timely to critique the political drivers of public health policy and educational approaches to promoting maternal health.

The findings of this study clearly show that many women did not experience weight-focused messaging as meaningful nor tailored to their unique social, cultural, and even medical contexts. A case in point, women's accounts revealed that their holistic health and wellbeing aspirations were unmet in maternity care contexts. This finding resonates with other studies that show, in biomedical care contexts, the focus is on fetal wellbeing rather than a holistic focus on health (Furber et al., 2013; Nyman et al., 2010). In the present study, maternity adopted a paternalistic, ethnocentric, and fetocentric focus, and pushed mainstream narratives about the harms of high BMI. Women with high weight were viewed as 'high risk' and experienced significant bodily, emotional, social, and cultural disruptions as a result of health policy, gestational weight gain guidance, and maternity care practice.

In the biomedical model, the majority of women in this study did not experience personalised, holistic, caring relationships in which they were seen as partners in care. Care was often exclusively focused on clinical features, namely their weight, other than social understandings and social concepts of risk. Negative social ideals and risk-focused narratives in maternity produced negative experiences, and a mood of being-in-flux was evident for women in this study. Under maternity's watchful gaze, some women made a shift from normalising their bodies to internalising and perpetuating biomedical narratives. This finding is consistent with Parker's (2017) study which challenged the accepted logic that "excess weight is harmful, and that they will respond unproblematically to weight related advice and interventions by adopting the recommended behaviour changes" (pp. 29-30).

In antenatal contexts, women saw their bodies as 'problem' bodies. Being marginalised in care interactions provoked experiences of dis-ease and distress. Women's experiences of (un)caring behaviours highlight a disconnection from their own understandings of body, alienating them from their feminine and cultural knowledges and disrupting the meaningful relationship between their bodies and the world. Thus, being cared for in medicalised maternity contexts provoked alternative understandings for some women as they came to see their bodies as 'at risk'. Even though women experienced maternity care as tumultuous, particularly in secondary care contexts, some women disagreed with how maternity concerns were prioritised and were active in producing a change to regain order and harmony. These women appeared to disconnect from weight-focused messaging to return to more familiar cultural and familial narratives. Rather than taking-up the biomedical understandings of health, they privileged salutary understandings in which they re-connected with their emotional and embodied

experiences. These women's narratives draw attention to the relationship between embodied experiences and wellbeing. Reliance on embodied, feminine, cultural, and spiritual ways of being, helped women find meaning in harmonising and normalising social and cultural contexts, or even values-based care contexts. In such contexts, they experienced factors which enabled increased health and wellbeing, and aligned with their social and cultural understandings of health.

Further, women were active in restructuring power dynamics with maternity care professions to minimise emotional harm. The spiritual realities of women were inextricable from their physical realities. Therefore, broader narratives were vital to the telling of lived experiences; hence, the importance and value of listening to and acknowledging multiple narratives rather than a single truth. These findings support the idea that women were active in adjusting and mobilising their internal resources to find meaning, and are in agreement with findings from other studies (Jarvie, 2017; Keely et al., 2017) which showed that women employed neutralisation strategies to defend and normalise the issue of weight. Similarly, findings from the present study demonstrated that women countered medical narratives and neutralised the threat of the risk messaging to minimise the disruption of weight management approaches in their lives. In doing so, women were active in reclaiming their unique understandings of the body and health.

The present study foregrounds the significance of receiving care in medicalised care contexts in which medicalised risk-narratives dominate care experiences. Findings indicate that risk-narratives surrounding body size and health in maternity contexts exacerbate a distrust for female physiology. Moreover, findings raise complexities about women's lack of jurisdiction over their maternal bodies and right to reject maternity's pathologising of bodies labelled as 'overweight' and 'obese' in pregnancy—themes which have been highlighted in other studies (Dahlen, Jackson, & Stevens, 2011; Dannaway & Dietz, 2014; Mander & Melender, 2009). The picture that emerges from the interpretation of the data is one of women being focused on holistic health dimensions, which seems intrinsic to maternal wellbeing. What is striking, is that maternity's model of care is focused on physical health. It has gone relatively unacknowledged that this represents a practice concern which creates a tension for women who contest and counter maternity's dominant focus on biomedical understandings of health. In light of these findings, I argue that the fetocentric, individually oriented, decontextualised approaches have led to contemporary maternal health promotion practices which are not person-centred or reflective of individual's situations, social context, and experiences. Findings call into question the relevance and efficacy of siloed problem-based approaches to maternal health promotion

which the system is funded to deliver. If current practice continues to remain unchallenged, there will be greater acceptance of these normalised approaches to weight management during pregnancy.

The Change that is Provoked and Produced Through this Study

Post-intentional phenomenological approaches for midwifery research can provoke and produce social change, as Vagle (2018) purported, and may even influence health system change. The voices of women presented in these pages challenge maternity to rethink how wellbeing is defined. While wellbeing is not for the system to define, maternity care professionals should be facilitating and supporting initiatives that deliver against the indicators of wellbeing, including identity, purpose, belonging, and social connectedness (T. Cassidy, personal communication, December 12, 2020). Thus, system change is not only about creating better services, but rather maternity care professionals also creating dialogues that influence new understandings, engaging with maternal health promotion from people-focused perspectives. Where maternity care recognises mutuality, health is restored.

My exploration of the topic concludes that system change is needed to promote the normalisation of diverse maternal bodies so that people-centred outcomes are prioritised in maternity. There is an urgent need to fundamentally alter the structures and behaviours that produce automated, paternalistic, coercive, and (un)caring ways of being towards women. Approaches which are reflective of women's situations, values, and worldviews and system change are needed to reorient public health and health promotion to provide more integrated responses to ethnically diverse women.

This study provokes a rethink in how science and risk is communicated in pregnancy. The current focus is on communicating the harms and consequences of 'obesity' rather than the social factors leading to 'obesity'. While it is not the intention to generalise from the present study, it is possible that contemporary approaches to maternal health promotion are provoking tense disruption, affecting emotional and mental wellbeing, as well as destabilising cultural understandings of health and the body through its individualised blaming processes. Findings show that some women contested these contemporary approaches at the interface of science and policy, and a case for the re-envisioning of maternal health promotion is warranted.

Findings can be put into a broader picture of something meaningful to midwifery. Practice shifts are urgently needed to realign care to focus on indigenous perspectives, models, and actions to promote health. A feminist model of maternal health promotion which takes account of indigenous values, beliefs, and embodied knowledge is proposed to create a system change

in maternity to reduce unintended consequences for women in larger maternal bodies cross-cultures. In midwifery research, there is a strong need for post-intentional approaches which consider larger cultural and historical contexts and societal structures beyond individuals' experiences. It is my hope that women's narratives can inform future policy making processes to promote the normalisation of diverse bodies and experiences in maternity service provision.

The Problems with Health Policy

Neoliberal obesity prevention policies are directly contributing to the over-reliance of weight-focused approaches in pregnancy (Parker & Pausé, 2018b). How women experience pregnancy care is a reflection of these "neoliberal, healthist, biomedical perspective that undergirds the lifestyle-focused health policy" (J. Brady & Beausoleil, 2017, p. 630). Furthermore, weight management guidance illustrates neoliberal values with emphases for women on "monitoring their own weight gain at regular periods during pregnancy" (Ministry of Health, 2014, p. 5). In the present study, women were encouraged to self-monitor, and were subjected to routine weighing during antenatal care. Yet, even though no hospital-level policy directive for the routine weighing of women with a BMI <40 kg/m^2 existed, medical dominance and neoliberal approaches prevailed. Findings from this study expose the erroneous emphasis on frequent weighing as part of hospital-based antenatal care for all women, regardless of body size. The tensions between women and maternity care professionals are explicit in women's stories, and women sought meaningful connections over technocratic approaches to managing their bodies. Thus, contemporary health system values are eroding what should be core values of maternity—wellbeing focused, individualised, person-centred care—and further medicalising pregnancy care practices. It is important to critically examine the effects of neoliberal policies, and how contemporary health promotion might compromise care.

Neoliberalist policy approaches are inextricably linked to medical paternalism in maternity care. According to Sandall et al. (2009), medical dominance presents a challenge for maternal autonomy and a barrier to equitable maternal health. As medical sociologist Eliot Freidson (1970) famously argued, medical dominance can be defined as the way in which maternity care professionals exercise autonomy over their individual work and collective practice. The concept of medical dominance in maternity care can be extended further to reflect the practice of pregnancy weight surveillance, which is an example of routine, unevidenced, and culturally insensitive practice deeply embedded in contemporary maternity care. Women's stories uncovered their beliefs that weight surveillance and BMI measurements were not meaningful components of pregnancy care. Consequently, women were involved in strategies of escape

and reclamation, with many women intentionally resisting patriarchal ideologies surrounding medicalised weight management approaches.

Even when women held competing understandings, many seemingly complied with the weight-focused advice and medical understandings of body weight because maternal responsibilisation was such a powerful force. Similarly, findings from Parker and Pausé's (2018a) study show how women were oppressed by the dominant, medicalised narratives, and involved in strategies of negotiation and resistances. These authors argued it is important to explore fat pregnant people's:

> attempts to resist the problematisation of their bodies as a pathway to the production of counter knowledge on pregnancy fatness that offers new (and less oppressive) meanings and possibilities for fat pregnant embodiment and subjectivity. (Parker & Pausé, 2018a, p. 2)

Medicalised narratives and maternity practices contributed to women having experiences of de-humanised care which were bereft of recognition and respect for autonomy. The biomedical and patriarchal approach to care changed the relationship women had with their bodies, as well as altering how women relate to others in maternity. In the present study, I explored the meaning of women's experiences of regular microaggressions, for instance the brief and frequent communications that relayed negative and harmful messaging. The ambiguous nature of microaggressions meant women were left wondering whether or not their maternity care professional was stigmatising them. For example, Jennifer's story of thickening her skin before care interactions reinforced her experience of being infantilised, as caregivers adopted moralistic attitudes to her—provoking her understanding of her body as deviant and defective. In sharing her story, Jennifer talked of the increased interference by other people, simply because her body was bigger in this pregnancy. Resultingly, the experience of negative liberty created intense disruption for Jennifer. While she sought freedom to govern her own body in a way that resonated with her understandings of pregnancy health, she was not afforded this freedom. According to De Marneffe (2006), paternalistic practices infantilise competent individuals, thereby positioning them as lacking competence to decide on what health and wellbeing mean to them. Given how the deleterious effects of paternalistic practices overlook respect for autonomy, Bellefleur and Keeling (2018) proposed it is unjustified to continue using these approaches. Attention should focus on reconciling health policy with respect for autonomy.

Other women, such as Sam, produced alternative, feminine narratives in which they described their bodies as capable and healthy even though maternity positioned their bodies as high risk. Sam spoke of how her individual preferences to not be weighed were not listened to and described the hostile care context. Sam's experience could be considered as hostility towards gender. In an act of counter-resistance, Sam shared her story about how photography might represent her beautiful pregnant body; thereby reinforcing understandings of pregnancy as beyond the physical body and broadening the meaning of pregnancy as a holistic life-stage (Parker & Pausé, 2018a). Similar to Parry's (2008) study, which showed that women resisted medicalisation of pregnancy and childbirth, women in the present study contested the dominant medical narratives. These women resisted the over-reliance on medicalisation by not standing on the scales and rejecting advice that their 'overweight' bodies were in need of fixing. As an illustration, Julie's story showed that when she was confronted with risk-narratives within medicalised secondary care contexts, her embodied knowledge was pushed to the periphery. Even though she knew her body best, her control and expertise over her own body and pregnancy went unacknowledged given the power differentials produced through neoliberal health policies and biomedical practices.

Medicalised narratives appeared to provoke tension with women's understandings of the causes of 'obesity'. Some women alluded to how medicalised health narratives represented a cover-up of the causes of 'obesity', offering counter-understandings which identified connections between complex contexts and 'obesity', rather than the narrative that individual choice was driving 'obesity' rates. Nina and Ruth's stories point to the influences of poverty and environmental contexts as contributing to their eating habits in childhood. Findings are significant in that they point to differences in ethnically diverse women's meaning of these narratives. Some first-generation Pacific women did not view pregnancy and the body through westernised biomedical ideals. It appeared that mainstream maternity procedures and protocols, particularly surrounding the measurement of BMI, seemed to hold little meaning for these women. Instead, these women privileged cultural knowledge. While it is not my intention to generalise Pacific women's experiences, it appears that for some Pacific women, historical and cultural understandings of the lived pregnant body were a persuasive force in meaning-making. This finding has important implications for showing how cultural narratives contest biomedical narratives and reinforce previous criticisms of the medicalisation of pregnancy (Parry, 2008). The deficiencies of the biomedical model are explicit in the crafted stories which illuminate women's experiences of pregnant embodiment as a complex interplay of historical, cultural, biological, and economic factors. Women have the right to reject paternalistic,

dominant medical narratives and, instead, put forth counter narratives that emphasise the significance of the cultural and social meanings.

Maternity care contexts privilege western culture and health beliefs above that of indigenous perspectives; thereby, diminishing meanings of health for ethnically diverse women. The marginalisation of cultural knowledges within health policy and individualised approaches to health pose significant challenges for indigenous groups. Of particular concern are the detrimental effects of the highly individualised approaches to health for Māori (Warbrick, Dickson, Prince, & Heke, 2016). Warbrick et al. (2016) argued that, "this fascination with weight is levelled particularly at Māori in New Zealand, whose health has been a source of sustained societal concern for many decades" (pp. 395-396). Considering that the colonial basis of the dominant culture and structures in Aotearoa New Zealand has severely impacted Māori health (Hobbs et al., 2019; Shackleton et al., 2019), it is concerning that health policy and associated guidelines represent a culturally biased approach to policy making through not sufficiently articulating a Te Ao Māori worldview. Contemporary developments in relation to reversing inequities for Māori (Waitangi Tribunal, 2019) point to a renewed urgency to design health care systems which actively acknowledge the ongoing impacts of colonisation to address the persistent health inequities for Māori and give effect to te Tiriti's guarantee of tino rangatiratanga. Therefore, omission of specific te Tiriti references in health policy and weight management guidance is of concern in the maternity sector.

The preoccupation with pregnancy weight surveillance is a routine and mundane practice which undermines the health status of ethnically diverse women. The undue focus on the weight biomarker in maternity is perhaps fuelling this interest. The BMI measure of health is underpinned by a western value system that does not align with diverse worldviews and can disadvantage indigenous women and marginalise indigenous values. Maternity's complacency surrounding the acceptance of the BMI tool seemingly ignores the context by which BMI reliability and validity is inflated. "BMI is empowered as a measurable quantity through the lens of medicalisation and evidence-based medicine" (Gutin, 2018, p. 1) and is an increasing part of the biomedical management of pregnancy. It also represents an example of a measure of health based on male-centred epidemiology (Daykin & Naidoo, 1995). This clinical measure represents a tool for assessing pregnancy risk in all women; yet, as a measurement of obesity, BMI offers little clinical benefit (Pizzorno, 2017). To put it succinctly, it is concerning that the BMI measure is an increasing part of the biomedical management of pregnancy and underpins the delivery of weight-focused advice in maternity care.

Findings from the present study showed women challenged the highly pathogenic focus of their maternity care provision. Many women described how their subjective experiences of wellbeing and pregnancy health were minimised, and shared that clinical markers (e.g., BMI measure) were often privileged. Women in the present study experienced an increased level of surveillance as high BMI was associated with 'unhealthy' and 'abnormal', requiring a more managed pregnancy. The power afforded the BMI in current health policy (B. Evans & Colls, 2009; Gutin, 2018) and, more concerningly, maternity care practice (Knox et al., 2018), has been questioned. It is difficult to see how these recommendations are supported by evidence, how they are helpful, or how they would positively impact women's experiences of pregnancy (Jette & Rail, 2013). Findings reveal the differing meanings women attached to the value and importance of BMI as a measure of health. Conforming with the BMI clinical marker, some women appeared to apply self-governance to weight management. Nina, for example, was familiar with using the BMI calculator to check her weight. Jennifer's story also illustrates that being advised to be "smart and clever", in relation to managing her weight, held meaning for her as it enabled her to reflect on previous lifestyle decisions. While she was labelled as 'high weight, high risk' due to body size, Jennifer indicated that she was glad to hear this advice. Other women, however, described a very different experience and their stories revealed the more negative aspects of BMI dominated pregnancy care. These women seemingly resisted the marker, withdrawing from routine weighing. They challenged the classificatory power of the BMI as a measure of health through declining to step on the scales; instead, putting forth their own understanding of healthy maternal bodies. Distrusting the tool, Christina refuted that she was 'overweight', though tentatively suggesting that she still looked healthy. Similarly, in other studies, women distrusted BMI as a tool to support an assessment of health (Kwan, 2012). For many women in the present study, the BMI tool reinforced women's sense of disruption in pregnancy, ensuring they remained in a state of anxiety about the possibility of their bodies being at-risk and sites of concern for their unborn baby.

The use of the BMI measurement alone fails to acknowledge that health can still be attainable for women classified as clinically 'overweight' or 'obese'. Knox et al. (2018) argued, "it is timely to expose a pathological paradox in which, if they have a BMI ≥25 kg/m2, this is understood as always abnormal, covering up that some of these women are actually enjoying a healthy pregnancy" (p. 31). Many women in the present study found these measures confusing and, at times, intrusive and offensive. Maternity care was seemingly delivered in a way that marginalised women's values. There is an unbalanced focus on markers of illness in pregnancy, such as BMI, which often leads to culturally stigmatising treatment that further seeks to problematise pregnant women with particular bodies and experiences. There is a need for

maternity care to use measures which capture a much broader understanding of health and wellbeing in pregnancy. Women have a right to evidence-based pregnancy care, and I question the continued use of BMI as a tool for assessing health of maternal women.

The Problems with Behaviour Change Approaches in Maternity

Behaviour change approaches continue to dominate health policy. M. Kelly and Barker (2016) alluded to how changing health behaviour is an attractive policy option because focusing on simplistic 'obesity' messaging avoids the need for creating complex policy solutions which would demand change at the socio-environmental level. However, most efforts at getting people to change behaviour in respect to 'obesity' prevention have had insufficient effects (O'Hara, Taylor, & Barnes, 2016; Salas, 2015), particularly for groups experiencing income inequalities (Michie, Jochelson, Markham, & Bridle, 2009). Furthermore, and important to the Aotearoa New Zealand context, behaviour change interventions are likely to increase health inequalities (Tengland, 2012). This is significant as Māori and Pacific women are subject to intensive targeting for weight-focused public health interventions. It is concerning that maternal health promotion continues to focus on fixing 'problem' behaviours and denying women the right to bodily autonomy and equality.

Contemporary maternal health promotion disciplines and regulates 'at-risk' lifestyles. Such biopolitical health promotion practices encourage self-regulation (Mulderrig, 2019) and calls women to internalise the narratives of responsibilisation to manage their weight (Parker & Pausé, 2018a). Thus, women are morally accountable for their actions. Women in the present study experienced health promotion interactions as moralistic and there are many aspects in women's narratives which show how women were subjected to moral criticism for failing to take-up the weight management advice. Brown (2018) argued against the moralisation of people's health related behaviour, contending that moralisation may inadvertently cause harm through reinforcing notions of individual choice and responsibility. Women's stories alluded to how their 'unhealthy' behaviour was often viewed as 'bad' behaviour. Jennifer, for example, talked of her fearfulness of a "telling off" in secondary care for failing to pursue a healthy body. Ruth's story alluded to how being a higher weight was not only considered a visible sign of poor health, but an outward sign that she was failing to care for baby. Ruth's experience of mothering doubt was underpinned by her belief that she could not be a mother to her son because she had not managed to slim before her pregnancy. Thus, behaviour change narratives problematise women's maternal bodies.

Emerging evidence alludes to the potential harms of contemporary weight management approaches. While there is evidence that health promotion is providing people with better and

more comprehensible information (Noggle, 2018), there is a growing body of research which shows the harmful impacts of current approaches. Parker (2017) explored pregnant women's views of weight-focused narratives and encounters in maternity care. This study showed that approaches which elicited experiences of fat shaming and fat stigma compromised women's health and wellbeing through provoking feelings of trepidation and fear. This insight is concerning yet unsurprising given strategies involving fear appeals to promote better maternal health are deeply embedded in maternity practice. Kok, Peters, Kessels, Ten Hoor, and Ruiter (2018) argued such strategies will be ineffective unless the necessary conditions for change exist. Concurring, Parker (2017) reminded us that, "when it comes to the complexity of women's weight, we leave well enough alone and do nothing at all" (p. 30). It is critical to change the narrative, shifting these taken-for-granted ways of caring for women by challenging the assumption that the educational approaches to weight management are unproblematic.

Coercive approaches and nudge tactics are a core feature of current policy and practice which push women to think about the potential harms of 'problem' behaviours. Mulderrig (2019) argued, the "use of nudge tactics helps legitimate a narrowing of the sphere of governmental responsibility for this complex and classed social problem by pathologising working class lifestyles as inherently irrational" (p. 101). In coercive contexts, nudging is used to encourage compliance with maternity care protocols. Where medical paternalism and authority coexist, it puts the individual in a weak position (Tengland, 2012). Many women in the present study received care in coercive contexts, which contributed to experiences of powerlessness and being psychologically disconnected from maternity care partners. Pania described how her involvement in her care was minimised. Speaking of her confusion surrounding machinelike care processes, she questioned if routine weighing was an incentivised practice in maternity. O'Hara et al. (2016) located strong evidence of coercive and paternalistic approaches concerning choice in their analysis of weight-related public health initiatives. In depersonalised care contexts, coercive strategies jeopardise women's rights to bodily integrity, self-determination, and expression.

Interest in maternal health promotion models based on emotional appeals and fear techniques is being fuelled in the current policy climate. Such models perpetuate the value of 'teachable moments' for motivating women to adopt risk-reducing behaviours (Paterson, Hay-Smith, & Treharne, 2016), positioning pregnancy as the best opportunity to disrupt the generational cycle of 'obesity' (Walker, Kumar, Blumfield, & Truby, 2018). Phelan's (2010) model for weight control is a hallmark of current medicalised forms of health promotion. Arguing that pregnancy prompts feelings of elation and fear about fetal wellbeing, Phelan pointed to the value of approaches which influence women's decision-making in relation to lifestyle change. Women

in the present study were subject to fear arousal techniques through maternity care professionals' use of direct telling strategies. Despite the popularity of such approaches, limited evidence exists for the continued application of the teachable moment model in supporting behaviour change (L. Atkinson, Shaw, & French, 2016). Furthermore, the use of fear to promote health is ineffective and unethical. What harm is being done to the midwife/woman partnership when maternal health promotion is based on the use of fear appeals, particularly when the necessary conditions for achieving a lifestyle change may not exist? Fear strategies have no place in person-centred, values-based approaches to pregnancy health, and it is timely to deprivilege the hegemonic practices of teachable moment models.

In accordance with current guidance, there is pressure on women to vigilantly monitor and self-regulate their own weight gain during pregnancy (Ministry of Health, 2014). In the present study, maternity care professionals imposed regular weighing during antenatal visits, even though no localised policy existed. Thus, women came to see that weighing was a necessary component of care. Maternity's intensive surveillance provoked meaning for women that high BMI was not simply a risk factor for future disease; rather, the large gestational body was treated as a disease in itself (Mulderrig, 2019). Some women described how coercive approaches lacked meaning for them. Ruth talked of her care provider's insistence at being weighed, even though she had advised that she did not want to be weighed. Similarly, other women appeared to tolerate maternity care practices and interactions in which care providers showed dislike and unfriendliness towards women in larger bodies. Such 'caregiving' strategies represent a move closer to medical paternalism. Care which prioritises an individual's lifestyle choices above their autonomy directly contradicts person-centred, humanised care, exposing a fundamental tension in maternity care. The governance of maternal bodies using intrusive interventions is unjustified.

Current literature emphasises the importance of lifestyle interventions to change 'problem' behaviours among pregnant women (Wilkinson, Donaldson, & McCray, 2018); yet, isolated lifestyle interventions to address weight gain in pregnancy appear to have only modest benefit (Hill et al., 2017). The most recent Cochrane review of approaches for preventing excessive gestational weight found that lifestyle interventions reduced the risk of high weight gain by 20% on average (Muktabhant, Lawrie, Lumbiganon, & Laopaiboon, 2015). The latter evidence base is seemingly neglected in favour of 'just-in-case' health care which adopts medicalised health promotion interventions targeting 'high risk' individuals.

Current approaches ignore the social context and rarely consider social and cultural norms as being important in public health (Hardin, McLennan, & Brewis, 2018). Health policy typically

abstracts behaviours from contexts within which they occur (M. Kelly & Barker, 2016), neglecting how childhood contexts, individual life histories, and environments shape the development of eating patterns. It is evident from women's narratives that wider social determinants of health created a dynamic set of complex conditions that undermined their ability to develop healthy eating patterns. Nina reflected how her dietary preferences took root when she was a child and influenced by her family's economic circumstances. In the same way, Silivia's story illuminates the harms of cheap food and the deep influence of unsupportive food environments. Health promotion intersects with westernised connotations of health and beauty, minimising diverse bodies and experiences and neglecting the legitimate embodied experiences of 'other' bodies. Silivia's story challenges the dominant medicalised understandings of the maternal body through her persuasive, attentive remembering which call us back to see Pacific pregnant bodies as beautiful bodies.

Furthermore, when policy approaches conflict with social and cultural obligations and economic concerns, interventions lack meaning. Again, Silivia's story of growing up in the big house and of food bringing the family together has profound social meaning from which she could not disengage. For Māori and Pacific peoples, notions of cultural identity and wellbeing are entwined with the preparation and consumption of food, as shown in Nive's story about how, "Being Islander, you are allowed to eat and eat and eat". Weight-focused behaviour change initiatives in pregnancy have ethical implications, as they neglect cultural patterns of social exchange, obligation, and connectedness. "Critical too is the need to better understand context as the (perceived) relevance of health behaviours will vary with women's individual obstetric and medical history, and their wider circumstances" (Olander, Smith, & Darwin, 2018, p. 2). Individualist health promotion problematises values and behaviours when these may well be aligned with women's cultural obligations and understandings of health.

The ethics of behaviour change approaches are increasingly being scrutinised, and research has questioned whether such approaches to health promotion are as helpful as they are promoted to be (Brown, 2018). Given weight-focused messaging is framed as enabling informed choice and promoting autonomy, it is unsurprising that these approaches attract minimal ethical criticism. The consequences of current approaches include moralisation of people's lifestyles. Moralisation was evident in the present study and the findings reveal that women experienced a disproportionate focus on medical concepts of health. Jennifer's story talked of moralisation; the meaning of health promotion for Jennifer was that she did not value health as she neglected to maintain a healthy body in-between pregnancies. The moralisation of larger pregnant bodies is un-just and my concern is the way in which maternal health promotion is

fuelling the moralising of maternal lifestyles, lessening attention on the systemic factors that hold poor health in place.

How Policy and Practice Provoked and Produced Women's Experiences

Paternalistic health promotion underpinned routine pregnancy care for women in the present study. While preventive health policy has a critical role in improving public health, "we risk being unjustifiably paternalistic towards those who reject these benefits" (Kniess, 2015, p. 892). Such practices restrict liberty and represent a form of medical paternalism which produced a tension for women. The negative impacts of medical paternalism in health care have been described Vallgårda (2012). Woliver (2010) pointed to how women actively and intentionally resist the medicalisation of pregnancy. While some women resisted medicalisation and rejected health promotion because it was incomprehensible, such as Emma and Lily who found it difficult to meet weight gain recommendations when their bodies were physiologically designed to gain weight, other women, who experienced being cared for in a paternalistic manner, described care as a negative experience, sharing stories of care experiences as being against freedom of choice. For these women, paternalistic forms of health promotion led to distorted power relationships and reduced wellbeing. Paternalistic care disrupted cultural meanings and understandings surrounding the maternal body. In maternity, the harms associated with limiting the liberty of women who have strong cultural inclinations around the role of food and eating in pregnancy appears to go unnoticed. Medicalised care contexts marginalise women's lived experiences, "ensuring women's perspectives and insights are rarely told, heard, or given any authority" (Parry, 2008, p. 786); emphasising the inadequacy of a narrow biomedical model for understanding women's experiences with pregnancy.

The focus in maternity is pathogenic—the emphasis being on morbidity, mortality, and risk reduction (Walsh & Murphy, 2007). One problem arising from maternity's uncritical adoption of policy is the over pathologising and problematising of higher weight maternal women. In the present study, pregnancy care was overshadowed by risk-averse practices and disease focused rules and protocols. It is problematic that health is being framed by maternity's pathogenic focus which, in the present study, led to unintended consequences that created a complex landscape of contradictory body norms. Nive's story, for example, demonstrates the complexity of caughtness between two cultural worlds. For Nive, being encouraged to "eat and eat and eat" demonstrates that what maternity sees as problematic, appeared to be the very thing that mattered to some women. The findings of the present study illuminate how maternity care professionals problematised larger maternal bodies. This stance by

professionals provoked women's experiences of their bodies as being at-risk and led to increased vigilance over bodies and behaviours. Risk-averse, just-in-case healthcare, in maternity contexts, represented a biomedical space in which women's understandings of health were being produced and re-produced. In these spaces, women were expected to minimise risk which created a tension between women's own views of responsibility and the neoliberal view which negatively affected women's sense of self. For Ruth, who described having no control over her future, the focus on risk and pathology raised feelings of apathy and fatalism. Risk management may only be part of the experience for diverse women (Crowther & Lau, 2019) and need not be the continuing force driving maternal health promotion efforts.

Maternity's fetocentric focus is a consequence of individualised policy, and women receive pregnancy care in environments which marginalise women's lived experiences of pregnancy. The present study found that fetal risk is omnipresent for higher weight women. This finding supports the work of other studies in this area, including McPhail-Bell, Bond, Brough, and Fredericks (2016) who described women's experiences of being in risky bodies which posed danger to their babies. Like these findings, almost consistently, women in the current study were not given information on how high BMI may be harmful. Natasha, for example, did not understand why weight was important and sought more understanding, finding it difficult to interpret her obstetrician's rationale. Women's stories alluded to how their bodies were marginalised and their behaviour monitored to protect their unborn baby, interpreting weight-focused advice as messaging about the body-as-packaging. In comparing her womb to an incubator, Ruth's story illuminates the meaning of her experience of going unnoticed, of being barely there, pointing to the politics of in/visibility (Woodward, 2015). As Baker, Choi, Henshaw and Tree (2005) argued, "the power and influence of the obstetric hegemony, with its philosophy of pathology and a paternalistic model of care enacted within a fetocentric environment" (p. 319), seeks to regulate and manage maternal bodies so that they are complicit passengers.

Reimagining Maternal Health Promotion

There is an urgent need for a paradigm shift in the scope and expansion of maternal health promotion in maternity. In the present study, women experienced their bodies as being problematised by maternity care professionals which provoked and produced sub-optimal wellbeing outcomes and experiences of care. The findings challenge the current paradigm of contemporary maternal health promotion and reveal how the biomedical model lacked relevance—creating disruption and negative consequences for women. Findings establish an evidence base that stimulates new directions for reimagining more equitable, weight-inclusive

health promotion for women in diverse maternal bodies living in complex contexts. A new conceptual model which recognises and celebrates women's differences within a health promoting paradigm can support a reimagining of public health efforts that do not further problematise and stigmatise women in diverse bodies.

Health promotion has struggled to retain its original essence, particularly the emphasis on health as a positive concept. Therefore, what has come to be accepted as contemporary practice poses a challenge to the original intent from which health promotion has evolved. Maternal health promotion is being delivered in patriarchal structures and is reliant on epigenetic frameworks which are given priority in biomedical science. The tendency to focus on pathology within health promotion contexts has contributed to technological dominance of women's bodies (Pendleton, 2019). Findings from the present study reveal that behaviour change is not always a valid goal; women's stories clearly show that health promotion founded on the principles of empowerment and caring is required to support women to achieve health. Thus, maternity care professionals need to critically reflect on the ongoing relevance of behaviour change approaches in pregnancy. Large maternal bodies are meaningful to some women and need to be acknowledged. There is a pressing need for a clearer conceptualisation of equity-based health promotion to support health policy. A rethink is needed to reinvest in maternity care that privileges cultural nuances and that account for the complexities of women's lives. The challenge for maternity lies in being prepared to validate women's divergent values and alternative mental narratives.

Reimagining maternal health promotion considers new possibilities for equitable and culturally competent approaches and responses to the diverse contexts in which women live. Understandings of maternal health and wellbeing need to extend beyond biomedical concepts and embrace caring as a relational phenomenon (Gillespie et al., 2018) in the delivery of health promotion. In this present investigation, women's needs were more concerned with caring ontologies (care processes and therapeutic relationships) than about weight management and goal-setting strategies. New directions for maternal health promotion, underpinned by caring ontologies, will go some way to acknowledging the unique role of women as partners in caring. Transitioning to approaches that focus on holistic understandings of health and wellbeing, rather than isolated pathologies, will enhance empowerment of women.

Revisioning of maternity care for 'high-weight, high-risk' ethnically diverse women, involves moving towards a model that privileges female bodily knowledges. Findings from the current study showed that women's embodied experiences were facilitated by the biomedical model of pregnancy and revealed the harmful effects of current practices. Concurring with McPhail-

Bell et al. (2016), who argued that *not* telling people what to do is of critical importance for health promotion in decolonised care contexts, I contend that a radical shift in the delivery of maternal health promotion is needed to avoid an undue reliance on individual behavioural change. A universal approach is insufficient, as demonstrated by findings that show women's rejection of medicalised narratives and responsibility-indicating interventions. Midwifery needs a model of maternal health promotion informed by midwifery ontological and epistemological underpinnings, otherwise midwives are at risk of defaulting to a dominant paradigm of individual blame so prevalent in the biomedical model (G. Parker, personal communication, February, 28, 2020).

Health and wellbeing promotion is a core midwifery competency, as highlighted in the Midwifery Scope of Practice (Midwifery Council of New Zealand, 2010); yet, the application of policy within a biomedical framework is undoubtedly creating tension for midwives who promote health and work within a wellness-oriented scope of practice. Women in the current study experienced health promotion based on pathogenesis and risk, and the majority of these women received shared care because high BMI constituted high-risk. Thus, midwifery care and possibilities for wellness promotion are likely to be diluted in a biomedical model. While the Midwifery Scope of Practice (Midwifery Council of New Zealand, 2010) does not specifically acknowledge the role of midwives in facilitating behaviour change, opportunities exist to reflect empowerment approaches to health promotion. Empowerment is based on collaboration, which is closely aligned with midwifery partnership principles. Midwifery needs to resolve the tensions and ethical issues inherent within the dominant behaviour change model.

Salutogenesis is a promising framework to reimagine maternal health promotion. Salutary approaches represent a way of seeing women in diverse maternal bodies as part of a population rather than positioning them as part of a shared high-risk group (Crowther & Lau, 2019). Antonovsky's theory of salutogenesis highlighted the inadequacy of risk-focused paradigms for understanding health and health promotion (Browne, O'Brien, Taylor, Bowman, & Davis, 2014) and, instead, introduced a resource-oriented perspective on generating wellbeing. While Browne and colleagues (2014) argued that midwifery broadly embraces a wellness approach to maternity care, findings from the current study show that this does not appear to be the case for women with higher weight. The challenge faced by midwives lies in leading a resurgence of a wellness approach in the context of antenatal care to scale-up efforts in the redesign and redelivery of maternal health promotion. Salutary ways of seeing could hold success for refocusing the current norm of surveillance and risk aversion (García-Moya & Morgan, 2017; Perez-Botella, Downe, Magistretti, Lindstrom, & Berg, 2015), leading to greater

possibilities of positive health for women in 'risky' bodies. Harmonising the technological and biomedical models (Schmid, 2011) to refocus health promotion on more salutogenic concepts, including Te Ao Māori concepts of wellbeing, requires urgent action.

Recommendations for Policy and Advocacy

This study has revealed that evidence-based policy approaches that take account of the interests of women from diverse backgrounds, as well as diverse bodies, is urgently needed. Post-normal policy making approaches are recommended as such approaches require policy and decision makers to more ethically address the uncertainty and decision-stakes associated with designing health policy in complex systems. Critical review of health policy and weight management guidelines in pregnancy is required as these politicised policies are driving the current practice norm of surveillance and risk aversion.

Political level advocacy is needed to contest the current government position by critiquing policies, practices, and ideologies to identify biases and knowledge gaps that may interfere with effective and equitable care of pregnant women. To improve the experiences of women, it is critical that future health policy is informed by an approach that acknowledges the significance of cultural contexts on health. This will go some way to adopting an inclusive approach to improving health through assessing the impact of cultural contexts on food choices and the effects on reinforcing or destabilising health and wellbeing (Napier et al., 2017).

Ngā Tūtohu Aotearoa – Wellbeing Indicators Aotearoa New Zealand[4] reflect an international movement to provide a more holistic view of wellbeing. It is recommended that Manatū Hauora/Ministry of Health should use these indicators to inform maternal health promotion policy to support individuals and whānau to make decisions around wellbeing for themselves. Furthermore, strengthening mātauranga Māori across the maternity system is an important enabler of maternal health and wellbeing. Manatū Hauora/Ministry of Health, in partnership with Māori partners and other stakeholders, should explore opportunities to consider how the priority areas for action in Whakamaua/Māori Health Action Plan (Ministry of Health, 2020) can enable change for Māori wahine, whānau, and communities.

Recommendations for Practice and Education

The recent health system reform plan advocates that a population health approach is needed to improve public health and health equity (Health and Disability System Review, 2020). The plan highlights that health promotion (which involves creating health promoting

[4] Source: Stats NZ and licensed by Stats NZ for reuse under the Creative Commons Attribution 4.0 International licence.

environments) is a core population health function necessary for a high-functioning health system. There is specific acknowledgement that, “Health promotion involves a broad set of actions to foster good health and wellbeing. It is much more than just providing information to people to encourage them to adopt healthy lifestyles” (Health and Disability System Review, 2020, p. 86). Also acknowledged is that

> sometimes the push for simple solutions can undermine the broad vision of health promotion and focus on changing the behaviours of individuals at risk of disease and illness, rather than looking to address the upstream factors that underpin risk behaviours across communities or populations. (Health and Disability System Review, 2020, p. 87)

Given maternity is at the centre of the health system for maternal women, maternity must invest in population health and lead all aspects of maternal health promotion. The maternity system must effectively collaborate with other parts of the system to make nutritional knowledge transculturally accessible for women. Thus, a key role for maternity care professionals is to understand how to make science communication in maternity more meaningful for women, whānau, and communities. Shifting the focus of individual behaviour change to promoting human rights and creating conditions for women to be empowered is critical to reinvigorating health promotion.

In Aotearoa New Zealand, providers of maternal and child health education rely heavily on the nutritional science perspectives. The role of such agencies in maintaining the dominant narratives concerning lifestyle behaviours and personal choice needs new scrutiny mechanisms (Getz, Sigurdsson, & Hetlevik, 2003). As the need for refocusing health promotion in maternity is becoming more apparent, curriculum providers similarly need to shift the emphasis towards the importance of basic relational skills to implement health promotion. Salutogenic theory can assist with changing the focus from a risk-averse education curriculum to one which theoretically is more health promoting. This would go some way to reorient health promotion, making space for divergent values and cultural understandings of the body.

Education on weight bias and weight neutral approaches to care could be incorporated into maternity professionals’ education to minimise negative attitudes towards women in larger maternal bodies. It is imperative that midwifery education providers take a neutral stance and discuss concepts from a social model, as well as biomedical model, of care to enhance midwives’ knowledge and understanding of competing discourses. Promoting culturally safe and culturally competent maternity care would re-vision medicine’s existing understandings and biases towards women and support the reframing of risk communication strategies.

Incorporating a focus on critical appraisal of contemporary health promotion approaches and the outcomes of these approaches will go some way to transforming approaches to promoting health and wellbeing.

Recommendations for Research

Research which explores approaches to improve the effectiveness of maternal health promotion and the equity of outcomes for Māori and Pacific peoples is urgently needed. Post-colonial indigenous research methodologies are required to ensure future research is inclusive of indigenous knowledge systems to understand the social change that can be produced from non-colonised health promotion approaches. Future studies in the context of indigenous research priorities, including research that emphasises equity of maternity care, is whānau-centric, and enhances socio-cultural, emotional, and physical wellbeing to inform indigenous health promotion approaches, are needed to contribute to wellbeing for all women, particularly Māori and Pacific women. Jasanoff (2007) suggested that research which draws on technologies of humility can accommodate the partiality of scientific knowledge and increase the focus on embodied knowledge and lived experiences to make for increased tolerance of diverse ways of knowing. Such research approaches would explore how bodies labelled as having maternal 'overweight' and 'obesity' are managed under the semblance of risk management.

While the theory of salutogenesis offers a viable alternative to the focus on pathogenesis (Bauer et al., 2020; Crowther & Lau, 2019; Perez-Botella et al., 2015) it is not being practically applied in maternity contexts (R. Kelly, Hauck, & Thomas, 2016). As a result, there is a lack of evidence which examines maternity care within a salutogenic framework (Perez-Botella et al., 2015). Future research, using a salutogenetic lens, could be useful to explore the complexities of contexts and to ask women to identify factors that support their own salutogenic sense of health in pregnancy. A salutary lens for understanding the ways in which women adapt to being in a large pregnant body in different contexts could provide useful insights about the diverse factors which positively influence health in caring contexts, with a particular focus on understanding salutogenic concepts from Māori and Pacific viewpoints. Considerably more work will need to be done to transform critique into a conceptual model based on, and informed by, midwifery ontology and epistemology, and produce a framework for midwives to use in practice. A possible post-doctoral study emerges which is focused on generating salutogenic insights for women categorised as at-risk in maternity.

This study focused on ethnically diverse maternal women's lived experiences of being labelled as clinically 'overweight' or 'obese'; however, there are further opportunities for research to

shed light on the implicit power dynamics that determine the way ethnically diverse women are viewed and cared for in maternity and to challenge the dominant biomedical mental models. One aspect worth future investigation would be to explore colonisation as a determinant of health for pregnant women; new transformative research approaches should recognise the socio-political-economic influences which are holding health disparities in place. Research which provides evidence on how maternity services meet the requirements of te Tiriti principles of active protection and equity is also needed to understand the level of compliance with the principles of te Tiriti. Such research could involve Māori women in designing and conducting studies.

Recommendations for Service Provision

There is a need to re-examine the governance mechanisms that can improve health outcomes and to consider how priorities are set. Health promotion is a non-clinical quality improvement activity and, as such, should be incorporated in the maternity quality standards (Ministry of Health, 2011). In light of these findings, urgent action is needed to change maternity services through developing maternal health promotion quality standards which recognise tikanga Māori and mātauranga Māori. Whakamaua/Māori Health Action Plan (Ministry of Health, 2020) should be used to support a review of the maternity quality standards to determine the extent to which quality standards and practice requirements are reflective of Tiriti obligations to improve the quality, safety, and experience of maternity services received by wahine hapū and their whānau. This measure would go some way to encouraging continuous self-reflection of the midwife's effectiveness in meeting women's needs—holistically and culturally—and would facilitate the provision of accessible care that is woman-centred and culturally safe, with an aim to ensure equity of health outcomes for Māori. It is recommended that a new DHB performance measure for Tiriti-inspired, holistic maternal health promotion is included. Given the majority of women with high BMI will receive shared care or obstetric care, all maternity care professionals should be compliant with standards. Evidence from the current study should go some way to inform a review of the Maternity Standards in Aotearoa New Zealand.

Whakamaua/Māori Health Action Plan emphasises the significance of the health and disability system in delivering more equitable outcomes for Māori (Ministry of Health, 2020). The long-standing health inequities between Māori and non-Māori (Marriott & Sim, 2015) reveal there is much scope to transform care provision. Māori and Pacific peoples have disproportionately higher health needs (Shackleton et al., 2019), and mainstream health promotion efforts often fail them because approaches are not informed by Tiriti-inspired thinking. It is legitimate to ask what the consequences might be for Māori consumers of maternity services, given providers'

response to the challenge of applying te Tiriti in the context of supporting Māori. There is a lack of information about how maternity quality and safety governance bodies meet Tiriti principles. It is unethical and harmful to continue to apply western frameworks to Māori maternal health in the face of persisting inequities.

This study has generated the following recommendations for maternity service provision. Under a Tiriti partnership model, Manatū Hauora/Ministry of Health and Māori partners should drive change to prioritise Māori and ethnically diverse women's values as a measure of reversing inequity:

- Establish a new independent non-governmental organisation or authority, in conjunction with Māori partners, to codesign culturally competent maternal health promotion, providing advice to Manatū Hauora/Ministry of Health and other Crown agencies.
- Appoint a new advisory group, which reflects mana Māori and mātauranga Māori expertise, to critique, re-develop, and implement a national guideline to guide maternity providers implementing health promotion standards.
- Partner with Whānau Ora Commissioning Agencies and Pasifika communities to build on the strengths and capabilities of whānau, supporting whānau-centred approaches and drive a shift from individually focused services towards a more holistic view of family wellbeing.
- Prioritise mātauranga Māori and kaupapa Māori approaches to explore cultural harms for Māori pregnant women and whānau receiving care in mainstream maternity care contexts, and empower Māori (tino rangatiratanga) to develop their own model of maternal health promotion with full resourcing.
- Prioritise codesign and wāhine-led strategies for new health promotion policy and transformation of how maternal health promotion is delivered in maternity contexts. A critical Tiriti analysis approach, such as that outlined by Came, O'Sullivan, and McCreanor (2020), should provide the overarching framework for conducting a retrospective review of the policy guidance for healthy weight gain in pregnancy (Ministry of Health, 2014) to identify where policy fails to incorporate Māori aspirations or reflect the provisions of te Tiriti.
- Engage in collaborative action involving Nga Maia Māori Midwives Aotearoa, the New Zealand College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Royal New Zealand College of General

Practitioners to take a Tiriti partnership approach to developing a joint position on maternal health promotion.

- Develop an indigenous measure of wellbeing in pregnancy that considers holistic concepts of health.

Strengths of this Thesis

To my knowledge, this study was the first to explicitly explore the phenomenon of being in larger maternal bodies from a post-intentional phenomenological perspective. Post-intentional phenomenology is important as it enables a combination of theories. Through the philosophical freedom afforded by post-intentional phenomenology, a notable strength of this thesis involved thinking with other theories to reveal the deepest interpretations and understandings of the phenomenon in their multiple and changing forms. For example, putting Leder's (2016) carceral theorising, namely the strategies of escape and reclamation, into dialogue with women's maternal body experiences, enabled a showing of how women used different strategies to protect their body and themselves where the size of their body and lifestyle decisions were judged intolerable. For Leder (2004), the construction of a lifeworld is not only provoked by mechanisms of power, but constitutes a strategic response to them. The crafted stories and interpretative approaches revealed women's strategies for coping with adversity and restraint in, at times, disempowering contexts. Thus, the political possibilities of post-phenomenology enabled a wider exploration of health messaging as yet another form of control. The uncovering of meaning with feminist theory enabled this interpretation to come to light.

Post-intentional phenomenology also enabled telling of a complex story and showed how intensities are constantly circulating and changing, from moment to moment, in a variety of contexts and situations. In doing so, the study illuminated the system change needed to transform women's experiences. Being a disruptive, politically oriented theory, the application of post-intentional phenomenology enables findings to disrupt dominant narratives surrounding the management of maternal bodies and illuminates how unrealistic policy and deeply entrenched medical narratives are driving inappropriate health promotion, intensifying the fetocentric contexts in which women receive care.

I believe this was the first study to combine a post-intentional exploration of large maternal bodies, and crafted stories in a post-intentional phenomenological research design. The combination of topic and methodological approach enhances trustworthiness such that research findings can lay a firm foundation for future research. Storytelling methods for midwifery research connects with midwifery. Midwifery has a long oral tradition knowledge,

wherein knowledge has been generated through storytelling rather than scientific data (Gould, 2017). The interviews were data-rich, and women's stories represent a way of knowing that is relevant to maternity. Scientific knowledge is dominating midwifery; yet, midwifery aims to support and enable physiology with minimal intervention. The current study clearly shows the challenges for midwifery in reconciling these tensions.

Another important strength of this study is the space it creates for social and system change. Findings act as a catalyst to create better services through an explorative reimagining of maternal health promotion and shift the pathological medical narratives, instilling new narratives which value difference. This study points to where resistance to change might lie, such as the mechanisms of power that are at play in care contexts that drive paternalistic care practices and the medicalisation of pregnancy for women whose bodies are categorised as outside normality. Maternal health promotion policy and practice is still dominated by generic and monocultural understandings, revealing the urgent need for Tiriti-dynamic solutions to redefine caring and the promotion of maternal health and wellbeing. Knowledge from this research supports our collective capacity to reimagine wellbeing for women in diverse maternal bodies. This study privileges women's voices to produce a different account of the relationship between medicine, bodily difference, and normality; and, in so doing, creates space for contemplative reflective practice which questions some foundational assumptions such as how to provide sensitive, holistic care for the majority of women.

Thesis Limitations

What emerges from this study are insights into the manner in which maternal health promotion, caring, cultural values, and wellbeing intersect for these women. A limitation is that this research was initially driven by a biomedical-oriented design and orientation towards pathogenesis. I created the basis for research towards targeting study populations within a 'high risk' category and set out to explore women's experiences of 'overweight' within a behaviour change paradigm. This determined how I recruited women to the study, designed the data collection tool, and interpreted the data. For example, recruitment materials used medical framing to recruit women labelled as 'overweight' and 'obese' in pregnancy.

The framing of the research questions and methods for gathering data was predominately euro western. I problematise my own research approach and I am critical of the inadvertent risks of applying a western research paradigm and knowledge system to study the impacts of contemporary maternal health promotion among ethnically diverse women. A core reason for this study design was to increase the voices of women marginalised in the maternity care system—either through ethnicity, class, or political drivers. This approach may have led some

women to consider their body was at risk, if it had not been made implicitly known. Adopting a medical framing to recruit women with a high BMI could have inadvertently communicated that women were at risk, in risky bodies, simply because of the nature of the risk-focused questions. A post-intentional design enabled my own uncovering of my increasing discomfort as I could not step inside cultural or spiritual worlds. As a result of doing this research, I now challenge and resist dominant discourses that marginalise women who experience discrimination and oppression within the maternity system. I have come to understand that a body that seems abnormal could be perfectly normal by a woman's individual standards and circumstances.

While insights into the manner in which caring, cultural values, and wellbeing intersect for women emerged from this study, taking a salutogenic approach to this kind of research would have required a shift of formulation of research questions and a shift in the study population (i.e., women in diverse bodies). Using a salutogenic framework to interpret the data would have, for example, provided a more innovative approach to gain new insights regarding how health can be produced and maintained in dynamic interplay between factors in a patriarchal, medically driven maternity care system. A natural progression of this work is to analyse women's experiences using a salutogenic framework.

Furthermore, it is possible that interviewing most of the participants only once represented missed opportunities to further uncover how the phenomenon may have changed shape over time and in different contexts. Reflecting further on the underlying assumptions of post-intentional phenomenology lends itself to an alternative approach—serial interviewing—that involves interviewing participants on multiple occasions. Further studies could focus on using serial interviewing to explore the experiences of the lived maternal body (as a post-intentional phenomenon) as phenomena are lived by individuals and are in a continual state of production and provocation, shifting in and over time (Vagle, 2018). According to Read (2018), serial interviewing can help produce more nuanced data to overcome biases associated with one-off interviews, including a tendency toward safe responses in which participants flatten complexity and minimise the impact of social and political power dynamics. Finally, I made the decision not to involve the women in confirming the crafted stories given the value and appropriateness of member checking in phenomenological research approaches has been questioned and human understanding is always evolving and open to ongoing interpretation (Crowther et al., 2016). Thus, while it could be argued that member checking is not essential, or even congruent, with post-intentional phenomenology, it is still possible that not engaging women in confirming the stories may have undermined the credibility of the data in this study.

Thesis Contribution – Summary

Exploring women's experiences using post-intentional phenomenology has provided rich interpretation with a post-intentional emphasis and was appropriate to answering the research questions. This research was sensitive to the dominant role of medicalised and patriarchal ideologies which continue to assert and maintain power over maternal bodies in contemporary maternity care contexts. Findings of this study expose the inadequacies of weight-normative approaches to health promotion and question who is benefiting from the normalcy that has been created through an increasing focus on medicalisation of pregnancy.

This study focused on the voices and stories of women classed as 'somehow on the edge' because of clinical 'overweight' or 'obesity'. It brings attention to the need for shifting the power dynamics and identifying the disconnections evident in maternal health promotion and caring contexts. Given the complex cultural and social contexts in which women live, it is important to realise that, for some women, western understandings of health and western values are secondary to their wellbeing aspirations. Thus, transforming maternal health promotion must involve challenging the current deficit mainstream mono-cultural health promotion to change the narrative about what produces wellbeing for women cross-cultures.

This study illuminates that prioritising women's voices in the future design of health policy and health promotion practice in maternity is a promising way to pursue more just and equitable care for all women. Women in this study were active in how they responded to care interactions and health promotion discourses; they exerted strategic responses—sometimes intentional, other times pre-reflective. Women retained the power to reclaim, resist to integrate, even in disruptive, alien, and at times, (un)caring contexts. The insights generated represent a gift to the literature to support new ways to provide personalised, relational care for women in complex maternity care contexts.

The present findings are significant in many respects; particularly for challenging the adequacy of current approaches to promoting health and wellbeing for maternal women. Findings from the current study show understandings about indigenous women's experiences to inspire decolonising ways of thinking about future design of health policy and health promotion interventions. There is a need to focus on indigenous perspectives, models, and actions to promote health. Working with all women, but particularly women with diverse bodies, requires holistic health promotion which has a salutary focus. Maternity care provision needs to acknowledge women's voices and move towards a system of care that is underpinned by holistic understandings of wellbeing. This is the social change I hope can be produced by the study. It is my intention that this research challenges the science-driven narratives and

practices which continue to disempower women and will actively promote new ways to conceptualise and normalise diverse pregnant bodies and experiences.

This study adds understanding to how risk is perceived and acted on for 'high-weight, high-risk' women. Attempts to control risk are introducing new areas of risk such as reduced wellbeing, mental ill-health, and cultural harm for Māori and Pacific women. Colonising health promotion contexts reinforce biomedical weight narratives and may inadvertently cause psychological, social, and cultural harm to indigenous women. Women's experiences of maternal health promotion, and of being in (un)caring contexts, present new opportunities to reinvigorate health promotion as a relational phenomenon. Reimagining maternal health promotion and deeply listening to women's experiences of maternity care have produced findings which call for the rejection of weight-focused approaches in maternity. Maternal health promotion is failing women, in particular, wahine Māori. The redesign of person-centred maternal health promotion must align with te Tiriti overall.

Finally, this thesis has provided deeper insight into the basis for development of a new model of maternal health promotion. A feminist, indigenous framework which uses a salutary lens is needed to inform health policy and the design of maternal health promotion. Findings have important implications for developing a model of maternal health promotion which legitimises feminine bodily knowledge and cultural knowledges, and situates interventions, "within a decolonising framework that empowers women, rejects deficit victim blaming discourses and recognises contexts of deprivation" (Reid, Anderson, Cormack, Reid, & Harwood, 2018, p. 7).

Concluding Thoughts

Maternity service provision in Aotearoa New Zealand is heavily focused on biomedical principles and practices, and this study sheds light on the implicit power dynamics in biomedical contexts that determine the experiences of maternal women in diverse bodies. In particular, women's experiences were provoked and produced through the underlying mental modes such as medicalised, colonised health promotion, and gender biases embedded in the maternity care system. Thus, a power shift in the mental and social narratives associated with diverse maternal bodies is needed as these feed into the stereotypes that undermine women's experiences. Findings clearly indicate that current approaches to maternal health promotion require a radical rethink; focusing on weight is a distraction to meeting the holistic needs of pregnant women. While other research might convey that behaviour change can occur as a result of nutrition and physical activity interventions during pregnancy, this body of evidence suggests behaviour change approaches should not be the goal. Instead, this thesis offers inspiring stories which challenge the legitimacy of current thinking in maternity that weight

equals health, and reveals future possibilities for changing the maternity culture. Inspiring stories help us reimagine what it might mean for women's health if we shift expertise in women's bodies away from medicine and maternity and back to women themselves. Exploring maternal women's experiences of caring practices in contemporary maternity services provides opportunity to advocate for more aspirational approaches to wellbeing. The task that lies ahead involves engaging maternity care consumers, and other influencers in maternity care, to engage in constructive dialogue to determine the system change that must occur to ensure women can manage their bodies as their own. Such dialogue is critical to shifting the factors that perpetuate paternalistic health promotion and medicalisation of bodies that medicine has defined as abnormal and in need of treatment.

References

Adamo, K. B., Ferraro, Z. M., Goldfield, G., Keely, E., Stacey, D., Hadjiyannankis, S., . . . Barrowman, J. (2013). The Maternal Obesity Management (MOM) trial protocol: A lifestyle intervention during pregnancy to minimize downstream obesity. *Contemporary Clinical Trials, 35*(1), 87-96. https://doi.org/10.1016/j.cct.2013.02.010

Adsit-Morris, C., & Gough, N. (2017). It takes more than two to (multispecies) tango: Queering gender texts in environmental education. *The Journal of Environmental Education, 48*(1), 67-78. https://doi.org/10.1080/00958964.2016.1249330

Ahmed, S. (2008). *Queer phenomenology: Orientations, objects, others*. Durham, UK: Duke University Press. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/aut/detail.action?docID=1169326

Al-Saji, A. (2010). Bodies and sensings: On the uses of Husserlian phenomenology for feminist theory. *Continental Philosophy Review, 43*(1), 13-37. https://doi.org/10.1007/s11007-010-9135-8

Allen-Collinson, J., & Pavey, A. (2014). Touching moments: Phenomenological sociology and the haptic dimension in the lived experience of motor neurone disease. *Sociology of Health and Illness, 36*(6), 793-806. https://doi.org/10.1111/1467-9566.12104

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity, 23*(3), 121-127.

Antonovsky, A. (1979). *Health, stress, and coping*. London, UK: Jossey-Bass.

Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International, 11*(1), 11-18. https://doi.org/doi.org/10.1093/heapro/11.1.11

Aphramor, L. (2005). Is a weight-centred health framework salutogenic? Some thoughts on unhinging certain dietary ideologies. *Social Theory & Health, 3*, 315-340. https://doi.org/10.1057/palgrave.sth.8700059

Atkinson, J., Salmond, C., & Crampton, P. (2014). *NZDep2013 Index of Deprivation*. Wellington, New Zealand: Department of Public Health, University of Otago.

Atkinson, L., Shaw, R. L., & French, D. P. (2016). Is pregnancy a teachable moment for diet and physical activity behaviour change? An interpretative phenomenological analysis of the experiences of women during their first pregnancy. *British Journal of Health Psychology, 21*(4), 842-858. https://doi.org/10.11111/bjhp.12200

Atkinson, S., & McNamara, P. M. (2017). Unconscious collusion: An interpretative phenomenological analysis of the maternity care experiences of women with obesity (BMI≥ 30 kg/m²). *Midwifery, 49*, 54-64. https://doi.org/10.1016/j.midw.2016.12.008

Avis, A. (2005). Collecting data. In I. Holloway (Ed.), *Qualitative research in health care* (pp. 3-15). Maidenhead, UK: Open University Press.

Backholer, K., Beauchamp, A., Ball, K., Turrell, G., Martin, J., Woods, J., & Peeters, A. (2014). A framework for evaluating the impact of obesity prevention strategies on socioeconomic inequalities in weight. *American Journal of Public Health, 104*(10), e43-e50. https://doi.org/10.2105/AJPH.2014.302066

Bacon, L., & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal, 10*(1), 69-69. https://doi.org/10.1186/1475-2891-10-69

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice, 25* (2), 127-131. https://doi.org/10.1093/fampra/cmn003

Baker, S. R., Choi, P. Y., Henshaw, C. A., & Tree, J. (2005). 'I felt as though I'd been in jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology, 15*(3), 315-342. https://doi.org/10.1177%2F0959-353505054718

Bauer, G., Roy, M., Bakibinga, P., Contu, P., Downe, S., Eriksson, M., . . . Lindström, B. (2020). Future directions for the concept of salutogenesis: A position article. *Health Promotion International, 35*(2), 187-195. https://doi.org/doi.org/10.1093/heapro/daz057

Bearman, M. (2019). Eliciting rich data: A practical approach to writing semi-structured interview schedules. *Focus on Health Professional Education: A Multi-disciplinary Journal, 20*(3), 1. https://doi.org/10.11157/fohpe.v20i3.387

Bellefleur, O., & Keeling, M. (2018). *How can we (and why should we) analyze the ethics of paternalistic policies in public health?* Montréal, Québec: National Collaborating Centre for Healthy Public Policy.

Benade, L. (2016). Teachers' reflective practice in the context of twenty-first century learning: Applying Vagle's five-component post-intentional plan for phenomenological research. *Open Review of Educational Research, 3*(1), 133-147. https://doi.org/10.1080/23265507.2016.1201777

Benner, P. (1994). *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness*. Thousand Oaks, CA: Sage Publications.

Berg, M. (2005). A midwifery model of care for childbearing women at high risk: Genuine caring in caring for the genuine. *The Journal of Perinatal Education, 14*(1), 9-21. https://doi.org/10.1624/105812405X23577

Berg, M., Lundgren, I., & Lindmark, G. (2003). Childbirth experience in women at high risk: Is it improved by use of a birth plan? *Journal of Perinatal Education, 12*(2), 1-15. https://doi.org/10.1624/105812403X106784

Bernstein, J. M. (2011). Trust: On the real but almost always unnoticed, ever-changing foundation of ethical life. *Metaphilosophy, 42*(4), 395-416. https://doi.org/https://doi.org/10.1111/j.1467-9973.2011.01709.x

Blunt, A. (2005). Cultural geography: Cultural geographies of home. *Progress in Human Geography, 29*(4), 505-515. https://doi.org/https://doi.org/10.1191%2F0309132505ph564pr

Blunt, A., & Varley, A. (2004). Geographies of home. *Cultural Geographies, 11*(1), 3-6. https://doi.org/10.1191%2F1474474004eu289xx

Bondas, T., & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research, 11*(6), 824-840. https://doi.org/10.1177/104973201129119415

Bottorff, J. L. (1991). The lived experience of being comforted by a nurse. *Phenomenology + Pedagogy, 9*, 237-252. https://doi.org/https://doi.org/10.29173/pandp15180

Brady, E., & Haapala, A. (2003). Melancholy as an aesthetic emotion. *Contemporary Aesthetics, 1*(1), 6. http://hdl.handle.net/2027/spo.7523862.0001.006

Brady, J., & Beausoleil, N. (2017). A response to "A critical analysis of obesity prevention policies and strategies". *Canadian Journal of Public Health, 108*(5-6), e630-e632. https://doi.org/10.17269/cjph.108.6520

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brewis, A. A., McGarvey, S. T., Jones, J., & Swinburn, B. A. (1998). Perceptions of body size in pacific islanders. *International Journal of Obesity, 22*(2), 185-189. https://doi.org/10.1038/sj.ijo.0800562

Brown, R. C. (2018). Resisting moralisation in health promotion. *Ethical Theory and Moral Practice, 21*(4), 997-1011. https://doi.org/10.1007/s10677-018-9941-3

Browne, J., O'Brien, M., Taylor, J., Bowman, R., & Davis, D. (2014). 'You've got it within you': The political act of keeping a wellness focus in the antenatal time. *Midwifery, 30*(4), 420-426. https://doi.org/10.1016/j.midw.2013.04.003

Browner, C. H., & Press, N. (1996). The production of authoritative knowledge in American prenatal care. *Medical Anthropology Quarterly, 10*(2), 141-156. https://doi.org/10.1525/maq.1996.10.2.02a00030

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health and Illness, 4*(2), 167-182. https://doi.org/10.1111/1467-9566.ep11339939

Cain, R. (2013). 'This growing genetic disaster': Obesogenic mothers, the obesity 'epidemic'and the persistence of eugenics. *Studies in the Maternal, 5*(2), 1-24. https://doi.org/10.16995/sim.20

Came, H., O'Sullivan, D., & McCreanor, T. (2020). Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities, 20*(3), 434-456. https://doi.org/10.1177/1468796819896466

Carcary, M. (2009). The research audit trial - Enhancing trustworthiness in qualitative inquiry. *Electronic Journal of Business Research Methods, 7*(1), 11-23.

Carel, H. (2013). Bodily doubt. *Journal of Consciousness Studies, 20*(7-8), 178-197.

Catalano, P., & Ehrenberg, H. (2006). Review article: The short- and long-term implications of maternal obesity on the mother and her offspring. *BJOG: An International Journal of Obstetrics and Gynaecology, 113*(10), 1126-1133. https://doi.org/doi:10.1111/j.1471-0528.2006.00989.x

Cheng, T. (2019). *There's more than meets the eye*. Retrieved from http://www.traciecheng.com/artist-statement.

Cheyney, M. J. (2008). Homebirth as systems-challenging praxis: Knowledge, power, and intimacy in the birthplace. *Qualitative Health Research, 18*(2), 254-267. https://doi.org/10.1177/1049732307312393

Connelly, L. M. (2016). Trustworthiness in qualitative research. *Medsurg Nursing: Official Journal Of The Academy Of Medical-Surgical Nurses, 25*(6), 435-436.

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91. https://doi.org/10.1188/14.ONF.89-91

Counihan, C. (1999). *The anthropology of food and the body: Gender, meaning and power*. New York: NY: Routledge.

Craig, E., Taufa, S., Jackson, C., & Han, D. (2008). *The health of Pacific children and young people in New Zealand*. Wellington, New Zealand: Ministry of Health.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2016). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research, 27*(6), 1-10. https://doi.org/10.1177/1049732316656161

Crowther, S., & Lau, A. (2019). Migrant polish women overcoming communication challenges in Scottish maternity services: A qualitative descriptive study. *Midwifery, 72*, 30-38. https://doi.org/10.1016/j.midw.2019.02.004

Cunningham, J., Endacott, R., & Gibbons, D. (2018). Communication with health professionals: The views of pregnant women with a raised BMI. *British Journal of Midwifery, 26*(9), 598-604. https://doi.org/10.12968/bjom.2018.26.9.598

Currie, J. (1989). Nothing ever happens. On *Waking Hours*. London, UK: A&M.

Dahlberg, H., & Berg, M. (2019). The lived experiences of healthcare during pregnancy, birth, and three months after in women with type 1 diabetes mellitus. *International Journal of Qualitative Studies on Health and Well-being, 15*(1), 1-12. https://doi.org/10.1080/17482631.2019.1698496

Dahlberg, K., Dahlberg, H., & Nystrom, M. (2008). *Reflective lifeworld research* (2nd ed.). Lund, Germany: Studentlitteratur.

Dahlen, H. G., Jackson, M., & Stevens, J. (2011). Homebirth, freebirth and doulas: Casualty and consequences of a broken maternity system. *Women and Birth, 24*(1), 47-50. https://doi.org/10.1016/j.wombi.2010.11.002

Dalrymple, K., Flynn, A., Relph, S., O'Keeffe, M., & Poston, L. (2018). Lifestyle interventions in overweight and obese pregnant or postpartum women for postpartum weight mangement: A systematic review of the literature. *Nutrients, 10*(11), 1-26. https://doi.org/10.3390/nu10111704

Dannaway, J., & Dietz, H. P. (2014). Unassisted childbirth: Why mothers are leaving the system. *Journal of Medical Ethics, 40*(12), 817-820. https://doi.org/10.1136/medethics-2012-101150

Dastur, F. (2000). Phenomenology of the event: Waiting and surprise. *Hypatia, 15*(4), 178-189.

Daykin, N., & Naidoo, J. (Eds.). (1995). *Feminist critiques of health promotion*. London, UK: Routledge.

De Marneffe, P. (2006). Avoiding paternalism. *Philosophy & Public Affairs, 34*(1), 68-94. https://doi.org/10.1111/j.1088-4963.2006.00053x

DeJoy, S. B., Bittner, K., & Mandel, D. (2016). A qualitative study of the maternity care experiences of women with obesity: "More than just a number on the scale". *Journal of Midwifery & Women's Health, 61*(2), 217-223. https://doi.org/doi:10.1111/jmwh.12375

Denison, F., Norwood, P., Bhattacharya, S., Duffy, A., Mahmood, T., Morris, C., . . . Scotland, G. (2014). Association between maternal body mass index during pregnancy, short-term morbidity, and increased health service costs: A population-based study. *BJOG: An International Journal of Obstetrics and Gynaecology, 121*(1), 72-82. https://doi.org/doi:10.1111/1471-0528.12443

Dodd, J. M., Grivell, R. M., Nguyen, A.-M., Chan, A., & Robinson, J. S. (2011). Maternal and perinatal health outcomes by body mass index category. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 51*(2), 136-140. https://doi.org/doi:10.1111/j.1479-828X.2010.01272.x

Doering, K. (2020). *The meaning of the woman–midwife relationship in Japan: A hermeneutic phenomenological study*. Unpublished doctoral thesis, AUT University, Auckland, New Zealand. https://doi.org/http://hdl.handle.net/10292/13742

Dovey, K. (1985). Home and homelessness: An introduction. In I. Altman & C. Werner (Eds.), *Home environments: Human behavior and environment* (pp. 33-64). New York: NY: Plenum Press.

Downe, S., & McCourt, C. (2008). From being to becoming: Reconstructing childbirth. In S. Downe (Ed.), *Normal childbirth: Evidence and debate* (2nd ed.). Beijing, China: Churchhill Livingstone.

Easthope, H. (2004). A place called home. *Housing, Theory & Society, 21*(3), 128-138. https://doi.org/10.1080/14036090410021360

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open, 4*(1), 1-10. https://doi.org/10.1177/2158244014522633

Eriksson, K. (1992). The alleviation of suffering—the idea of caring. *Scandinavian Journal of Caring Sciences, 6*(2), 119-123. https://doi.org/10.1111/j.1471-6712.1992.tb00134.x

Evans, B., & Colls, R. (2009). Measuring fatness, governing bodies: The spatialities of the Body Mass Index (BMI) in anti-obesity politics. *Antipode, 41*(5), 1051-1083. https://doi.org/doi.org/10.1111/j.1467-8330.2009.00706.x

Evans, B., & Cooper, C. (2016). Reframing fatness: Critiquing 'obesity'. In S. Atkinson, J. Macnaughton, J. Richards, A. Whitehead, & A. Woods (Eds.), *The Edinburgh companion to the critical medical humanities* (pp. 225-241). Edinburgh, Scotland: Edinburgh University Press. https://doi.org/10.3366/edinburgh/9781474400046.001.0001

Evans, B. C., Coon, D. W., & Ume, E. (2011). Use of theoretical frameworks as a pragmatic guide for mixed methods studies: A methodological necessity? *Journal of Mixed Methods Research, 5*(4), 276-292. https://doi.org/10.1177/1558689811412972

Finlay, L. (2014). Engaging phenomenological analysis. *Qualitative Research in Psychology, 11*(2), 121-141. https://doi.org/10.1080/14780887.2013.807899

Forbes, Y., & Donovan, C. (2019). The role of internalised weight stigma and self-compassion in the psychological well-being of overweight and obese women. *Australian Psychologist, 54*(6), 471-482. https://doi.org/10.1111/ap.12407

Foster, C. E., & Hirst, J. (2014). Midwives' attitudes towards giving weight-related advice to obese pregnant women. *British Journal of Midwifery, 22*(4), 254-262. https://doi.org/10.12968/bjom.2014.22.4.254

Fraser, A., Tilling, K., Macdonald-Wallis, C., Sattar, N., Brion, M. J., Benfield, L., . . . Lawlor, D. A. (2011). Association of maternal weight gain in pregnancy with offspring obesity and metabolic and vascular traits in childhood. *Circ, 121*(23), 2557–2564. https://doi.org/10.1161/circulationaha.109.906081

Freeman, L. (2014). Toward a phenomenology of mood. *The Southern Journal of Philosophy, 52*(4), 445-476. https://doi.org/10.1111/sjp.12089

Freeman, M., deMarrais, K., Preissle, J., Roulston, K., & St. Pierre, E. (2007). Standards of evidence in qualitative research: An incitement to discourse. *Educational Researcher, 36*(1), 25-32. https://doi.org/10.3102/0013189X06298009

Freeman, M., & Vagle, M. (2009). Grafting the intentional relation of hermeneutics and phenomenology in linguisticality. *Qualitative Inquiry, 19*(9), 725-735. https://doi.org/10.1177/1077800413500933

Freidson, E. (1970). *Profession of medicine*. New York, NY: Dodd & Mead.

Fuchs, T. (2012). The phenomenology of body memory. In S. C. Koch, T. Fuchs, M. Summa, & C. Muller (Eds.), *Body memory, metaphor and movement* (pp. 9-22). Amsterdam, Holland: John Benjamins Publishing Company. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/aut/detail.action?docID=835002

Furber, C., & McGowan, L. (2011). A qualitative study of the experiences of women who are obese and pregnant in the UK. *Midwifery, 27*(4), 437-444. https://doi.org/10.1016/j.midw.2010.04.001

Furber, C. M., McGowan, L., Bower, P., Kontonpantelis, E., Quenby, S., & Lavender, T. (2013). Antenatal interventions for reducing weight in obese women for improving pregnancy outcome. *Cochrane Database Systematic Review, 1*, 1-26. https://doi.org/10.1016/j.midw.20100.4.001

Furness, P. J., McSeveny, K., Arden, M. A., Garland, C., Dearden, A. M., & Soltani, H. (2011). Maternal obesity support services: A qualitative study of the perspectives of women and midwives. *BMC Pregnancy and Childbirth, 11*. https://doi.org/10.1186/1471-2393-11-69

Galtier-Dereure, F., Bogner, C., & Bringer, J. (2000). Obesity and pregnancy: Complications and cost. *The American Journal of Clinical Nutrition, 71*(5), 1242s-1248s. https://doi.org/10.1093/ajcn/71.5.1242s

Galtier, F., Raingeard, I., Renard, E., Boulot, P., & Bringer, J. (2008). Optimizing the outcome of pregnancy in obese women: From pregestational to long-term management. *Diabetes and Metabolism, 34*(1), 19-25. https://doi.org/10.1016/j.diabet.2007.12.001

García-Moya, I., & Morgan, A. (2017). The utility of salutogenesis for guiding health promotion: The case for young people's well-being. *Health Promotion International, 32*(4), 723-733. https://doi.org/10.1093/heapro/daw008

Getz, L., Sigurdsson, J., & Hetlevik, I. (2003). Is opportunistic disease prevention in the consultation ethically justifiable? *British Medical Journal, 327*(7413), 498-500. https://doi.org/10.1136/bmj.327.7413.498

Gibas, P. (2019). Between roots and rhizomes: Towards a post-phenomenology of home. *Transactions of the Institute of British Geographers, 44*(3), 602-615. https://doi.org/10.1111/tran.12304

Gibbs, R. W. (2006). *Embodiment and cognitive science*. Cambridge, UK: Cambridge University Press. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b11138579&site=eds-live

Gillespie, H., Kelly, M., Gormley, G., King, N., Gilliland, D., & Dornan, T. (2018). How can tomorrow's doctors be more caring? A phenomenological investigation. *Medical Education, 52*(10), 1052-1063. https://doi.org/10.1111/medu.13684

Gilmore, L. A., Klempel-Donchenko, M., & Redman, L. (2015). Pregnancy as a window to future health: Excessive gestational weight gain and obesity. *Seminars in Perinatology, 39*(4), 296-303. https://doi.org/10.1053/j.semperi.2015.05.009

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA: Duquesne University Press. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b19582857&site=eds-live

Gluckman, P. (2015). *The challenge of policy development in areas of post-normal science*. presented at the meeting of the SuPERU Childhood Obesity Seminar, Wellington, New Zealand.

Gould, J. (2017). Storytelling in midwifery: Is it time to value our oral tradition? *British Journal of Midwifery, 25*(1), 41-45. https://doi.org/10.12968/bjom.2017.25.1.41

Grosz, E. A. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington, IN: Indiana University Press. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b10130184&site=eds-live

Guba, E. G., & Lincoln, Y. S. (1994). Handbook of qualitative research. In N. Denzin & Y. S. Lincoln (Eds.), *Competing paradigms in qualitative research* (Vol. 2, pp. 105-117). Thousand Oaks: CA: Sage.

Gustin, L. W. (2018). Being mindful as a phenomenological attitude. *Journal of Holistic Nursing, 36*(3), 272-281. https://doi.org/10.1177/0898010117724928

Gutin, I. (2018). In BMI we trust: Reframing the body mass index as a measure of health. *Social Theory & Health, 16*(3), 256-271. https://doi.org/ 10.1057/s41285-017-0055-0

Hannah, M. (2014). *Humanising healthcare: Patterns of hope for a system under strain*. Devon, UK: Triarchy Press.

Hardin, J., McLennan, A. K., & Brewis, A. (2018). Body size, body norms and some unintended consequences of obesity intervention in the Pacific islands. *Annals of Human Biology, 45*(3), 285-294. https://doi.org/10.1080/03014460.2018.1459838

Harper, E., & Rail, G. (2012). 'Gaining the right amount for my baby': Young pregnant women's discursive constructions of health. *Health Sociology Review, 21*(1), 69-81.

Health and Disability System Review. (2020). *Health and Disability System Review – Final Report – Pūrongo Whakamutunga*. Wellington, New Zealand: Author.

Heidegger, M. (2002). Hermeneutical phenomenology and fundamental ontology. In D. Moran & T. Mooney (Eds.), *The phenomenology reader* (pp. 243-307). New York: NY: Routledge.

Heslehurst, N., Lang, R., Rankin, J., Wilkinson, J., & Summerbell, C. (2007). Obesity in pregnancy: A study of the impact of maternal obesity on NHS maternity services. *BJOG: An International Journal of Obstetrics and Gynaecology, 114*(3), 334-342. https://doi.org/10.1111/j.1471-0528.2006.01230.x

Heslehurst, N., Russell, S., Brandon, H., Johnston, C., Summerbell, C., & Rankin, J. (2015). Women's perspectives are required to inform the development of maternal obesity services: A qualitative study of obese pregnant women's experiences. *Health Expectations, 18*(5), 969-981. https://doi.org/10.1111/hex.12070

Hill, B., McPhie, S., Moran, L. J., Harrison, P., Huang, T. T.-K., Teede, H., & Skouteris, H. (2017). Lifestyle intervention to prevent obesity during pregnancy: Implications and recommendations for research and implementation. *Midwifery, 49*, 13-18. https://doi.org/10.1016/j.midw.2016.09.017

Hobbs, M., Ahuriri-Driscoll, A., Marek, L., Campbell, M., Tomintz, M., & Kingham, S. (2019). Reducing health inequity for Māori people in New Zealand. *The Lancet, 394*(10209), 1613-1614. https://doi.org/10.1016/S0140-6736(19)30044-3

Holton, S., East, C., & Fisher, J. (2017). Weight management during pregnancy: A qualitative study of women's and care providers' experiences and perspectives. *BMC Pregnancy and Childbirth, 17*(351), 1-10. https://doi.org/10.1186/s12884-017-1538-7

Huda, S., Brodie, L., & Sattar, N. (2010). Obesity in pregnancy: Prevalence and metabolic consequences. *Seminars in Fetal & Neonatal Medicine, 15*(2), 70-76. https://doi.org/10.1016/j.siny.2009.09.006

Ihde, D. (1993). *Postphenomenology: Essays in the postmodern context*. Evanston, IL: Northwestern University Press.

James, W., Nelson, M., Ralph, A., & Leather, S. (1997). Socioeconomic determinants of health: The contribution of nutrition to inequalities in health. *British Medical Journal, 314*(7093), 1545. https://doi.org/10.1136/bmj.314.7093.1545

Jarvie, R. (2017). Lived experiences of women with co-existing BMI≥ 30 and gestational diabetes mellitus. *Midwifery, 49*, 79-86. https://doi.org/10.1016/j.midw.2016.12.009

Jasanoff, S. (2007). Technologies of humility. *Nature, 450*, 33. https://doi.org/10.1038/450033a

Jette, S., & Rail, G. (2013). Ills from the womb? A critical examination of clinical guidelines for obesity in pregnancy. *Health (London), 17*(4), 407-421. https://doi.org/ 10.1177/1363459312460702

Jonas, W., & Crawford, C. (2004). The healing presence: Can it be reliably measured? *Journal of Alternative and Complementary Medicine, 10*(5), 751-756.

Jones, C., & Jomeen, J. (2017). Women with a BMI ≥ 30 kg/m² and their experience of maternity care: A meta ethnographic synthesis. *Midwifery, 53*, 87-95. https://doi.org/10.1016/j.midw.2017.07.011

Kagan, P. N. (2008). Feeling listened to: A lived experience of humanbecoming. *Nursing Science Quarterly, 21*(1), 59-67. https://doi.org/10.1177/0894318407310779

Keely, A., Cunningham-Burley, S., Elliott, L., Sandall, J., & Whittaker, A. (2017). "If she wants to eat… and eat and eat… fine! It's gonna feed the baby": Pregnant women and partners' perceptions and experiences of pregnancy with a BMI> 40 kg/m2. *Midwifery, 49*, 87-94. https://doi.org/10.1016/j.midw.2016.09.016

Keely, A., Gunning, M., & Denison, F. (2011). Maternal obesity in pregnancy: Women's understanding of risks. *British Journal of Midwifery, 19*(6), 364-369. https://doi.org/10.12968/bjom.2011.19.6.364

Kelly, M., & Barker, M. (2016). Why is changing health-related behaviour so difficult? *Public Health, 136*, 109-116. https://doi.org/10.1016/j.puhe.2016.03.030

Kelly, R., Hauck, Y., & Thomas, S. (2016). Salutogenesis: A framework for perinatal mental wellbeing. *Australian Journal of Child and Family Health Nursing, 13*(2), 4-9. http://hdl.handle.net/20.500.11937/30352

Kennedy, H. P., Shannon, M. T., Chuahorm, U., & Kravetz, M. K. (2004). The landscape of caring for women: A narrative study of midwifery practice. *Journal of Midwifery and Women's Health, 49*(1), 14-23. https://doi.org/10.1016/j.jmwh.2003.09.015

Kerrigan, A., Kingdon, C., & Cheyne, H. (2015). Obesity and normal birth: A qualitative study of clinician's management of obese pregnant women during labour. *BMC Pregnancy and Childbirth, 15*(256), 1-11. https://doi.org/10.1186/s12884-015-0673-2

Khazaezadeh, N., Pheasant, H., Bewley, S., Mohiddin, A., & Oteng-Ntim, E. (2011). Using service-users' views to design a maternal obesity intervention. *British Journal of Midwifery, 19*(1), 49-56. https://doi.org/10.12968/bjom.2011.19.1.49

Kirova, A. (2002). Forgotten experiences. In M. van Manen (Ed.), *Writing in the dark: Phenomenological studies in interpretive inquiry* (pp. 155-166). London, UK: Althouse Press.

Kleinert, S., & Horton, R. (2015). Rethinking and reframing obesity. *Lancet, 385*(9985), 2326-2328. https://doi.org/10.1016/S0140-6736(15)60163-5

Kleinert, S., & Horton, R. (2019). Obesity needs to be put into a much wider context. *Lancet, 393*(10173), 724-726. https://doi.org10.1016/S0140-6736(18)33192-1

Kleinman, A., & van Der Geest, S. (2009). 'Care' in health care: Remaking the moral world of medicine. *Medische Antropologie, 21*(1), 159-168. http://hdl.handle.net/11245/1.314817

Kniess, J. (2015). Obesity, paternalism and fairness. *Journal of Medical Ethics, 41*(11), 889-892. https://doi.org/10.1136/medethics-2014-102537

Knight-Agarwal, C. R., Williams, L. T., Davis, D., Davey, R., Shepherd, R., Downing, A., & Lawson, K. (2016). The perspectives of obese women receiving antenatal care: A qualitative study of women's experiences. *Women and Birth, 29*(2), 189-195. https://doi.org/10.1016/j.wombi.2015.10.008

Knox, S., Crowther, S., McAra-Couper, J., & Gilkison, A. (2018). Health policy and its unintended consequences for midwife-woman partnerships: Is normal pregnancy at risk when the BMI measure is used? *New Zealand College of Midwives 54*(1), 30-37.

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882-890. https://doi.org/10.1046/j.1365-2648.1998.00725.x

Kok, G., Peters, G.-J. Y., Kessels, L. T., Ten Hoor, G. A., & Ruiter, R. A. (2018). Ignoring theory and misinterpreting evidence: The false belief in fear appeals. *Health Psychology Review, 12*(2), 111-125. https://doi.org/ 10.1080/17437199.2017.1415767

Kolcaba, K. Y. (1991). A taxonomic structure for the concept comfort. *Nursing Scholarship, 23*(4), 237-240. https://doi.org/10.1111/j.1547-5069.1991.tb00678.x

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Kukla, R., Kuppermann, M., Little, M., Lyerly, A., Mitchell, L., Armstrong, E., & Harris, L. (2009). Finding autonomy in birth. *Bioethics, 23*(1), 1-8. https://doi.org/10.1111/j.1467-8519.2008.00677.x

Kumm, B., & Johnson, C. (2014). Becoming-shaman, becoming-sherpa, becoming healer: Leisure as becoming. *Leisure/Loisir, 38*(2), 103-118. https://doi.org/10.1080/14927713.2014.967926

Kwan, S. (2012). Lay perspectives on the biomedical paradigm on 'obesity': Theorizing weight, health and happiness. *Social Theory & Health, 10*(1), 61-77. https://doi.org/10.1057/sth.2011.12

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL: University of Chicago press.

Lang, R. (1985). The dwelling door: Towards a phenomenology of transition. In D. Seamon & R. Mugerauer (Eds.), *Dwelling, place and environment: Towards a phenomenology of person and world* (pp. 201-213). Dordrecht, Netherlands: Martinus Nijhoff Publishers.

Lashen, H., Fear, K., & Sturdee, D. W. (2004). Obesity is associated with increased risk of first trimester and recurrent miscarriage: Matched case–control study. *Human Reproduction, 19*(7), 1644-1646. https://doi.org/10.1093/humrep/deh277

Lather, P. (1993). "Fertile obsession: Validity after poststructularism". *Sociological Quarterly, 34*(4), 673-693. https://doi.org/10.1111/j.1533-8525.1993.tb00112.x

Lauridsen, D. S., Sandøe, P., & Holm, L. (2018). Being targeted as a "severely overweight pregnant woman" - A qualitative interview study. *Health Expectations, 21*(5), 878-886. https://doi.org/10.1111/hex.12681

Lavender, T., & Smith, D. M. (2016). Seeing it through their eyes: A qualitative study of the pregnancy experiences of women with a body mass index of 30 or more. *Health Expectations, 19*(2), 222-233. https://doi.org/10.1111/hex.12339

Leder, D. (1984). Toward a phenomenology of pain. *Review of Existential Psychology & Psychiatry, 19*(2-3), 255-266.

Leder, D. (2004). Imprisoned bodies: The life-world of the incarcerated. *Social Justice, 31*(1/2), 95-96.

Leder, D. (2016). *The distressed body: Rethinking illness, imprisonment, and healing*. Chicago, IL: The University of Chicago Press. Retrieved from

http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=4519390

Lems, A. (2016). Ambiguous longings: Nostalgia as the interplay among self, time and world. *Critique of anthropology, 36*(4), 1-19. https://doi.org/10.1177/0308275X16654549

Leslie, W. S., Gibson, A., & Hankey, C. R. (2013). Prevention and management of excessive gestational weight gain: A survey of overweight and obese pregnant women. *BMC Pregnancy and Childbirth, 13*(1), 10. https://doi.org/10.1186/1471-2393-13-10

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324-327. https://doi.org/10.4103/2249-4863.161306

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Newbury Park, CA: Sage.

Lindhardt, C., Rubak, S., Mogensen, O., Lamont, R., & Joergensen, J. (2013). The experience of pregnant women with a body mass index >30 kg/m2 of their encounters with healthcare professionals. *Acta Obstetricia et Gynecologica Scandinavica, 92*(9), 1101-1107. https://doi.org/10.1111/aogs.12186

Lloyd, A. (2010). Corporeality and practice theory: Exploring emerging research agendas for information literacy. *Information Research, 15*(3), 15-13.

Lomax, M. (2019). *Doing time: The experiences for women hospitalised for an extended time in pregnancy*. Unpublished Master's thesis, Auckland University of Technology, Auckland, New Zealand.

Lorraine, T. (2005). "Lines of flight". In A. Parr (Ed.), *The Deleuze dictionary* (pp. 147-148). Edinburgh, Scotland: Edinburgh University Press.

Lupton, D. (2012). *Medicine as culture: Illness, disease and the body* (3rd ed.). London, UK: SAGE Publications. Retrieved from http://ebookcentral.proquest.com/lib/aut/detail.action?docID=880837

Macdonald, J. (2005). *Environments for health: A salutogenic approach*. London, UK: Earthscan.

MacKenzie, C. (2001). On bodily autonomy. In S. K. Toombs (Ed.), *Handbook of phenomenology and medicine* (pp. 417-438). Dordrecht, Germany: Springer-Science+Business Media. Retrieved from http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=3565733

Makowski, A. C., Kim, T. J., Luck-Sikorski, C., & von dem Knesebeck, O. (2019). Social deprivation, gender and obesity: Multiple stigma? Results of a population survey from Germany. *BMJ Open, 9*(4), e023389. https://doi.org/10.1136/bmjopen-2018-023389

Malone, H., Nicholl, H., & Tracey, C. (2014). Awareness and minimisation of systematic bias in research. *British Journal of Nursing, 23*(5), 279-282. https://doi.org/10.12968/bjon.2014.23.5.279

Mander, R., & Melender, H.-L. (2009). Choice in maternity: Rhetoric, reality and resistance. *Midwifery, 25*(6), 637-648. https://doi.org/10.1016/j.midw.2007.10.009

Marchi, J., Berg, M., Dencker, A., Olander, E. K., & Begley, C. (2015). Risks associated with obesity in pregnancy, for the mother and baby: A systematic review of reviews. *Obesity Reviews, 16*(8), 621-638. https://doi.org/10.1111/obr.12288

Marriott, L., & Sim, D. (2015). Indicators of inequality for Maori and Pacific people. *Journal of New Zealand Studies*(20), 24-50. https://doi.org/10.26686/jnzs.v0i20.3876

McCosker, H., Barnard, A., & Gerber, R. (2001). Undertaking sensitive research: Issues and strategies for meeting the safety needs of all participants. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 2*(1), 272-285.

McDonough-Means, S., Kreitzer, M., & Bell, I. (2004). Fostering a healing presence and investigating its mediators. *Journal of Alternative and Complementary Medicine, 10*(Supplement 1), S-25-S-41. https://dio.org/10.1089/1075553042245890

McNeill, J., & Nolan, A. (2011). Midwifery research by midwifery researchers: Challenges and considerations. *Evidence Based Midwifery, 9*(2), 61-70.

McPhail-Bell, K., Bond, C., Brough, M., & Fredericks, B. (2016). 'We don't tell people what to do': Ethical practice and indigenous health promotion. *Health Promotion Journal of Australia, 26*(3), 195-199. https://doi.org/10.1071/HE15048

Merleau-Ponty, M. (1962). *The phenomenology of perception*. London, UK: Routledge Classics. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=1433878

Michie, S., Jochelson, K., Markham, W. A., & Bridle, C. (2009). Low-income groups and behaviour change interventions: A review of intervention content, effectiveness and theoretical frameworks. *Journal of Epidemiology and Community Health, 63*(8), 610-622. https://doi.org/10.1136/jech.2008.078725

Midwifery Council of New Zealand. (2010). *Midwifery scope of practice*. Retrieved from https://www.midwiferycouncil.health.nz/midwives/midwifery-scope-practice.

Mills, A., Schmied, V. A., & Dahlen, H. G. (2013). 'Get alongside us', women's experiences of being overweight and pregnant in Sydney, Australia. *Maternal & Child Nutrition, 9*, 309-321. https://doi.org/10.1111/j.1740-8709.2011.00386.x

Ministry of Health. (2000). *New Zealand Public Health and Disability Act*. Wellington: New Zealand: Parliamentary Counsel Office.

Ministry of Health. (2011). *New Zealand maternity standards: A set of standards to guide the planning, funding and monitoring of maternity services by the Ministry of Health and District Health Boards*. Wellington, New Zealand: Author.

Ministry of Health. (2012). *Ethical guidelines for observational studies: Observational research, audits and related activities*. Wellington, New Zealand: Author. https://doi.org/978-0-478-39364-4

Ministry of Health. (2014). *Guidance for healthy weight gain in pregnancy*. Wellington, New Zealand: Author. https://doi.org/ISBN 978 0 478 42836-0 (online)

Ministry of Health. (2015). *Childhood obesity plan*. Wellington, New Zealand: Author.

Ministry of Health. (2018). Annual data explorer 2017/18: New Zealand health survey [Data file]. Retrieved February 1, 2019, from https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/

Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan 2020-2025*. Wellington, New Zealand: Author.

Moch, S. D. (1998). Health-within-illness: Concept development through research and practice. *Journal of Advanced Nursing, 28*(2), 305-310. https://doi.org/10.1046/j.1365-2648.1998.00790.x

Mourtakos, S. P., Tambalis, K. D., Panagiotakos, D. B., Antonogeorgos, G., Arnaoutis, G., Karteroliotis, K., & Sidossis, L. S. (2015). Maternal lifestyle characteristics during pregnancy, and the risk of obesity in the offspring: A study of 5,125 children. *BMC Pregnancy and Childbirth, 15*(66), 1-8. https://doi.org/10.1186/s12884-015-0498-z

Muktabhant, B., Lawrie, T. A., Lumbiganon, P., & Laopaiboon, M. (2015). Diet or exercise, or both, for preventing excessive weight gain in pregnancy. *Cochrane Database of Systematic Reviews*(6). https://doi.org/10.1002/14651858

Mulderrig, J. (2019). The language of 'nudge'in health policy: Pre-empting working class obesity through 'biopedagogy'. *Critical Policy Studies, 13*(1), 101-121. https://doi.org/10.1080/19460171.2017.1398672

Mulherin, K., Miller, Y. D., Barlow, F. K., Diedrichs, P. C., & Thompson, R. (2013). Weight stigma in maternity care: Women's experiences and care providers' attitudes. *BMC Pregnancy and Childbirth, 13*(19), 1-13. https://doi.org/10.1186/1471-2393-13-19

Murray, C. L. (2014). "It's a wild ride": A phenomenological exploration of high maternal, gestational weight gain. *Health, 6*(18), 2541-2552. https://doi.org/10.4236/health.2014.618293

Murray, S. (2008). *The 'fat' female body*. New York, NY: Palgrave Macmillan. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b11580951&site=eds-live

Muth, W. (2016). "A big circle of unity": Incarcerated fathers being-in-text. *Journal of Literacy Research, 48*(3), 317-345. https://doi.org/10.1177/1086296X16661609

Myers, J. C. (2016). Phenomenology of place: Re-grounding environmental ethics through story. *Journal of Sustainability Education, 11*(February), 1-7.

Napier, A. D., Depledge, M., Knipper, M., Lovell, R., Ponarin, E., Sanabria, E., & Thomas, F. (2017). *Culture matters: Using a cultural contexts of health approach to enhance policy-making*. Copenhagen, Denmark: World Health Organization.

Nash, M. (2013). *Making 'postmodern' mothers: Pregnant embodiment, baby bumps and body image* [Electronic document]. England, UK: Palgrave Macmillan. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b12782361&site=eds-live

NCD Risk Factor Collaboration. (2016). Trends in adult body-mass index in 200 countries from 1975 to 2014: A pooled analysis of 1698 population-based measurement studies with 19·2 million participants. *Lancet, 387*(10026), 1377-1396. https://doi.org/10.1016/S0140-6736(16)30054-X

Neubauer, B., Varpio, L., & Witkop, C. T. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90-97. https://doi.org/10.1007/s40037-019-0509-2

Nguyễn, T., & Su'O'Ng, T. (2008). *The SAGE encyclopedia of qualitative research methods* (1st ed.). Thousand Oaks, CA: Sage. https://doi.org/http://dx.doi.org.ezproxy.aut.ac.nz/10.4135/9781412963909

Noggle, R. (2018). The ethics of manipulation. In E. N. Zalta. (Ed.), *The Stanford encyclopedia of philosophy*. Retrieved from plato.stanford.edu/archives/sum2020/entries/ethics-manipulation

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*, 1-13. https://doi.org/10.1177/1609406917733847

Nyman, V. M. K., Prebensen, A. K., & Flensner, G. E. M. (2010). Obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth. *Midwifery, 26*, 424-429. https://doi.org/10.1016/j.midw.2008.10.008

O'Hara, L., Taylor, J., & Barnes, M. (2016). The extent to which the public health 'war on obesity' reflects the ethical values and principles of critical health promotion: A multimedia critical discourse analysis. *Health Promotion Journal of Australia, 26*(3), 246-254. https://doi.org/10.1071/HE15046

Olander, E. K., Smith, D. M., & Darwin, Z. (2018). Health behaviour and pregnancy: A time for change. *Journal of Reproductive and Infant Psychology, 36*(1), 1-3. https://doi.org/10.1080/02646838.2018.1408965

Organisation for Economic Co-operation Development. (2017). *Obesity update 2017*. Paris, France: Author.

Parker, G. (2014). Mothers at large: Responsibilizing the pregnant self for the "obesity epidemic". *Fat Studies, 3*(2), 101-108. https://doi.org/10.1080/21604851.2014.889491

Parker, G. (2017). Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care. *Women's Studies Journal, 31*(1), 22-33.

Parker, G., & Pausé, C. (2018a). "I'm just a woman having a baby": Negotiating and resisting the problematization of pregnancy fatness. *Frontiers in Sociology, 3*, 5. https://doi.org/10.3389/fsoc.2018.00005

Parker, G., & Pausé, C. (2018b). Pregnant with possibility: Negotiating fat maternal subjectivity in the "War on Obesity". *Fat Studies, 7*(2), 124-134. https://doi.org/10.1080/21604851.2017.1372990

Parry, D. C. (2008). “We wanted a birth experience, not a medical experience”: Exploring Canadian women's use of midwifery. *Health Care for Women International, 29*(8-9), 784-806. https://doi.org/10.1080/07399330802269451

Paterson, H., Hay-Smith, E. J. C., & Treharne, G. J. (2016). Women's experiences of changes in eating during pregnancy: A qualitative study in Dunedin, New Zealand. *New Zealand College of Midwives Journal, 52*, 5-11. https://doi.org/10.12784/nzcomjnl52.2016.1.5-11

Pendleton, J. (2019). What role does gender have in shaping knowledge that underpins the practice of midwifery? *Journal of Gender Studies, 28*(6), 629-634. https://doi.org/10.1080/09589236.2019.1590185

Pereira, H. (2012). Rigour in phenomenological research: Reflections of a novice nurse researcher. *Nurse Researcher, 19*(3), 16-19. https://doi.org/10.7748/nr2012.04.19.3.16.c9054

Perez-Botella, M., Downe, S., Magistretti, C. M., Lindstrom, B., & Berg, M. (2015). The use of salutogenesis theory in empirical studies of maternity care for healthy mothers and babies. *Sexual & Reproductive Healthcare, 6*(1), 33-39. https://doi.org/10.1016/j.srhc.2014.09.001

Phelan, S. (2010). Pregnancy: A “teachable moment” for weight control and obesity prevention. *American Journal of Obstetrics and Gynecology, 202*(2), e131-135. https://doi.org/10.1016/j.ajog.2009.06.008

Pirkola, J., Pouta, A., Bloigu, A., Hartikainen, A.-L., Laitinen, J., Järvelin, M.-R., & Vääräsmäki, M. (2010). Risks of overweight and abdominal obesity at age 16 years associated with prenatal exposures to maternal prepregnancy overweight and gestational diabetes mellitus. *Diabetes Care, 33*(5), 1115-1121. https://doi.org/10.2337/dc09-1871

Pizzorno, J. (2017). Is obesity a disease? *Integrative Medicine, 16*(3), 8-11.

Polit, D., F., & Beck, C., Tatano. (2018). *Essentials of nursing research: Appraising evidence for nursing practice* (9th ed.). Philidelphia, PN: Wolters Kluwer. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b19977839&site=eds-live

Radovic, F., & Radovic, S. (2002). Feelings of unreality: A conceptual and phenomenological analysis of the language of depersonalization. *Philosophy, Psychiatry, & Psychology, 9*(3), 271-279. https://doi.org/10.1353/ppp.2003.0048

Ramachenderan, J., Bradford, J., & McLean, M. (2008). Maternal obesity and pregnancy complications: A review. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 48*(3), 228-235. https://doi.org/10.1111/j.1479-828X.2008.00860.x

Ramis, H. (Director). (1993). *Groundhog day* [Film]. Columbia Pictures.

Rand, K., Vallis, M., Aston, M., Price, S., Piccinini-Vallis, H., Rehman, L., & Kirk, S. F. (2017). “It is not the diet; it is the mental part we need help with.” A multilevel analysis of psychological, emotional, and social well-being in obesity. *International Journal of Qualitative Studies on Health and Well-being, 12*(1), 1-14. https://doi.org/10.1080/17482631.2017.1306421

Ratcliffe, M. (2012). The phenomenology of existential feeling. In J. Fingerhut & S. Marienberg (Eds.), *Feelings of being alive* (pp. 23-54). Berlin, Germany: De Gruyter.

Ratcliffe, M. (2015). *Experiences of depression: A study in phenomenology* (1st ed.). New York, NY: Oxford University Press. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/aut/detail.action?docID=1876207

Ratima, M., & Crengel, S. (2013). Antenatal, labour, and delivery care for Maori: Experiences, location within a lifecourse approach, and knowledge gaps. *Pimatisiwin: A Journal of Aboriginal and Ingidenous Community Health, 10*(3), 353-366.

Ray, L. (1999). Evidence and outcomes: Agendas, presuppositions and power. *Journal of Advanced Nursing, 30*(5), 1017-1026. https://doi.org/10.1046/j.1365-2648.1999.01207.x

Read, B. L. (2018). Serial interviews: When and why to talk to someone more than once. *International Journal of Qualitative Methods, 17*(1). https://doi.org/10.1177/1609406918783452

Reid, J., Anderson, A., Cormack, D., Reid, P., & Harwood, M. (2018). The experience of gestational diabetes for indigenous Māori women living in rural New Zealand: Qualitative research informing the development of decolonising interventions. *BMC Pregnancy and Childbirth, 18*(1), 478. https://doi.org/10.1186/s12884-018-2103-8

Renert, H., Russell-Mayhew, S., & Arthur, N. (2013). Recruiting ethnically diverse participants into qualitative health research: Lessons learned. *The Qualitative Report, 18*(12), 1-13. Retrieved from https://nsuworks.nova.edu/tqr/vol18/iss12/1

Rodham, K., Fox, F., & Doran, N. (2015). Exploring analytical trustworthiness and the process of reaching consensus in interpretative phenomenological analysis: Lost in transcription. *International Journal of Social Research Methodology, 18*(1), 59-71. https://doi.org/10.1080/13645579.2013.852368

Ryan, D. (2007). Obesity in women: A life cycle of medical risk. *International Journal of Obesity, 31*, S3. https://doi.org/10.1038/sj.ijo.0803729

Saevi, T. (2005). *Seeing disability pedagogically: The lived experience of disability in the pedagogical encounter*. Unpublished doctoral dissertation, Faculty of Psychology, University of Bergen, Sweden.

Salas, X. R. (2015). The ineffectiveness and unintended consequences of the public health war on obesity. *Canadian Journal of Public Health, 106*(2), E79-81. https://doi.org/10.17269/CJPH.106.4757

Sandall, J., Benoit, C., Wrede, S., Murray, S. F., van Teijlingen, E. R., & Westfall, R. (2009). Social service professional or market expert? Maternity care relations under neoliberal healthcare reform. *Current Sociology, 57*(4), 529-553. https://doi.org/10.1177/0011392109104353

Sandelowski, M. (2004). Using qualitative research. *Qualitative Health Research, 14*(10), 1366-1386. https://doi.org/10.1177/1049732304269672

Sargeant, J. (2012). Qualitative research part II: Participants, analysis, and quality assurance. *Journal of Graduate Medical Education* (March), 1-3. https://doi.org/10.4300/JGME-D-11-00307.1

Sartre, J. (2003). *Being and nothingness: An essay on phenomenological ontology*. London, UK: Routledge. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b1082277x&site=eds-live

Saw, L., Aung, W., & Sweet, L. (*in press*). What are the experiences of women with obesity receiving antenatal maternity care? A scoping review of qualitative evidence. *Women and Birth*. https://doi.org/10.1016/j.wombi.2020.09.014

Schmid, V. (2011). The need to reconceptualise birth and harmonise the technological and biological models. In S. Donna (Ed.), *Promoting normal birth: Research, reflections and guidelines* (pp. 139-149). London, UK: Fresh Heart Publishing.

Schmied, V. A., Duff, M., Dahlen, H. G., Mills, A. E., & Kolt, G. S. (2011). 'Not waving but drowning': A study of the experiences and concerns of midwives and other health professionals caring for obese childbearing women. *Midwifery, 27*(4), 424-430. https://doi.org/10.1016/j.midw.2010.02.010

Schrobsdorff, S., Sifferlin, A., & Bajekal, N. (2018). What mother doesn't know. *Time, 192*(3), 17-18.

Schumacher, L. A. (2010). *The caregiver's journey: A phenomenological study of the lived experience of leisure for caregivers in the sandwich generation who care for a parent with dementia.* Unpublished Master's thesis, University of Iowa, Iowa, IA.

Sedikides, C., Wildschut, T., Arndt, J., & Routledge, C. (2008). Nostalgia: Past, present, and future. *Current Directions in Psychological Science, 17*(5), 304-307. https://doi.org/10.1111/j.1467-8721.2008.00595.x

Shackleton, N., Derraik, J. G., Audas, R., Taylor, R. W., Glover, M., Morton, S. M., . . . Cutfield, W. S. (2019). Decomposing ethnic differences in body mass index and obesity rates among New Zealand pre-schoolers. *International Journal of Obesity, 43*(10), 1951-1960. https://doi.org/10.1038/s41366-019-0390-4

Signal, L. N., Walton, M. D., Ni Mhurchu, C., Maddison, R., Bowers, S. G., Carter, K. N., . . . Pearce, J. (2013). Tackling 'wicked' health promotion problems: A New Zealand case study. *Health Promotion International, 28*(1), 84-94. https://doi.org/heapro/das006

Smith, D., & Lavender, T. (2011). The maternity experience for women with a body mass index ≥ 30kg/m2: A meta-synthesis. *BJOG: An International Journal of Obstetrics and Gynaecology, 118*(7), 779-789. https://doi.org/10.1111/j.1471-0528.2011.02924.x

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain, 9*(1), 41-42. https://doi.org/10.1177%2F2049463714541642

Smythe, E. (1998). *'Being safe in childbirth': A hermeneutic interpretation of the narratives of women and practitioners*. Unpublished doctoral thesis, Massey University of New Zealand, Auckland, New Zealand.

Sokolowski, R. (2000). *Introduction to phenomenology*. New York: NY: Cambridge University Press.

Solnit, R. (2017). *The mother of all questions*. London, UK: Granta Books.

Soule, K., & Freeman, M. (2019). So you want to do post-intentional phenomenological research? *The Qualitative Report, 24*(4), 857-872.

Spencer, J., & Mcintosh, T. (2016). What are women's lived experiences of weight management in pregnancy? *Midirs Midwifery Digest, 26*(2), 179-185.

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). *Quality in qualitative evaluation: A framework for assessing research evidence*. London, UK: National Centre for Social Research.

Stotland, N. E. (2009). Obesity and pregnancy. *British Medical Journal, 338*, 107-110. https://doi.org/10.1136/bmj.a2450

Sutherland, G., Brown, S., & Yelland, J. (2013). Applying a social disparities lens to obesity in pregnancy to inform efforts to intervene. *Midwifery, 29*(4), 338-343. https://doi.org/10.1016/j.midw.2012.01.016

Suzuki, L. A., Ahluwalia, M. K., Kwong Arora, A., & Mattis, J. S. (2007). The pond you fish in determines the fish you catch: Exploring strategies for qualitative data collection. *The Counseling Psychologist, 35*(295-327). https://doi.org/10.1177/0011000006290983

Svenaeus, F. (2000). The body uncanny - Further steps towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*(2), 125-137. https://doi.org/10.1023/a:1009920011164

Svenaeus, F. (2011). Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy, 14*(3), 333-343. https://doi.org/10.1007/s11019-010-9301-0

Swinburn, B. A., Kraak, V. I., Allender, S., Atkins, V. J., Baker, P. I., Bogard, J. R., . . . Devarajan, R. (2019). The global syndemic of obesity, undernutrition, and climate change: The Lancet Commission report. *The Lancet, 393*(10173), 791-846. https://doi.org/10.1016/S0140-6736(18)32822-8

Taylor, V., Forhan, M., Vigod, S., McIntyre, R., & Morrison, K. (2013). The impact of obesity on quality of life. *Best Practice & Research Clinical Endocrinology & Metabolism, 27*(2), 139-146. https://doi.org/10.1016/j.beem.2013.04.004

Tengland, P.-A. (2012). Behavior change or empowerment: On the ethics of health-promotion strategies. *Public Health Ethics, 5*(2), 140-153. https://doi.org/10.1093/phe/phs022

Thangaratinam, S., & Jolly, K. (2010). Obesity in pregnancy: A review of reviews on the effectiveness of interventions. *BJOG: An International Journal of Obstetrics and Gynaecology, 117*(11), 1309-1312. https://doi.org/10.1111/j.1471-0528.2010.02670.x

Thomas, S. L., Hyde, J., Karunaratne, A., Herbert, D., & Komesaroff, P. A. (2008). Being 'fat' in today's world: A qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations, 11*(4), 321-330. https://doi.org/10.1111/j.1369-7625.2008.00490.x

Thompson, J. (2018). 'Shared intelligibility' and two reflexive strategies as methods of supporting 'responsible decisions' in a hermeneutic phenomenological study. *International Journal of Social Research Methodology, 21*(5), 575-589. https://doi.org/10.1080/13645579.2018.1454641

Todres, L., & Galvin, K. T. (2012). "In the middle of everywhere": A phenomenological study of mobility and dwelling amongst rural elders. *Phenomenology & Practice, 6*(1), 55. https://doi.org/10.29173/pandpr19854

Toombs, S. K. (1995). Sufficient unto the day: A life with multiple sclerosis. In S. K. Toombs, D. Barnard, & R. Carson (Eds.), *Chronic illness: From experience to policy* (pp. 3-23). Bloomington, IN: Indiana University Press.

Torloni, M. R., Betran, A. P., & Merialdi, M. (Eds.). (2012). *Demography of obesity*. New York, NY: Cambridge University Press.

Trigg, D. (2017). *Topophobia : A phenomenology of anxiety* [Electronic document]. London, UK: Bloomsbury Academic. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b23849058&site=eds-live

Vagle, M. (2014). *Crafting phenomenological research* (1st ed.). New York, NY: Routledge.

Vagle, M. (2015). Curriculum as post-intentional phenomenological text: Working along the edges and margins of phenomenology using post-structuralist ideas. *Journal of Curriculum Studies, 47*(5), 594-612. https://doi.org/10.1080/00220272.2015.1051118

Vagle, M. (2018). *Crafting phenomenological research* (2nd ed.). New York, NY: Routledge.

Vagle, M. (2019). *Post-intentional phenomenology and studies of social change in teaching*. Oxford University Press. https://doi.org/10.1093/acrefore/9780190264093.013.350

Vagle, M. (2020a). It is known. *Qualitative Inquiry, 26*(5), 554-556. https://doi.org/10.1177/1077800418819636

Vagle, M. (2020b). Post-intentionally considering post-qualitative inquiry. *Qualitative Inquiry*. https://doi.org/10.1177/1077800420931129

Vagle, M., Clements, C., & Coffee, A. (2017). Analytic productions in post-intentional phenomenological research. *Cultural Studies-Critical Methodologies, 17*(6), 427-441. https://doi.org/10.1177/1532708616643983

Vagle, M., & Hofsess, B. (2016). Entangling a post-reflexivity through post-intentional phenomenology. *Qualitative Inquiry, 22*(5), 334-344. https://doi.org/10.1177/1077800415615617

Vagle, M., Monette, R., Thiel, J. J., & Wester-Neal, K. (2017). Enacting post-reflexive teacher education. *Pedagogies: An International Journal, 12*(3), 295-312. https://doi.org/10.1080/1554480X.2017.1344555

Vagle, M., Thiel, J., & Hofsess, B. (2020). A prelude-unsettling traditions: Reimagining the craft of phenomenological and hermeneutic inquiry. *Qualitative Inquiry, 26*(5), 427-431. https://doi.org/10.1177/1077800419829791

Valentine, K., Kopcha, T., & Vagle, M. (2018). Phenomenological methodologies in the field of educational communications and technology. *TechTrends*. https://doi.org/https://doi.org/10.1007/s11528-018-0317-2

Vallgårda, S. (2012). Nudge—A new and better way to improve health? *Health Policy, 104*(2), 200-203. https://doi.org/10.1016/j.healthpol.2011.10.013

van Gennip, D., van den Hoven, E., & Markopoulos, P. (2016). The phenomenology of remembered experience: A repertoire for design*ACM.* Symposium conducted at the meeting of the Proceedings of the European Conference on Cognitive Ergonomics, Salamanca, Spain. https://doi.org/http://dx.doi.org/10.1145/2970930.2970942

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.
van Manen, M. (2002). *Writing in the dark: Phenomenological studies in interpretive inquiry*. London, UK: Althouse Press.
van Manen, M. (2007). Phenomenology of practice. *Phenomenology & Practice, 1*(1), 11-30. https://doi.org/10.29173/pandpr19803
van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing.* Walnut Creek, CA: Left Coast Press.
van Manen, M. (2016). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, UK: Routledge. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://ebookcentral.proquest.com/lib/aut/detail.action?docID=4558596
Waitangi Tribunal. (2019). *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry (WAI 2575)*. Lower Hutt, New Zealand: Legislation Direct.
Walker, R., Kumar, A., Blumfield, M., & Truby, H. (2018). Maternal nutrition and weight management in pregnancy: A nudge in the right direction. *Nutrition Bulletin, 43*(1), 69-78. https://doi.org/10.1111/nbu.12308
Walsh, J., & Murphy, D. (2007). Weight and pregnancy. *BMJ, 335,* 169. https://doi.org/10.1136/bmj.39267.518808.80
Warbrick, I., Came, H., & Dickson, A. (2018). The shame of fat shaming in public health: Moving past racism to embrace indigenous solutions. *Critical Public Health*. https://doi.org/10.1016/j.puhe.2018.08.013
Warbrick, I., Dickson, A., Prince, R., & Heke, I. (2016). The biopolitics of Māori biomass: Towards a new epistemology for Māori health in Aotearoa/New Zealand. *Critical Public Health, 26*(4), 394-404. https://doi.org/10.1080/09581596.2015.1096013
Warin, M., Turner, K., Moore, V., & Davies, M. (2008). Bodies, mothers and identities: Rethinking obesity and the BMI. *Sociology of Health and Illness, 30*(1), 97-111. https://doi.org/10.1111/j.1467-9566.2007.01029.x
Weir, Z., Bush, J., Robson, S. C., McParlin, C., Rankin, J., & Bell, R. (2010). Physical activity in pregnancy: A qualitative study of the beliefs of overweight and obese pregnant women. *BMC Pregnancy and Childbirth, 10*. https://doi.org/10.1186/1471-2393-10-18
Wendell, S. (1996). *The rejected body: Feminist philosophical reflections on disability*. New York, NY: Routledge. Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=cat05020a&AN=aut.b10599885&site=eds-live
Wennberg, A. L., Lundqvist, A., Hogberg, U., Sandstrom, H., & Hamberg, K. (2013). Women's experiences of dietary advice and dietary changes during pregnancy. *Midwifery, 29*(9), 1027-1034. https://doi.org/10.1016/j.midw.2012.09.005
Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177. https://doi.org/10.1037/0022-0167.52.2.167
Wilkinson, S. A., Donaldson, E., & McCray, S. J. (2018). Re-evaluating the nutritional awareness, knowledge and eating behaviours of women attending a tertiary maternity hospital following iterative service redesign. *Nutrition & Dietetics, 75*(4), 372-380. https://doi.org/10.1111/1747-0080.12475
Wilson, R., & Abbott, J. H. (2018). Age, period and cohort effects on body mass index in New Zealand, 1997-2038. *Australian and New Zealand Journal of Public Health, 42*(4), 396-402. https://doi.org/10.1111/1753-6405.12804
Woliver, L. R. (2010). *The political geographies of pregnancy*. Urbana, IL: University of Illinois Press.
Woodward, K. (2015). *The politics of in/visibility: Being there*. London, UK: Palgrave MacMillan.
Yeo, S., & Logan, J. (2014). Preventing obesity: Exercise and daily activities of low-income pregnant women. *Journal of Perinatal and Neonatal Nursing, 28*(1), 17-25. https://doi.org/10.1097/JPN.0000000000000000

Young, C. M. (2011). *The experience of burnout in case loading midwives: An interpretive phenomenological study*. Unpublished doctoral thesis, Auckland University of Technology, Auckland, New Zealand. http://hdl.handle.net/10292/2447

Young, I. M. (1980). Throwing like a girl: A phenomenology of feminine body comportment motility spatiality. *Human Studies, 3*(2), 137-156. https://doi.org/10.1007/BF02331805

Young, I. M. (1990). *Throwing like a girl and other essays in feminist philosophy and social theory* (1st ed.). Bloomington, IN: Indiana University Press.

Zhou, X., Sedikides, C., Wildschut, T., & Ding-Guo, G. (2008). Counteracting loneliness: On the restorative function of nostalgia. *Psychological Science, 19*(10), 1023-1029. https://doi.org/10.1111/j.1467-9280.2008.02194.x

GLOSSARY[5]

Aroha	To love; feel pity, concern for, compassion; empathise.
Bipolar affective disorder	A severe and chronic mental health condition.
Diverse maternal bodies	A term to describe maternal bodies which are labelled as 'overweight' and 'obese' in pregnancy according to the Body Mass Index. These bodies constitute 'high-weight, high-risk' and are considered outside of medicine's definition of 'normal' weight.
Endometriosis	A chronic inflammatory condition driven by the hormones oestrogen and progesterone.
Graves' disease	An autoimmune disorder that results in the overproduction of thyroid hormones
Kaupapa Māori approach	Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology – a philosophical doctrine incorporating the knowledge, skills, attitudes, and values of Māori society.
Mana	Prestige, authority, control, power, influence, status, spiritual power, charisma – *mana* is a supernatural force in a person, place, or object.
Manaakitanga	Hospitality, kindness, generosity, support - the process of showing respect, generosity, and care for others.
Māori	Indigenous New Zealander, indigenous person of Aotearoa/New Zealand – a new use of the word resulting from Pākehā contact in order to distinguish between people of Māori descent and colonisers.
Mātauranga Māori	Māori knowledge – the body of knowledge originating from Māori ancestors, including the Māori world view and perspectives, Māori creativity and cultural practices.
Medical paternalism	Views, attitudes, behaviours, and practices in maternity contexts which do not support the principles of autonomy and decision-making.

[5]The Māori Dictionary https://maoridictionary.co.nz/ is the source for all Māori terms in this glossary except for the term Whānau ora.

Medicalisation of pregnancy	The general medicalisation of pregnancy refers to the physiological processes of pregnancy that are now controlled by the medical profession and viewed as medical conditions to be monitored and treated.
Multigravida	A woman who has been pregnant more than once.
Multiple sclerosis	A disease of the central nervous system.
Pacific peoples	The term Pacific peoples does not refer to one homogenous group of people. In this document, it is used to encompass a variety of Pacific Island nations and communities who are linguistically, culturally, and geographically distinctive from each other.
Primigravida	A woman pregnant for the first time.
Raukau	A food dish baked with corned beef, coconut cream, wrapped in taro leaves.
Rhesus disease	A condition where antibodies in a pregnant woman's blood destroy her baby's blood cells.
Salutogenesis	A term applied in health sciences to refer to an approach to wellbeing which focuses on health and not on disease.
Tangata Whenua	Local people, hosts, indigenous people – people born of the whenua (i.e., of the placenta and of the land where the people's ancestors have lived and where their placenta are buried).
Te Ao Māori	The Māori world view which acknowledges the inter-connectedness and interrelationship of all living and non-living things.
Te Tiriti o Waitangi	New Zealand's foundation document which represents an agreement between the British Crown and representatives of Māori hapū.
Tikanga Māori specialists	Tikanga are Māori customary behaviours and practices; specialists provide advice on engagement with Māori as they apply to research.
Tino rangatiratanga	Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power.
Weight-inclusive	Emphasis on health and wellbeing as multifaceted.
Weight-normative	Emphasis on weight when defining health and wellbeing.

Whakawhanaungatanga	Process of establishing relationships, relating well to others.
Whānau	Extended family, family group, a familiar term of address to a number of people – the primary economic unit of traditional Maori society. In the modern context, the term is sometimes used to include friends who may not have any kinship ties to other members.
Whānau Ora[6]	Whānau Ora is a major contemporary indigenous health initiative in New Zealand, driven by Māori cultural values. Its core goal is to empower communities and extended families to support families within the community context rather than individuals within an institutional context.

[6] Wikipedia

APPENDICES

Appendix A: Information brief on proposed health research involving Māori and Pacific peoples

AUT UNIVERSITY HEALTH + ENVIRONMENTAL SCIENCES

Information brief on proposed health research involving Māori and Pacific peoples

The purpose of this brief

This brief has been produced to support the researcher to begin initial consultation and conversations with a variety of Māori and Pacific peoples before putting a full research proposal together.

Consultation process

A consultation process will guide the researcher in establishing research practices which ensure that research outcomes contribute to improving Māori and Pacific health and wellbeing. Consultation will provide the researcher with an opportunity to:

- Develop meaningful engagement in the development of the research to develop clarity around the proposed project and understand the relevance of the project for Māori and Pacific communities
- Match research interests with local needs
- Hear perspectives on the acceptability of the intended research topic
- Provide the opportunity for Māori and Pacific stakeholders to add to, build on and refine the project
- Understand how Māori and Pacific Peoples can be involved in the research project
- Identify which Māori and Pacific groups and communities could be involved in the consultation process.

<u>Consultation plan</u>

Initial consultation will be held with Waiwhetu (Arohanui ki te Tangata), the constituent Marae of Te Atiawa. Following advice from tangata whenua, further consultation may occur with a variety of national and regional bodies including:

- Ngā Maia
- Te Ora Rata o Aotearoa
- New Zealand College of Midwives
- Maternity Services Consumer Council
- [redacted] Maternity Service
- [redacted] Board and [redacted] Board

1

- [redacted] Māori Health Services Development Group
- [redacted] Māori and Pacific Health Units
- [redacted] Pacific Health Service
- [redacted] Whānau Ora collectives [redacted]
- Tamariki Ora.

Timeframe for developing the research proposal

2 March – 5 October 2015.

Summary of the proposed research

Working title

Women's experiences of being overweight and pregnant in Hutt Valley.

Rationale and significance of the study

There is a rising prevalence of excessive weight gain in pregnancy and more women are already obese when they become pregnant. Excessive gestational weight gain increases maternal risks for: pre-eclampsia, gestational diabetes, and weight retention postpartum with associated long-term health consequences (Nehring et al 2011; Alavi et al 2013). The literature has also reported lifelong consequences for the baby, including a fourfold increased risk of large-for-gestational-age infants (Chung et al 2013) and a consistent increase in BMI and blood pressure and an abnormal metabolic profile in childhood and early adult life (Fraser et al 2010; Mamun et al 2009; Oken et al 2007).

As a result, cases of maternal obesity in antenatal clinics are growing. Weight management strategies are increasingly focusing on pregnancy as an opportunity for optimising gestational weight gain (Campbell et al, 2011). However, women's perceptions of obesity, nutrition and physical activity are socially bound. They are viewed differently by different populations and the social and cultural context in which people live may influence the success of dietary or physical activity interventions targeted at pregnant women (Warin, 2008). There is, however, little New Zealand literature on this topic, despite its importance for effective maternity care. While previous research has examined factors affecting healthy change in pregnancy it has been primarily quantitative in nature and has been limited by small sample size and homogeneous samples. Furthermore, studies have focused on women of all BMI categories and varying ethnicities (Sui, Turnbull and Dodd, 2013) and there has been no analysis based on minority perspectives. Therefore, studies exploring socio-contextual factors which influence the uptake and effectiveness of interventions during pregnancy, particularly for Māori and Pacific pregnant women, are required.

Key issues to be investigated

To better understand Māori and Pacific women's experiences of being overweight and pregnant a qualitative investigation is proposed. This study aims to answer four questions:

1. How do overweight and obese women experience maternity care, advice and interventions following the implementation of the New Zealand weight management guidelines?
2. Is antenatal weight management advice delivered according to the cultural needs of Māori and Pacific pregnant women?
3. What are women's perceptions about the approaches which are required to prevent excessive weight gain in during pregnancy?
4. What factors preclude making healthy change during pregnancy for Māori and Pacific women?

Research participants

Participants will include women aged 16 years and older, primigravidas, multigravidas, women with a BMI ≥ 30 kg/m^2, women with singleton pregnancies and women of varying ethnicities (including Māori and Pacific women). A sample of 30 pregnant women attending [redacted] maternity will be sought.

Recruitment

The maternity service will be invited to support recruitment of women.

Data collection

Data will be collected using semi-structured kanohi-ki-te-kanohi interviews to gain insights into the experiences of the participants.

Principle stages of the investigation

Initial stages of the investigation will involve consultation with key stakeholders and collaborators. A participatory approach to research design will be developed with stakeholders and approaches to data collection with Māori and Pacific consumers will be co-created with cultural advisory groups. A preliminary review of the literature will be conducted to finalise the research aim and objectives. Thereafter ethical considerations will be explored. A locality assessment will be completed between the university and [redacted] to provide a high-level agreement as required by the AUT Ethics Committee.

Research benefits

Understanding women's experiences is pivotal to improving their health. The needs and experiences of pregnant women with a BMI ≥30 kg/m^2 need to be central to the design and implementation of their care if recommendations are to be met; this in turn should increase their satisfaction with the maternity service and improve their attendance and health. Understanding the lived experience of obesity in pregnancy will help the Ministry of Health and maternity services at the policy, commissioning, and clinical level to improve clinical and public health interventions. In addition, findings will inform behaviour change strategies for meeting pregnancy weight gain recommendations and increase lead maternity carers' understanding of socio-cultural factors influencing weight gain during pregnancy. Promoting research with Māori and Pacific consumers

of maternity services will benefit local communities by increasing awareness of the factors which contribute to social and cultural wellbeing and minimise health inequalities for priority populations.

About the researcher

The research will be carried out by Susan Knox, the primary investigator. Susan's current role is a project manager with Regional Public Health at [redacted]. Susan is managing the [redacted] project which is a collaborative partnership between Regional Public Health, the Service Integration and Development Unit of the three DHBs, Te Awakairangi Health Network and Compass Health. Susan has a clinical background in midwifery practice. Additionally, she has broad experience in public health including seven years within Regional Public Health.

Susan's research will be conducted independently of [redacted] DHB. The research is being undertaken as part of a PhD study within the Faculty of Health and Environmental Sciences at Auckland University of Technology. Susan's primary supervisor is Associate Professor Judith McAra-Couper, Head of Department Midwifery and Co-director at the Centre for Midwifery and Women's Health Research. Dr Andrea Gilkison, Programme Leader and Senior Lecturer Midwifery is the secondary supervisor to the study. In addition, tikanga advice will be sought from a research advisory group (involving Māori and Pacific advisors) which will provide informal advice and direction at each stage of the project.

Contact details for the researcher

Please contact Susan to discuss any aspect of this project:

Susan.knox@[redacted]

Appendix B: Letter confirming support – Māori Health Directorate

[redacted]

Mr Charles Grinter
Research Ethics Advisor
Auckland University of Technology Ethics Committee
Room WA 505 D
Level 5
WA Building
55 Wellesley Street East
Private Bag 92006
Auckland 1020

5th June 2015

Mr Grinter

Letter of Support for Research Proposal

The research proposal to explore *"The maternity experience of weight management advice for pregnant women with a body mass index ≥ 30 kg/m²"* has my strong support. Susan has led a satisfactory consultation process in [redacted] District Health Board and I am confident that this research contributes to Māori health development. A strong foundation for co-operation and collaborative relationships with local Māori health service providers has been created. Susan has also established research practices which work to ensure Māori are engaged in the planning and design of this study.

As the Director of Māori Health at [redacted] District Health Board, I believe this research study is important and will be implemented in a way which is consistent with Māori cultural values.

Nga mihi,

[redacted]
Director Māori Health

c.c. Susan Knox

[redacted]

Appendix C: Letter confirming support – Pacific Health Directorate

[redacted]

6 March 2015

Mr Charles Grinter
Research Ethics Advisor
Auckland University of Technology Ethics Committee
Room WA 505 D
Level 5
WA Building
55 Wellesley Street East
Private Bag 92006
Auckland 1020

Dear Mr Grinter

Letter of Support for Research Proposal – PhD Candidate Susan Knox

I would like to express my strong support for Susan Knox's (PhD candidate) research proposal, *"The maternity experience of weight management advice for pregnant women with a body mass index ≥ 30 kg/m^2"*. This proposal builds well on the current Minister of Health's priorities to improve maternal and child health outcomes.

As the Director of Pacific Health at [redacted] District Health Boards, I believe this research study is important, feasible, and will be implemented in a way which is consistent with Pacific cultural values. Susan's research is significant to improving Pacific health outcomes and I am hopeful that this proposal will be a success.

Yours faithfully

[redacted]

Director Pacific Health
[redacted] District Health Boards

c.c. Susan Knox

[redacted]

Appendix D: Research advisory group terms of reference

AUT UNIVERSITY HEALTH + ENVIRONMENTAL SCIENCES

Research advisory group terms of reference

Purpose and remit of the advisory group

The purpose of the research advisory group is to provide an effective engagement point for the researcher to access advice and input to the research being undertaken with AUT University. This group is established to ensure this research is conducted in a manner that is consistent with the Treaty of Waitangi principles, that is culturally responsive and informed by service and consumer perspectives. The aim of the group will be to work collaboratively to inform the development of the research. In particular the group will support the researcher to:

- establish cultural safety for the project providing appropriate cultural oversight and advice
- identify approaches to collecting data with Māori and Pacific participants
- talk safely about the research and its associated challenges.

The group will also contribute to the development of the research through:

- providing critique in ways which are challenging to the researcher
- sharing knowledge on the maternity systems and processes
- advising on the process of obtaining consents for data collection
- providing advice to ensure relevant audiences/stakeholders are engaged in the research
- providing a consumer voice to the development of the research proposal and research design
- Identifying emerging issues which are encountered along the research journey.

Membership

The group will comprise of representatives of maternity services (including Māori and Pacific practitioners and tikanga specialists) and a consumer advisor to the study.

Frequency of meetings

The group will meet on a quarterly basis throughout the duration of the study (March 2015 – March 2019). However, the group may be asked to provide assistance and guidance out with scheduled meetings.

Re-imbursement of Expenses

Payments are available on a koha basis for meeting attendance.

Appendix E: Letter confirming ethics approval for the study

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

1 June 2016

Judith McAra-Couper
Faculty of Health and Environmental Sciences

Dear Judith

Re Ethics Application: **16/126 A critical hermeneutic study exploring the experience of being overweight and obese in pregnancy and the impact of health promotion messages and contemporary discourse on behaviour change.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 30 May 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

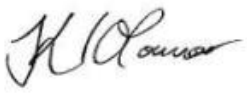
- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 30 May 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 30 May 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Susan Knox, Andrea Gilkison

Appendix F: Letter confirming access to the DHB locality

[redacted]

06 April 2016

Susan Knox
PhD Student
Centre for Midwifery & Women's Health Research
AUT

Dear Ms Knox

Research Application: Women's experiences of being overweight and pregnant

Thank you for forwarding your research application for completion of the [redacted] DHB's internal approval process for clinical research.

Following internal consultation, I am pleased to advise that locality approval has been granted. Sarah Boyes, as Director of Operations, Surgical Directorate, has been appointed as the DHB lead for this research project and should be contacted in the first instance for any enquiries you have.

On completion of this study please forward a copy of the final report for inclusion in an annual report to be developed of all clinical research activities undertaken throughout the year in [redacted] DHB.

Yours sincerely

[redacted]
Executive Director Quality & Risk
[redacted] **District Health Board**

Hutt Valley District Health Board | High Street | Private Bag 31907, Lower Hutt 5010
P 04 566 6999 | F 04 570 9001

Appendix G: Study introduction letter – maternity services providers

Study introduction letter - maternity service providers

Date study introduction letter produced

01 April 2016

Dear maternity services provider,

Working study title: Women's experiences of being overweight and pregnant

My name is Susan Knox and I am a PhD student at AUT. I am writing to let you know about a research study that pregnant women and new mothers could take part in. The research study is being conducted by researchers in the Centre for Midwifery and Women's Health Research at AUT. We are writing to ask you to support us in recruitment of women to this important study.

Why is this study being conducted?

This study is being done to learn more about women's experiences of being overweight and pregnant. In addition, we are interested in finding out women's views on weight-focused advice and interventions. The reason we want to know more about this is that obesity is a rising problem in New Zealand. As obesity prevention efforts are being targeted at pregnant women, we want to better understand how to help women engage with nutrition and physical activity advice and health promotion interventions.

Has ethics approval been granted?

This study has been approved by [redacted] DHB Quality Team and has received ethics approval from AUT Ethics Committee.

Who are the participants?

We are looking for pregnant women and new mothers who want to take part in this research study. There are two phases of the study. In the first phase, we want to recruit 12-18 pregnant women to take part in individual interviews. In the second phase, 15-20 pregnant women and new mothers will be recruited to focus groups.

We are interested in recruiting pregnant women and new mothers who:

- Self-identify as living with overweight or obesity
- Are overweight at the start of pregnancy or have gained too much during pregnancy
- Have been given advice on how to gain the right amount of weight during pregnancy
- Use maternity services in [redacted] such as hospital maternity care or Māori and Pacific health providers.

Women who take part in the study will be able to bring a support person. As a thank you for taking part in the study, women will be compensated for expenses incurred in participating.

What support would we like?

We would like to invite you to raise awareness of this study which women who meet the inclusion criteria. Participant information packs will be provided to support you to talk with women about taking part. These packs contain information for women and include:

- Participant Information Sheet
- Consent Forms
- Poster advertisement.

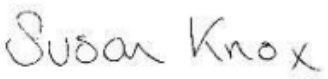
Susan Knox, Lead Researcher's, contact details are included in the pack. Please encourage women who are interested in taking part to contact Susan directly.

What to do if you would like more information

If you need more information on this study I welcome the opportunity to talk with you or your team. Please do not hesitate to call if you have any questions as you read over this material. We are happy to review any of this with you and answer any questions you may have. If you would like to speak with Susan please contact her at susan.knox@aut.ac.nz (022 368 4632).

Thank you for your time.

Sincerely,



Susan Knox (Lead Researcher and PhD Candidate)
Associate Professor Judith McAra-Couper
Dr Andrea Gilkison
Centre for Midwifery & Women's Health Research, AUT

Approved by the Auckland University of Technology Ethics Committee on 1 June 2016, AUTEC reference number - 16/126

Appendix H: Participant information sheet

Participant information sheet

Date information sheet produced:

01 April 2016

Working project title

Women's experiences of being overweight and pregnant

An invitation

My name is Susan Knox and I am a student at AUT. I am inviting you to take part in research exploring women's experiences of being overweight and pregnant. I am recruiting pregnant women who use maternity services in [redacted] Please take time to read this information sheet. This sheet will tell you what the study is about and explains what your participation would involve. Your participation is voluntary. You may withdraw from the study up until the time when data collection is complete (01 January 2017). This research will contribute toward my studies for a Doctor of Health Science degree.

What is the purpose of this research?

The study will explore women's experiences of being overweight and pregnant. I also want to understand what women think about the advice they have been given on healthy weight gain in pregnancy and whether this advice has led to lifestyle changes.

How was I identified and why am I being invited to participate in this research?

Your midwife or other health care provider may have invited you to take part in the study if you are pregnant and identify as overweight. Your midwife or health provider may have given you advice on how to gain the right amount of weight during your pregnancy. You may also have found out about the study from a poster advertisement. The invitation is open to pregnant women who were overweight at the start of pregnancy or have gained too much during pregnancy.

What will happen in this research?

Taking part in this research will involve an interview lasting about one hour. I may also ask you to take part in a follow-up focus group. In the focus groups we will discuss your thoughts and feelings towards different kinds of health promotion booklets and other materials. In the interview you will be asked about the meaning of advice about healthy eating and keeping active. You will be asked to talk about the things that make it difficult or easy to make changes to your lifestyle during pregnancy. The interview will be held at a place that is private and convenient for you. You can invite a support person to be with you during the interview.

The interview will be audio taped and later transcribed. These tapes and transcripts remain confidential to my research supervisors and myself. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity.

What are the discomforts and risks?

I do not anticipate any risks to you from this study. However, sometimes such interviews in which you share your thoughts and emotions can make a person feel vulnerable. Some women may find questions are sensitive or cause embarrassment. This may happen because I ask you to think about how you felt when your health worker talked to you about weight gain in pregnancy.

How will these discomforts and risks be alleviated?

You will be in control of how much information you share. You do not have to answer all the questions and you can stop the interview at any time. No information will be reported in the research that could identify any person without the express permission of the person or persons concerned. Counselling services will be available should you need them as a result of the study. You may get in touch directly with the counselling services by contacting them at:

Wellington Women's Health Collective
Level 5
175 Victoria Street
Wellington
Phone: 04 384 7709
Email: wwhc54@xtra.co.nz

What are the benefits?

The benefits of taking part in this study are that you will be part of exciting new research that has the potential to benefit women and families through increasing health workers' understanding of the types of support women need to make healthy lifestyle changes during pregnancy. The study may also assist me in obtaining a qualification.

How will my privacy be protected?

Confidentiality will be assured. Each interview will be audio taped and later transcribed. These tapes and transcripts remain confidential to my research supervisors, transcribers, and myself. Transcribers involved in the study will be required to sign a confidentiality form. If you take part in a focus group, each participant in the focus group will agree to keeping all discussions confidential to group members.

To ensure confidentiality and data protection your identity will not be disclosed to anyone. A pseudonym or false name will be used on all the tapes, transcripts and reports to protect your identity. All information relating to you will stored securely for five years. The researcher will be responsible for destroying the data and nothing that identifies you will be stored.

What are the costs of participating in this research?

The costs to you will include your time involved in attending the interview and your transport costs to the venue for the interview.

What opportunity do I have to consider this invitation?

If you would like to take part in the study, a commitment from you will be required at the time of the interview.

How do I agree to participate in this research?

You will be required to sign a consent form that will be available at the time of the interview.

Will I receive feedback on the results of this research?

You will be invited to a presentation to hear the results of the study. You will also be offered a written summary of the findings within six months of the study finishing. Findings may also be presented at conferences and seminars. Your identity will not be revealed in any of these contexts. The final research

will be published as a PhD thesis, which will be available in the university library. There will also be publications from the study that will appear in journals.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Judith McAra-Couper, jmcaraco@aut.ac.nz, 09 921 9999 ext. 7193. Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 09 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this information sheet and a copy of the consent form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Susan Knox (PhD Student)
Centre for Midwifery & Women's Health Research, AUT
Phone: 022 368 4632
Email: susan.knox@aut.ac.nz

Project Supervisor Contact Details:

Judith McAra-Couper
Centre for Midwifery & Women's Health Research, AUT
Phone: 09 921 9999 ext. 7193
Email: jmcaraco@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 1 June 2016, AUTEC Reference number 16/126

Appendix I: Participant consent form

Consent form

Project title: ***Women's experiences of being overweight and pregnant***

Project supervisor: ***Judith McAra-Couper***

Researcher: ***Susan Knox***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 01 April 2016.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's contact details:

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 1 June 2016, AUTEC reference number - 16/126

Note: The Participant should retain a copy of this form.

Appendix J: Recruitment poster

AUT

A research study to understand the experiences of women who are overweight and pregnant.

Researchers at AUT want to find out whether weight-focused advice helps women make lifestyle changes.

This study is for pregnant women who identify as overweight.

Research is always voluntary!

This study might be a good fit for you if:

- You use maternity services in [redacted]
- You were overweight at the start of pregnancy or have gained too much during pregnancy
- You have been given advice on how to gain the right amount of weight.

If you decide to take part in the study you will be invited to an interview to share your experiences. You can bring a support person with you.

Compensation for expenses incurred in giving your time is offered.

To take part or for more information please contact the researcher - Susan Knox.

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Overweight in Pregnancy Study
Email: susan.knox@aut.ac.nz
Phone or text: 022 368 4632

Appendix K: Letter confirming the provision of counselling services for participants – Wellington Women's Health Collective

WELLINGTON WOMEN'S HEALTH COLLECTIVE INC
WĀHINE ORA O TE WAIMĀPIHI
Level 5 175 Victoria St PO Box 11 731 Wellington 6142
***www.wwhc.org.nz Telephone 04 384 7709* Email wwhc54@xtra.co.nz**

5 April 2016

Dear Ethics Committee,

We have been approached by Susan Knox, who would like to know that women taking part in her research project can have access to counselling at WWHC if needed.

We have outlined our position to Susan, as below.

Women in Susan's study who are eligible for WWHC's counselling service are welcome to contact WWHC for counselling. If our service is waitlisted at the time, we will work with the client to find an acceptable alternative.

Eligibility is determined primarily by income. There is no set level (we use a little discretion) but the woman needs to be in a position where she can't afford counselling elsewhere. If the woman is actively suicidal, presenting primarily because of rape/sexual abuse or alcohol and drug problems, we will support them to find the specialised agencies who work with these issues.

Women whose income is too high to be eligible for counselling here are still welcome in the support service, where they will have access to a support worker as they need her. They can come for a session in or ring up for support. The support service can also 'carry' clients while they are waiting for counselling, here or elsewhere.

We will always work with clients to find alternative counselling if need be, and encourage them to stay in touch until they have obtained counselling.

We hope this is clear. Please feel welcome to contact us if necessary.

Yours sincerely,

Robyn Goldsmith
Coordinator
Wellington Women's Health Collective

Appendix L: Interview topic guide

Interview topic guide

Opening questions

- Tell me about becoming a mum
- Tell me about your pregnancy so far

Referral to a clinic theme

- What was your experience of coming to the clinic/weight management service/diabetes appointment?
- Tell me about why you were referred to the clinic.

Weight theme

- What is the meaning of being overweight for you? (Women's own terms to be substituted).
- How did your midwife or doctor talk with you about your weight?

Advice/health promotion theme

- What advice were you given about healthy eating/keeping active/ looking after yourself/protecting baby/pepe?
- How were you involved in a conversation about your weight/nutrition/exercise/feeding intentions?

Contextual factors theme

- What is your family's eating patterns or cultural traditions around food and exercise during pregnancy?
- Describe the place you live and the social or cultural parts of your life that affect weight.

Concluding the interview

- Is there anything you were hoping I would ask that I have not, or anything else you can think of that might be helpful to me?

Appendix M: Interview reflection sheet - Lily's example

Interview reflection sheet - Lily's example

Immediate reflections following the interview	- Lily was the second woman to be interviewed. I had a strong sense that I was not asking questions in phenomenological ways; ways that would elicit a story. I experienced a discomfort in the way I 'directed' my conversation with Lily. Being mindful of my influence as a researcher, I wondered if my questions inadvertently increased Lily's perception of weight-related risk. While she self-identified as overweight, neither Lily nor her midwife perceived any risk associated with her pre-pregnancy BMI or increasing weight gain. Lily said, "I can't stop the scales from rising". As a follow-up, I asked: "Where does this leave you thinking about how to manage your weight and look after your health, given your midwife doesn't feel it's an issue to worry about"? On reflection, I became aware that I needed to more carefully frame my questions to stay focused on the woman's experience and avoid perpetuating risk.
Initial thinking on the parts that might contribute to the phenomenological text	- The experience of high weight gain and the impacts on bodily movement. - The relationship between weight gain and a hurrying of pregnancy. - What it feels like to be in a body that is 'struggling to keep up'. - The experience of weight gain while eating within nutritional guidelines and how it feels when it becomes intuitive to 'eat for two'.
What are my assumptions in relation to this phenomenological material?	- Normal pregnancy symptoms, such as pelvic pain, minimise opportunities to be physically active.
Reflections on how I might hone my craft	- Focusing the research on the phenomenon and using phenomenological approaches to dig down into meaning. - Explore women's use of language more as language is a core feature of phenomenology.
Supervisors' responses to the raw data and my reflections on the interview	- My supervisors' perspectives reminded me that the 'participants determine the interview'. This means I let the interview go where it will and don't leave the story behind. While the interview was tricky to navigate, my supervisors noted my attempts to return to the original questions. - Analysis could focus on how body image issues seemed very real for Lily, as well as the adaptation women make when weight gain recommendations are unrealistic.

Appendix N: Phenomenological material not included in the study

Phenomenological material not included in the study

Teuili's crafted story: Our loving shelter for baby

Being active held greater significance for Teuili when she was pregnant. For Teuili, bodily movement revealed her desire for a strong and healthy baby. Perceiving movement as a significant and vital aspect of her human existence, Teuili's story uncovered how movement was an expression of her innate need to nurture and keep her baby safe. Resisting tiredness, she challenged herself by moving her body and found comfort in physically moving her body to help her baby be strong. Though being pregnant meant it was difficult for her to exercise, she intuitively knew that moving her body was a way for her to embody her natural maternal instinct to nurture her baby. Teuili's story spoke of her intense yearning to protect her baby:

> *It's the happiest thing that I'm pregnant but it's hard for me to move my body. I feel like sleeping but I push myself to do everything, so I can look after my baby. I must move my body, so the baby can move, and so the baby can be strong when he or she is born. Last year my brother had a new baby, but she was just one month when she passed away. She was breastfeeding baby on the bed lying down and then she went fast asleep. The breast stopped the baby's breath. It fell on top of the baby's face. That's why the baby's dead. It's really hard for me to forget that experience. Because of this I want to help baby be strong and be prepared for the new-born. I don't want to ride in the car. I just want to stay home and move my body, so the baby can be strong.*

Teuili was exposed to critical life event which caused emotional distress. This factor brought about an unbalance in several dimensions for Teuili and a mood of sadness enveloped Teuili as she recounted an experience of loss in her family. She seemed haunted by the details surrounding the death of the baby and drew on a vivid anthropomorphic metaphor, as though to draw us into her story and help us understand the significance of this loss. She described how, "the breast stopped the baby's breath". Her tendency to anthropomorphise the breast speaks to us about her values in a visceral and emotional way and allowed her to make her point more concrete. Loss affected Teuili's bodily experience of being-in-the-world. In grief and sadness, she reflected on loss as a possible situation she might experience. Her body was so affected by this experience and her response was to reflect on her embodied life.

Teuili searched for ease and painlessness. Her need was to experience more relief and she restored order in her world through physically moving her body. She was pulled towards the protective and

comforting qualities of staying at home which seemed to be provoked by her experience of family loss. It was as though she wanted to temporarily put aside the outside world, until after her baby was born. Being outside of her home threatened her sense of wellbeing and it was as though being outside separated her from her purpose of helping baby be strong. She seemed to have a conscious awareness of how her lived space protected and provided her with comfort. Intuitively Teuili knew that being outside of the home, in the car for example, could pose a threat to her body and to her baby and she became distrustful of the outside. It appeared that though her very existence, a loss of self even, might be experienced if she left home. For Teuili, staying at home was not oppressive, but a relieving experience, and in this context, positive wellbeing was obtained by the reassurance of being inside. To be inside the home, helped her feel safe and offered a stabilising effect on her world, shielding her from difficult or unpleasant realities. Thus, home became a protective place where she could recollect herself in a space of familiarity. Being at home sheltered her body and provided a structure for her life during pregnancy. In this way, staying at home supported her intuitive ways of coping, helping her connect with her baby and experience a deep sense of wellbeing.

Appendix O: Post-reflexion journal extract – peer-debriefing with cultural advisors

Post-reflexion journal extract: Peer-debriefing with cultural advisors

The following extract from my post-reflexion journal provides extracts from the cultural advisors' responses to the data:

Pacific advisor's written response to the crafted stories:

> These crafted stories were so rich that each time I read through the analysis I experienced ranges of emotions about what was shared. It gave me confidence that with each read, I experienced consistent commitment in applying an empathy lens to how you reflect, articulate and describe what each respondent had shared with you. There were no surprises in the data and analysis for me, my reflective lens is one of lived experience. This is best defined as a New Zealand born woman of Tokelau and NZ-Euro descent, who has navigated the process of carrying and giving birth to four children with my Samoan husband. In this process we embraced and valued raising our family in constant support and close contact with both our immediate and extended families who live in proximity. Being a family of multi ethnicities, my reflective lens also includes an ongoing lived experience of the strengths and challenges of committing to navigate and live up to or mediate any similar or conflicting familial, cultural and religious traditions and/or expectations.
>
> Having lived some of the elements of these stories, my emotions were stirred on reading and through this personal response I experienced an effectiveness in the methodology used. I appreciate the analysis and crafting as meaningful, knowing that Susan does not have this lived experience in a Pacific context. The data and stories these women shared with you and paired with your empathetic and consistent methodology/analysis gives me a sense that you were ethical and trustworthy in your approach with the respondents. How someone will share a story is different based on their personal experience and perspective. But it is consistently evident you have formed enough trust with each respondent through their willingness to share. There is evidence of the depth at which you gained trust in that they communicate beyond what happened and have defined how they felt, or how they were impacted – it is in these rich definitions that I sense actuality of your research. In my lived experience I have experienced or seen these behaviours and heard some of these feelings you articulate very well (A. So'otaga, personal communication, October, 12, 2017)

Ana provided affirmation of my data interpretation in important ways. For example, Ana suggested a deepening of the analysis to write-in interpretive conjectures surrounding the meaning of 'being

lazy' from Pasifika perspectives. On noticing the multiple references to this concept in the data, Ana helped me to think about Pasifika meanings and discourses, as opposed to western meanings:

> For Pasifika women, it helps to think of the concept 'being lazy' as a claim that can also refer to women not being seen as reaching, or striving to participate in or undertake familial, religious or cultural norms, traditions or advice. For example, a woman, that is pregnant may perceive her goal and actions will lead her to produce a healthy baby if this looks different to, or she seems resistant to her cultural or family tradition where she allows everyone or particular family members to have a role also in ensuring baby is healthy – then 'being lazy' could allude to this resistance. Being lazy in this context could mean, they are failing their baby and their family. In doing so this is dishonourable to the family, bringing shame upon the family unit. Ana pointed to the constant cycle of judgement around ideals that Pasifika women navigate during pregnancy. There are often different ideals also based on the placement of the parents and baby in the family. To ensure the best outcome for the baby the woman must be cared for. Depending on who the parents are and the status of the baby to be, this can mean being, 'totally bubble wrapped, cared for and served' through to an expectation to move into an identified family members home to prepare for baby being born into a wider family support system. (Ana So'otaga, personal communication, October, 13, 2017)

Ana was selected because she is an insider, with prior experience of Pasifika traditional knowledge as well as the research topic. She self-identified as a mother of four to a Samoan husband, preventive health worker, and woman with an interest in healthy environments, nutrition and sport. Ana brought a New Zealand born Tokelau lens to the data and was ideally positioned to comment on the data from a Pasifika and western world view. Ana was supplied with initial crafted stories from each of the five Pacific participants in the study. She read and re-read the crafted stories over a period of a few months, after which time a single meeting was held. I asked Ana to comment on my assumptions operating about Pasifika women's stories, namely that spirituality appeared to be influential for some Pasifika women in how maternal obesity was produced and provoked–these influences closely connected women to the health of their baby. Supported by Ana's Pasifika view on the data, I came to appreciate the importance of the micro and macro contexts more deeply, for women in the study.

Māori advisor's oral response to the crafted stories:

Bubba Hiko was similarly selected as an insider with experience of Māori traditional knowledge. Bubba was New Zealand born Māori and Samoan woman who brought knowledge and understanding of Māori, Samoan, and European culture to the data; and importantly ensured input from a Tiriti perspective. Bubba had prior experience with the topic of research through her personal interest in nutrition and fitness. Bubba was supplied with initial crafted stories from each of the three Māori participants in the study, which she read and re-read over a month. A single meeting was held with Bubba as her preference was to provide feedback through conversation. This post-reflexion extract provides Bubba's oral response to the data:

> Bubba felt that the Māori participants were alluding to aspects of whānaungatanga, or village approach, in their stories. Bubba explained the village approach is not focused on the individual but rather looked at women's experiences from a family or 'village' lens. Bubba's interpretation of the stories revealed that all the women related to the concept of 'village' (village defined as whānau or medical teams) in their telling of stories; though this manifested in different ways. Two women talked about the concept of village support in positive terms i.e., decisions being made on their behalf by medical professionals. From a Māori perspective, the importance of making connections is culturally embedded. Referring to Julie's story, Bubba described the importance for Julie of her doctors taking control of Julie's weight gain. It was a challenge for Julie not to gain weight and Bubba thought Julie was educating herself through clinic appointments. Julie was not necessarily being passive in the handover of her care, as I at first assumed. Instead, this connection with the doctor seemed to constitute a meaningful connection for Julie, as it was her intention to bring in and involve these clinicians as part of her village of support. Julie's village consisted of doctors and specialists and perhaps Julie trusted them in the same way that others would trust whānau. Bubba interpreted that it was a positive experience for Julie to hand over her care to the medical team, as this supported her safe passage through pregnancy and childbirth. In a different story, Pania involved her previous partner as her village, even speaking of her experience as being thankful to Anaru, as a result of which she was then positioned to support her own whānau. Bubba thought that these women did not want to feel that they are making decisions alone; rather they wanted to trust in others to help them. In this way, Bubba said, women have less chance of 'stuffing up'. For Julie and Pania, whānaungatanga was a positive element of their experience; yet for another participant, Cheree, she was lonely and had no help. As Bubba reminded me, there was no one in Cheree's village to say, "Yeah, all good Cheree, all good!" From her reading of the stories,

> Bubba uncovered that Cheree had a deep need for whānaungatanga yet could not access this. Though Cheree visibly had a village (her partner's whānau), Cheree had no meaningful connections and thus no support. For Cheree this meant that she couldn't take control of her unhappiness because she had no village. (B. Hiko, personal communication, December, 14, 2017)

I shared with Bubba my judgements and surprise that Māori appeared passive in clinic settings and eager for this knowledge. My assumptions were that being Māori, these women would have access to more traditional whānau knowledge and given this, they may have less reliance with mainstream pregnancy care. Bubba thought that in lots of ways Māori have been pulled out of their own culture and now must rely on cross-cultural trust and opportunities for educating themselves in mainstream environments. On hearing this, I felt naïve in that I had failed to understand the impact of displacement on Māori, which might be apparent for some of these women who experience a sense of isolation and loss. Though I initially came to the data with a fixed-focus western lens on these women's stories, involving Bubba in a peer-debriefing role, led to me re-writing these stories to reveal deeper aspects related to cultural context. It was not that I shied away from this but more that I simply did not see it. Through dialoguing with Bubba, I noticed how phenomena had exploded through my relations. My ability to stay open to alternative understandings saw the phenomena reveal its own complexity rather than imposing an external structure on it.

Appendix P: Conference contributions resultant from this thesis work

Knox, S., McAra-Couper, J., & Gilkison, A. (2020, October). *Women's maternal body experiences: Narrated stories*. Verbal presentation at Victoria University of Wellington/New Zealand College of Midwives Research Day, Wellington, New Zealand.

Knox, S., McAra-Couper, J., & Gilkison, A. (2019, May). *Complex contexts: Stories of being pregnant in a large body.* Verbal presentation at Counties Manukau, Obstetrics and Gynaecology Women's Health Update Day, Auckland, New Zealand.

Knox, S., McAra-Couper, J., & Gilkison, A. (2017, May). *A phenomenological encounter. A tale of two betrayals: Being pregnant in a large body in a system under strain*. Verbal presentation at AUT Midwifery and Women's Health Symposium, Auckland, New Zealand.

Knox, S., McAra-Couper, J., & Gilkison, A. (2016, August). *Fat Future? Weighty issues affecting uptake of nutrition advice during pregnancy*. Verbal presentation at New Zealand College of Midwives, 14th NZCOM Biennial Conference, Auckland, New Zealand.

Appendix Q: Published manuscript resultant from this thesis work

COMPARATIVE CASE STUDY

Health policy and its unintended consequences for midwife-woman partnerships: Is normal pregnancy at risk when the BMI measure is used?

Susan Knox[A,B] PhD (Cand), MHSc, PGDip HPromoHEd, BSc (Mid) • **Susan Crowther**[C] PhD, MSc, BSc (Hons), RM, RN • **Judith McAra-Couper**[B] PhD, PGDipEd, BA, DipMid, RGON • **Andrea Gilkison**[B] PhD, MEd (Dist), BSocSci, RM, RCpN

[A] Corresponding Author: suknox@aut.ac.nz

[B] Centre for Midwifery and Women's Health Research, Auckland University of Technology

[C] Robert Gordon University, Scotland

ABSTRACT

Background: Little attention has been paid to understanding the unintended consequences of health policy for midwife-woman partnerships. The measure of Body Mass Index (BMI) is one such policy example which has become established in contemporary midwifery practice as a tool for assessing pregnancy risk. The universal acceptance of BMI creates an unsettling paradox for midwives concerned with promoting woman-centred practice. The increasing focus on BMI is challenging for midwives as they navigate ethical tensions when directed to undertake practices which have potential unwonted consequences for the midwife-woman partnership.

Aim: The aim of the study was to explore the use of an indicator, using BMI as an example, to provide an international perspective on obesity prevention policy and maternity care provision.

Method: A comparative case study approach was taken, using descriptive cross-national comparative analysis of obesity prevention policy, weight management guidelines and midwifery models of care in New Zealand and Scotland.

Discussion: Despite promoting healthy weight gain in pregnancy, New Zealand and Scottish health policies may be missing health promotion opportunities. Focusing on BMI in maternity, per se, should not prohibit other assessment of lifestyle issues or delivery of services based on individual needs, capacities, histories and sociological characteristics. Relying solely on pre-pregnancy BMI as a marker of health in all women has remained relatively unchallenged and, as such, constitutes a policy problem because it occludes the factoring in of other lifestyle issues that may significantly alter individual risk status. Further, such an assessment of risk status is ideally arrived at within a partnership model of maternity care, rather than reliance on an a priori medical test.

Conclusion: Decontextualised policies are challenging for midwives where medical and midwifery values are in conflict. Policy which fails to consider the multiple and complex contexts of women's lives is confronting for midwives as they attempt to re-articulate the meaning of woman-centred practice. Furthermore, BMI as a tool may be ineffectual. The current focus on BMI in policy and practice requires re-consideration.

Keywords: midwifery partnership, health policy, weight management guidelines, BMI, New Zealand, Scotland

INTRODUCTION

Little attention has been paid to understanding the unintended consequences of health policy for midwife-woman partnerships. Torloni, Betran, and Merialdi (2012) highlighted how maternal obesity is a real concern in pregnancy. Evidence shows that maternal obesity significantly increases the risk of adverse maternal and infant outcomes (Marchi, Berg, Dencker, Olander, & Begley, 2015) and of admissions for specialist care (Denison et al., 2014). The growing evidence has led to obesity-targeted policy recommendations in New Zealand and Scotland (Ministry of Health, 2015b; Scottish Government, 2010; Scottish Government, 2011), yet little is known about the potential impact of such policies on midwifery practice. The measure of Body Mass Index (BMI) is one such policy example which has become established in contemporary midwifery practice as a tool for assessing pregnancy risk. One unintended consequence of such policy, and its associated gestational weight management guidelines, is an apparent preoccupation with weight surveillance. Such a focus on weight rather than pregnancy lifestyle care, in turn can pathologise the whole pregnancy for the woman.

BMI was originally intended as a tool used to monitor progress towards government targets on overweight and obesity (Hall & Cole, 2006). Subsequently, BMI has been widely adopted in policy and practice as a tool for individual assessment of overweight and obesity during pregnancy (Institute of Medicine, & National Research Council, 2009). BMI is therefore now used as the sole method of weight-based risk stratification in pregnancy. We are not disputing that BMI can be useful when used across populations but contest its use as the sole basis of risk stratification. We are concerned that the use of the BMI measurement alone may fail to

consider or recognise that some women are overweight and remain healthy. Their BMI is often the dominating focus of their care plan, when what matters most to women is a positive care experience based on compassion, choice and dignity (Morad, Parry-Smith, & McSherry, 2013). This appears to contradict the bespoke nature of care. Thus, the intrusive BMI is one such case that highlights a tension between individualised care to women juxtaposed to the routine nature of the dominant policy approaches to weight management. It is timely to expose a pathological paradox in which, if they have a BMI ≥25 kg/m², this is understood as always abnormal, covering up that some of these women are actually enjoying a healthy pregnancy. In other words, the BMI-related policy implication is that this places all women with a BMI over 25 as at risk, which leads to standardisation of care and may be moving us away from our focus on women-centred, individualised care.

The aim of our paper is to explore the use of an indicator, using BMI as an example, to provide an international perspective on policy and maternity care provision. New Zealand and Scotland are used for comparison as they are two countries with high-income economies and are served by well-educated, regulated, registered, health care practitioners. Both countries have persisting disparities in socio-economic statuses and a rising obesity prevalence within low-income populations, which are growing causes for concern (Ministry of Health, 2015b; Scottish Government, 2010). See Table 1 for the comparison of prevalences between the two countries.

Table 1. Comparative demographics between adults in New Zealand and Scotland

Variable	New Zealand	Scotland
Overweight and obesity	Overweight (66%) Obese (31%)	Overweight (65%) Obese (28%)
Obesity by gender	Women (32%) Men (29%)	Women (29%) Men (26%)
Obesity by ethnicity	Pacific peoples (66%) Māori (47%) Asian peoples (12%)	Chinese (4%) Asian/Other (9%)
Obesity by deprivation	Most deprived areas (42%) Least deprived areas (22%)	Most deprived areas (37%) Least deprived areas (21%)

Sources: Ministry of Health (2015a) and Scottish Government (2015)

While the countries in terms of obesity prevalence are not vastly different, the issues related to health inequalities, maternity service provision and maternity policy approaches to address obesity are dissimilar. An ideographic approach was chosen to understand each country in its own terms (Kohn, 1989). Each nation was treated as an object of study, and the approach was selected to highlight the unique elements related to maternity service provision and maternity care policy to address obesity. Here, we explore how policy and maternity practice diverge and converge in the two regions. We are particularly concerned with uncovering the unintended consequences of adopting a population tool in woman-centred practice, the potential consequences of which have gone relatively unexplored. By examining two sets of policies across different regions, the salient aspects of the issue related to the routine measurement of BMI in pregnancy can be highlighted. Further, we discuss the tensions evident for midwives as they implement BMI-focused policy while engaging with women in partnership relationships.

This paper begins with a brief overview of relevant literature in relation to obesity and weight gain in pregnancy. We then describe policy measures in New Zealand and Scotland which aim to promote healthy gestational weight gain, before describing how the countries have sought to implement weight management guidelines in pregnancy. This is followed by analysis of each country's midwifery models of care to answer: "How far and in what ways are New Zealand and Scotland promoting woman-centred practice in pregnancy?" To conclude, we highlight the lessons drawn and reflect on the challenges of implementing policy in ways which ensure the well-woman focus.

Literature review

Overweight and obesity are defined as abnormal or excessive fat accumulation that presents a risk to health (World Health Organization, 2015b). The negative impacts associated with overweight and obesity in pregnancy for mothers and their infants are well documented. It is argued that excessive gestational weight gain is the most deleterious consequence of pregnancy (Gilmore, Klempel-Donchenko, & Redman, 2015). Maternal obesity leads to an increased risk of both gestational diabetes and hypertensive conditions for women and, for the infant, perinatal death, congenital anomalies, birth trauma and high birth weight (Adamo et al., 2013; Catalano & Ehrenberg, 2006; Dodd, Grivell, Nguyen, Chan, & Robinson, 2011; Furber et al., 2013; Galtier, Raingeard, Renard, Boulot, & Bringer, 2008; Galtier-Dereure, Boegner, & Bringer, 2000; Lashen, Fear, & Sturdee, 2004; Leslie, Gibson, & Hankey, 2013; Ramachenderan, Bradford, & McLean, 2008; Ryan, 2007; Stotland, 2009). Low-income women were found to be more at risk than middle- and high-income women for excessive gestational weight gain, pointing to obesity-related disparities being a growing concern (Yeo & Logan, 2014). Furthermore, the predisposition to obesity is hereditary and is thought to impact the health of future generations (Mourtakos et al., 2015; Pirkola et al., 2010). Such evidence is fueling interest in pregnancy as a critical period to promote healthy weight gain (Huda, Brodie, & Sattar, 2010).

Despite pregnancy being an opportunity for health promotion, current obesity prevention initiatives have shown little evidence of success. Questions have been raised about the effectiveness of obesity-related policy approaches, with few of these approaches subject to rigorous evaluation and fewer still showing unequivocal evidence demonstrating efficacy in stabilising or reducing body weight (Essington & Hertelendy, 2016). It is unsurprising that the weight-focused approach to obesity management is being challenged (Bacon & Aphramor, 2011; Hafekost, Lawrence, Mitrou, O'Sullivan, & Zubrick, 2013).

In common with biomedical approaches to weight management, the emphasis on "one size fits all" (Hill et al., 2017) seeks standardised care pathways, neglecting the multiple contexts within which women exist (Keely, Cunningham-Burley, Elliott, Sandall, & Whittaker, 2017). The International Confederation of Midwives (ICM; 2017a) argues that the provision of maternity care that is service-centred rather than woman-centred can contribute to the medicalisation of pregnancy and childbirth. Inhorn (2006) describes medicalisation as the biomedical tendency to pathologise otherwise normal bodily states, leading to incumbent medical management. Pregnancy is a life event which has been medicalised with pregnant women's experiences epitomising the process of medicalisation (Zadoroznyj, 1999).

BMI appears to be part of the increasing medicalisation of pregnancy, with pregnant women increasingly being viewed through the lens of pathology. Pregnancy is a normal human

process which, like many processes, can vary from person to person. As such, biological approaches are narrow in focus and minimise opportunities for midwives to enable women to make sense of their health and well-being. Policy has paid little attention to the social context of maternal populations at risk of obesity (Heslehurst et al., 2011). Concurring, Sutherland, Brown and Yelland (2013) suggest that approaches which focus on behaviours that immediately lead to obesity, without considering the social circumstances that shape behaviours, are likely to have limited reach and impact on low-income groups. The rhetoric of personal choice, within which the obesity epidemic debate is framed, makes it difficult to see the structural barriers which encourage poor health or poor diet for women living in unhealthy environments (Cain, 2013). According to Greener, Douglas and van Teijlingen (2010), the prevailing biomedical interventions aim to enhance the health promoting capability of existing services to prevent or reduce obesity. Yet, without evidence from large-scale trials, it remains unclear whether adherence to suggested weight gain ranges improves maternal and infant health (National Institute Health and Clinical Excellence [NICE], 2010).

As sociologist C. Wright Mills (Mills, 1959) famously argued, we need to see personal problems (including and especially medical ones) as public issues and vice versa; it is inadvisable and misleading to see personal issues as separate from their complex historical and social contexts. Further, such approaches as those referred to above, serve to heighten anxiety and increase weight-based stigma (Lindhardt, Rubak, Mogensen, Lamont, & Joergensen, 2013; Mills, Schmied, & Dahlen, 2013). Emerging evidence supports the view that focusing on healthy lifestyles rather than on gestational weight is likely to be more effective (Keely et al., 2017; Smith et al., 2015). For example, in her study of women's lived experiences of co-existing BMI >30 and gestational diabetes mellitus, Jarvie (2017) found women sought less directive, more collaborative care. Similarly, findings from a feasibility study, and the degree of acceptability of a brief midwife-led intervention in that study, showed that women welcomed individualised discussion regarding diet and exercise (Warren, Rance, & Hunter, 2017). Arguably, a greater focus on promoting healthy lifestyles tailored to individual needs and preferences would be more acceptable and aligns more closely with the midwifery model of working in partnership with women.

Midwifery is based upon a partnership between women and midwives which aims to promote healthy outcomes (ICM, 2017b). The ICM Code of Ethics for Midwives (2008) urges midwives to develop a partnership with individual women, in which they actively share information and support women in their right to actively participate in decisions about their care. The midwife's role is to facilitate the safe passage of women and babies through the maternity care system (Koniak-Griffin, 1993), yet policy constraints potentially impact upon this primary midwifery focus, compromising the optimal ability of midwives to support women in achieving a normal pregnancy.

Design

Comparative analyses of policy and models of care in New Zealand and Scotland are presented. Descriptive cross-national comparisons can provide important new insights (Kan & Lau, 2013; Room et al., 2013; Shield et al., 2013). Similarly, Musingarimi (2009) conducted a descriptive comparative analysis of obesity-related policies within the devolved administrations in the United Kingdom (UK). We used descriptive methods to analyse related literature, policy and guidelines to explore how policy and practice diverge and converge in the two countries. A literature review was conducted to identify stand-alone policy documents, dated 2010-2016, which propose public health frameworks for action and guidance for weight management during pregnancy in New Zealand and Scotland. We examined pre-conception, pregnancy and postpartum-related policies relating to weight on entering pregnancy and weight gain during pregnancy, paying particular attention to how BMI is used in maternity practice. Case studies outline the high-level policy response and the major lifestyles interventions in place to optimise gestational weight gain. It is not in the scope of this paper to explore how government arrangements affect policy; nor is it our intention to advance understanding of policy processes or identify the successes and failures of the current measures. We do not intend to critique policies for their impacts but rather we seek to understand current approaches and the extent to which policy and maternity guidance supports pregnant women to adopt healthy lifestyles. The following section describes the policy response and models of maternity care in each country as a basis for undertaking a comparative case study.

FINDINGS

New Zealand case study

The New Zealand Health Strategy's Roadmap of Actions (Ministry of Health, 2016) lays down a plan to tackle long term conditions and obesity. The recently launched Childhood Obesity Plan (Ministry of Health, 2015b) sets the direction for prevention of, and early intervention to address, obesity. A package of initiatives to prevent and manage obesity in children and young people is being implemented. The initiatives aim to take a life-course and progression of condition approach and include: targeted interventions for those who are obese; increased support for those at risk of becoming obese; and broad approaches to make healthier choices easier for all New Zealanders. The focus is on food, the environment and being active at each life stage, starting during pregnancy and early childhood. Development of the policy drew on national and international evidence outlined in the Interim Report on Ending Childhood Obesity (World Health Organization, 2015a).

The New Zealand maternity care model is unique in that women choose their lead maternity carer (LMC), usually a midwife, who provides continuity of care for women from early pregnancy, through the labour and birth and up to six weeks postpartum (Rowland, McLeod, & Forese-Burns, 2012). LMC midwives claim from the government for the services they provide, so that maternity services are free to eligible women, unless the woman chooses a private obstetrician, who can charge over and above government funding. This model means that the LMC midwife is able to build a close relationship with a woman and her family/whānau (extended family group) during her pregnancy, developing trust and preparing the woman for the labour, birth and becoming a parent. Thus, LMC midwives have an opportunity to tap into what is known as that "teachable moment" and potentially effect change to support healthy lifestyles and better outcomes for both the woman and her family (Pan, Dixon, Paterson, & Campbell, 2014).

Guidance for Healthy Weight Gain in Pregnancy was published to support a reduction in the incidence of "inappropriate" weight gain in pregnancy (Ministry of Health, 2014). This guidance updated the advice provided in the Food and Nutrition Guidelines for Healthy Pregnant and Breastfeeding Women (Ministry of Health, 2006). The advice is to encourage women to monitor their own weight at regular intervals during pregnancy and the postpartum period and discuss this with their LMC as part of their care plan.

BMI is normally calculated at booking/first visit, ideally before 10 weeks' gestation (Ministry of Health, 2014).

The healthy range for BMI is defined as 18.5 to 25 kg/m², with obesity being recognised as a BMI of 30 kg/m² or above (World Health Organization, 2015b). Maternal obesity is defined as pre-pregnancy BMI ≥30 kg/m² (Chen, Feresu, Fernandez, & Rogan, 2009). In order to identify overweight and obese women, midwives measure women's BMIs which are calculated through height and weight measurements (kg/m²). Midwives and other providers of maternity care measure women's BMIs at the beginning of pregnancy to guide care and assess risk, given the significantly elevated risk associated with overweight and obesity in pregnancy for both mother and child, as signalled over the past two decades or so. It is expected that dietary and lifestyle advice is offered, or the woman is referred to a specialist, based on her BMI (Ministry of Health, 2012). It is a requirement, for example, to elevate care from low risk to higher risk categories in many hospitals across New Zealand.

Despite the availability of guidance since 2006, little is known about midwives' actual practice in relation to giving advice to women in relation to gestational weight gain. A nationwide cohort study involving 428 midwives described the practices of LMC midwives when discussing nutrition, activity and weight gain during pregnancy (Pan et al., 2014). Findings showed the majority of midwives provided information on nutrition and exercise during pregnancy and measured the height and weight of women in order to determine BMI. However, little is known in New Zealand about how such weight-focused advice leads to behaviour change, or not, in women with a high BMI within a continuity of carer model.

Scotland case study

Scotland has one of the worst obesity records among Organisation for Economic Cooperation and Development (OECD) countries (Scottish Government, 2010). A number of government policies and initiatives aimed at addressing obesity are in place there. Maternal obesity in isolation from contextual forces is not the focus. The focus is on improvements within the wider community of Scotland rather than in individuals, or individual groups in isolation (Scottish Government, 2011). In the Prevention of Obesity Route Map (Scottish Government, 2010), the government and the Convention of Scottish Local Authorities (COSLA) outline their long term commitment to tackle overweight and obesity. The goals are to have the majority of Scotland's adult population within a normal weight range and to have fewer overweight or obese children in Scotland. Thus, the majority of policy initiatives are focused on childhood obesity, the school environment and the workplace. The commitment to reducing prevalence of childhood obesity is reinforced by the inclusion of a national indicator to increase the proportion of healthy weight children (Scottish Government, 2011). Following analysis of the Route Map using the ANGELO (Analysis Grid for Environments Linked to Obesity) framework, Mooney, Jepson, Frank and Geddes (2015) found that, while all of the four domains of physical, economic, legislative and socio-cultural influences are represented, there is a disproportionate imbalance of policies in the attitude/behavioural arena compared to the built environment and at the expense of the legislative and economic domains. These authors further argue that, while the picture is unsurprising, it is at odds with the increasing body of international evidence about what works best.

Despite obesity being a UK-wide public health concern, there remains no evidence-based UK guidelines on recommended weight gain ranges during pregnancy (NICE, 2010). The Scottish Government launched Improving Maternal and Infant Nutrition: A Framework for Action in 2011 (Scottish Government, 2011). While this policy recognises the importance of good nutrition before conception, during pregnancy and in the early years, it did not go so far as to publish guidance on what is considered a healthy gestational weight gain. Despite this paucity of evidence on recommended weight gain ranges, direction has been provided at the policy level, not in terms of clear guidelines but as continuous advice on lifestyle and activity levels throughout pregnancy across the UK maternity systems (NICE, 2010). NICE suggests offering supportive specific and practical information to elicit behavioural changes which includes: discussing eating habits and safe physical activity; providing practical and tailored information; dispelling myths about what and how much to eat during pregnancy; measuring weight and height; calculating BMI at the first contact; and being sensitive to any concerns mothers-to-be may have about their weight. The advice is to not weigh women repeatedly during pregnancy as a matter of routine but only if clinical management can be influenced or if diet and weight changes become problematic. Offering a referral to a dietitian or appropriately trained health professional is encouraged to support women to lose weight after pregnancy.

The Midwifery 2020 programme emphasises the public health role of the midwife across the UK and provides guidelines on care in relation to obesity and measuring height and weight on booking (Midwifery 2020, 2010). If the woman's BMI is more than 30 it is recommended that midwives discuss the risks and explore the woman's diet. Many Scottish regions emphasise continuity across antenatal care but often without continuity of carer; nor does this care, except in rare circumstances, traverse intrapartum and all postnatal care. The fragmented style of midwifery care for the majority of the Scottish population would seem at odds with providing individualised dietary advice. However, the health care culture and systems in Scotland are now evolving. A recent review of maternity and neonatal services (Scottish Government, 2017) recommended continuity of carer for all regions across Scotland within five years. Recommendation 1 out of 76 in the review states, "Every woman will have continuity of carer from a primary midwife who will provide the majority of their antenatal intrapartum and postnatal care…" (p.64). At the time of writing, early adopter sites have been identified that will work on implementing this priority recommendation across Scotland.

Policy convergence and divergence between New Zealand and Scotland

Policy responses converged in a number of areas. Maternal obesity remains a priority on the policy agendas of both New Zealand and Scotland. However, weight management interventions to address obesity in pregnancy are in their infancy in both countries. Written policy refers to obesity as a "societal problem" which goes beyond individual responsibility; the rationale being that obesity cannot be viewed simply as a health issue, nor will it be solved by reliance on individual behaviour change. Despite acknowledgement of the broader socio-environmental influences on health, New Zealand and Scottish policies continue to offer a narrow, medicalised, non-individualised approach to healthy weight management.

Four areas of policy divergence were found. First, the Scottish Government has selected national indicators to monitor progress of the Prevention of Obesity Route Map (Scottish Government, 2010). A key indicator for children is to "reduce the rate of increase in the proportion of children with their body mass index outwith a healthy range by 2018" (Scottish Government, 2010, p.2).

Subsequent to this, Scotland developed physical activity targets as an indicator for adults, aimed at increasing the proportion of adults reaching recommended levels of exercise (Musingarimi, 2009). In New Zealand, no similar targets have been identified for reducing child obesity or for increasing physical exertion.

Second, the New Zealand Childhood Obesity Plan (Ministry of Health, 2015b) directs midwives to use the national guidelines on healthy weight gain during pregnancy (Ministry of Health, 2014). No such guidelines have been published by the Scottish Government. In the UK, NICE (2010) failed to offer guidance with regard to what constitutes appropriate gestational weight gain, due to the uncertainty surrounding the recommendations available, particularly the widely used Institute of Medicine (IOM) guidelines (Poston, 2017; Scott et al., 2014). Consequently, while weighing women throughout pregnancy is not standard practice in Scotland, New Zealand practitioners are recommended to provide BMI specific advice to avoid excessive gestational weight gain.

Third, while New Zealand's obesity prevention policy is centred on a life-course approach for pregnant women, this is less evident in Scottish policy. In contrast, Scottish policy focuses less on early life interventions, leaning more toward environmental change.

Given the differences in ethnic group composition between New Zealand and Scotland, we might expect to see cross-national differences in policy making to support ethnic populations at high risk of obesity-related inequities. There is no such divergence. Despite the fact that Māori and Pacific peoples account for over 20% of the population in New Zealand and face a disproportionate health burden attributable to high rates of overweight and obesity (Theodore, McLean, & TeMorenga, 2015), New Zealand policy fails to provide increased support for minority populations. Instead, the New Zealand Childhood Obesity Plan proposes increasing access to sporting opportunities for young people in communities where participation rates are low and the risk of poor health is consequently higher.

Recent evidence points to the loss of funding for Māori-led initiatives. This is described by Theodore et al. (2015) as a lost opportunity to identify the most effective interventions for improving health and reducing health inequities. This in turn, they say, represents a substantial risk to optimal Māori health, despite the responsibility of the New Zealand Government under the Treaty of Waitangi (New Zealand's founding document) to ensure Māori have at least the same standard of health as non-Māori (Medical Council of New Zealand, 2008). Paradoxically, the Childhood Obesity Plan has failed to gain support among Māori and Pacific peoples. Scotland, on the other hand, a country unaffected by obesity-related ethnic inequities, acknowledges the consequences of obesity and cautions health professionals to avoid approaches which "reflect, perpetuate and potentially increase social inequalities in health in Scotland" (Scottish Government, 2010, p.2).

From comparative exploration of the two countries' policies, it is evident that two themes are worthy of further discussion: the impact of models of midwifery care that focus on relationships and continuity of care and the role of the midwife within these countries.

DISCUSSION

The UK's Centre for Maternal and Child Enquiries, the Royal College of Obstetricians and Gynaecologists (Modder & Fitzsimons, 2010) and NICE (2010) advise that all obese pregnant women be provided with accurate and accessible information about associated risks and how these may be minimised. They all recommend that obstetric care is prudent for women whose BMIs are more than 30kg/m² rather than midwifery-led care. Yet caution needs to be taken not to pathologise the woman due to her weight alone. An individualised approach is called for that recognises the specific and complex contextual factors that impinge on the health status of all consumers, including pregnant women.

Both countries under review recognise the midwife as the key health professional; albeit the models of care are completely different otherwise in philosophy and practice arrangements. The one universal feature of both regimes is that, regardless of the model of care, all midwives promote woman-centred practice. Scottish midwifery services are currently fragmented compared to New Zealand's integrated services which are based on continuity of carer. In this context, fragmented care means that Scottish women receive care from community midwives who provide antenatal and postnatal care but rarely provide intrapartum care, other than the occasional primary birth either at home or, where available, at a stand-alone birth centre. Even when a primary/community birthing service is provided by community midwives, this is rarely by the named antenatal community midwife but whoever is on call at the time. In this way, fragmented care in Scotland refers to the fact that a named midwife does not follow the woman throughout her childbirth experience, as is the case for many New Zealand women who book with an LMC. The fragmented style of midwifery care for the majority of the Scottish population would seem at odds with providing individualised care. This fragmented experience has been highlighted in Cheyne et al.'s (2015) review of Scottish maternity experience, in which women frequently reported the dissatisfaction with having to repeat their story to different health care professionals throughout the childbirth experience. It is now rare that GPs and community midwives share pregnancy care in Scotland. Although many Scottish regions attempt midwifery continuity across antenatal care, they do not provide the degree of continuity across intrapartum and postnatal care as experienced by most New Zealand women. For the most part, in the Scottish context, community midwives provide a degree of continuity of care in pregnancy because antenatal clinics can be arranged around the off-duty entitlements of the community midwife. However, intrapartum care is unpredictable and postnatal care may fall over weekends when the rostered community midwife who provided the antenatal care is neither on call nor scheduled to work. In addition, the Scottish community midwife, unlike in New Zealand, does not follow the woman wherever her care is being provided. None of these community midwives, however, shares the same level of potential as the continuity of carer model in forging optimal midwife-woman relationships over time and, therefore, the facilitation of health promotion opportunities. As Scotland moves towards implementation of the Best Start recommendations for continuity of carer, it will be important to establish how evaluation of the continuity of carer service measures the standard that the service intends to achieve over time; e.g., "what does continuity of carer look like?" and "how will it be measured?" are very pertinent questions now needing to be answered as the implementation of the service rolls out across Scotland.

Treating each woman individually, that is, as a person with a unique combination of history, capacities, life-chances, opportunities and sociological characteristics based on gender, ethnicity, age, status, educational and religious affiliations, to mention just a few, not only better serves the woman herself, but also enables the LMC to offer specialised advice and support to facilitate optimal management and lifestyle changes, if necessary. It is an anathema to good health and a human rights agenda to simply label a woman as obese and treat her as personally irresponsible or incompetent just because this practice makes the UK nurse or midwife professionally

compliant (Nursing and Midwifery Council, 2008). Referring to the UK midwives, Swann and Davies (2012) agree that midwives have a major public health role in addressing obesity, yet argue for individualistic care to help promote normal birth for obese women. As they state:

> *The concept of the woman as expert in her own body, with the right to make informed decisions, is central to the midwifery model and should not be abandoned simply because risk factors are identified (p.11).*

The above commentary reflects the by now standard midwifery philosophy to always focus on the normal; although, as Scamell (2016) points out, tensions can arise when divergent care objectives are in conflict. In practice, therefore, managing risk while promoting normality is a reality for the majority of midwives who must perpetually guard against "the midwifery rhetoric of normal birth…[being]…devitalised by the hegemonic prioritisation of risk management and sensitivity" (Scamell, 2016, p.19).

Swann and Davies (2012) contend that more evidence is required to identify how midwifery care with obese women can improve their health outcomes. Evidence-based decision-making necessitates that midwives scrutinise the evidence, listen to women and deliver critically informed, woman-centred care recommendations; although, in our opinion, this may not be politically popular nor supported by the dominant medical group in most maternity domains.

Practice should be in line with best available evidence, but whose evidence? Ménage (2016) affirms a broader definition of evidence is required, including evidence derived from the woman, the midwife and research, alongside the environmental factors. The decision-making model developed by Ménage (2016) can assist midwives in considering and analysing evidence for decision-making in partnership with women, ensuring that, "the weighting of one piece of evidence over another is something that is discussed and negotiated within the woman-midwife partnership" (p.140). While further evaluation of the model is needed, this framework holds promise for a more respectful and equitable approach to risk assessment that better reflects the complex lived realities of women on low incomes.

A salient feature to emerge from obesity-targeted policies is an explosion of weight-focused discourses leading to increasing surveillance and focus on risk in contemporary maternity care. McGlone and Davies (2012) maintain that the BMI calculation was never intended for individual diagnosis, yet the pre-pregnant BMI has emerged as the standard measure to label women with a high BMI as "at risk" (McGlone & Davies, 2012) and as a singular tool in "helping midwives to help obese pregnant women towards a healthier pregnancy" (Poston, 2017). The use of a standard BMI measurement fails to factor in women's complex histories, capacities and sociological characteristics. Further, reliance on BMI alone compromises the midwifery model of partnership which does appreciate complexities and forges collaboration between midwife and woman. Our aim is to endorse the view that obesity in pregnancy represents a multifaceted and complex social process and, although it has serious medical implications, the extent of these involves more than just calculation of BMI. Instead, we aim to stimulate debate on the reliability and validity of a blanket approach of using pre-pregnancy BMI as a tool for all women in assessing risk in a normal pregnancy.

Further, we warn against an uncritical ingestion of a discourse underpinning much BMI messaging leading to standardised care pathways in favour of a little publicised, countervailing discourse that gives a realistic appraisal of health at any size (Rowe & Fisher, 2015). Unfortunately, although midwives are charged with enabling woman-centred, family-centred and culturally sensitive care, generic, biomedical health policies continue to dominate. The effect is to create an unstable relational space which challenges the professional/consumer partnership that could potentially flourish; a partnership which is foundational to the salutogenesis lying at the heart of midwifery practice. Ideally, midwives adopt the role of critic and conscience of maternity care; the challenge for midwifery being to locate itself more explicitly in a public health care context to better enable critique of the research which may impact upon women's experiences of care.

STRENGTHS AND LIMITATIONS

Our argument is made on the basis of a comparative analysis of health policy and models of care rather than on what women or midwives say about this, so caution needs to be taken in drawing conclusions. The paper contributes a description of the variations in policy contexts and maternity practice between New Zealand and Scotland and has highlighted important differences in the models of maternity care across these two countries. The opportunity to foreground divergent and convergent policy and practice across two different regions is a strength of this analysis because aspects worthy of further investigation (such as the voices of women and midwives) have been identified.

CONCLUSION

Midwifery philosophy has developed over time in contradistinction with medical philosophy to interpret pregnancy as a normal life event. The unintended consequences of health policies such as singular reliance on BMI to determine risk status have the potential to universally pathologise the individual, in this case to reinterpret pregnancy as a high risk life event. Hence, the use of BMI in maternity merits rigorous debate. The role of midwives extends beyond the provision of woman-centred care to the critique of emergent approaches and therefore promotes the autonomy of midwifery. We have shown that policies designed to regulate and diminish what has been called the obesity pandemic in Western countries have had the effect of directing midwives to undertake practices which are potentially detrimental to the midwifery partnership relationship based upon person-centredness and salutogenesis. The ongoing challenge for midwives is to drive improvements in health policies that are simultaneously congruent with the partnership model of midwifery practice. This may entail replacing a simplistic and singular medical indicator, such as BMI, with a composite indicator representing complex underlying factors unique to individual women. The value of this shift in policy would be an enhanced focus on outcomes that matter to individual women and better facilitate the management of overall health, including weight gain, before, during and after pregnancy. Congruence between health policy and midwifery practice is important if best practice and optimal outcomes are to be achieved.

Our paper is a small contribution to understanding the unintended consequences of health policy on midwifery practice. We point towards future possibilities for more effective approaches in maternity care. There are multiple influences that serve to shape government policy. We have highlighted how the BMI measure has become established in maternity care, yet its universal implementation and acceptance is unlikely to meet the needs of the majority of women. Policy which fails to consider the multiple and complex contexts of women's lives challenges the very nature of woman-centred practice which lies at the heart of midwifery practice in New Zealand and Scotland.

ACKNOWLEDGEMENTS AND CONFLICT OF INTEREST DISCLOSURE

We thank Nicola Jackson, Registered Midwife in Wellington, who assisted in the review of this paper. The authors declare that there are no conflicts of interest.

REFERENCES

Adamo, K.B., Ferraro, Z.M., Goldfield, G., Keely, E., Stacey, D., Hadjiyannakis, S.,… Barrowman, N.J. (2013). The Maternal Obesity Management (MOM) Trial Protocol: A lifestyle intervention during pregnancy to minimize downstream obesity. *Contemporary Clinical Trials, 35*(1), 87-96.

Bacon, L., & Aphramor, L., (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal, 10*(9), 2-13.

Cain, R. (2013). 'This growing genetic disaster': Obesogenic mothers, the obesity 'epidemic'and the persistence of eugenics. *Studies in the Maternal, 5*(2), 1-24.

Catalano, P., & Ehrenberg, H. (2006). Review article: The short- and long-term implications of maternal obesity on the mother and her offspring. *BJOG: An International Journal of Obstetrics and Gynaecology, 113*(10), 1126-1133.

Chen, A., Feresu, S.A., Fernandez, C., & Rogan, W.J. (2009). Maternal obesity and the risk of infant death in the United States. *Epidemiology, 20*(1), 74-81.

Cheyne, H., Critchley, A., Elders, A., Hill, D., Milburn, E., & Paterson, A. (2015). *Having a Baby in Scotland 2015: Listening to Mothers - National Report.* Edinburgh, Scotland: Scottish Government.

Denison, F., Norwood, P., Bhattacharya, S., Duffy, A., Mahmood, T., Morris, C.,…Scotland, G. (2014). Association between maternal body mass index during pregnancy, short-term morbidity, and increased health service costs: A population-based study. *BJOG: An International Journal of Obstetrics and Gynaecology, 121*(1), 72-81.

Dodd, J.M., Grivell, R.M., Nguyen, A.M., Chan, A., & Robinson, J.S. (2011). Maternal and perinatal health outcomes by body mass index category. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 51*(2), 136-140.

Essington, M., & Hertelendy, A.J. (2016). Legislating Weight Loss: Are Antiobesity Public Health Policies Making an Impact? *Journal of Health Politics, Policy and Law, 41*(3), 453-461.

Furber, C.M., McGowan, L., Bower, P., Kontopantelis, E., Quenby, S., & Lavender, T. (2013). Antenatal interventions for reducing weight in obese women for improving pregnancy outcome, *Cochrane Database of Systematic Review, Jan 31*(1), 1-26.

Galtier, F., Raingeard, I., Renard, E., Boulot, P., & Bringer, J. (2008). Optimizing the outcome of pregnancy in obese women: From pregestational to long-term management. *Diabetes & Metabolism, 34*(1), 19-25.

Galtier-Dereure, F., Boegner, C., & Bringer, J. (2000). Obesity and pregnancy: Complications and cost. *The American Journal of Clinical Nutrition, 71*(5), 1242s-1248s.

Gilmore, L.A., Klempel-Donchenko, M., & Redman, L.M. (2015). Pregnancy as a window to future health: Excessive gestational weight gain and obesity. *Seminars in Perinatology, 39*(4), 296-303.

Greener, J., Douglas, F., & van Teijlingen, E. (2010). More of the same? Conflicting perspectives of obesity causation and intervention amongst overweight people, health professionals and policy makers. *Social Science & Medicine, 70*(7), 1042-1049.

Hall, P., & Cole, T. (2006). What use is the BMI? *Archives of Disease in Childhood, 91*(4), 283-296.

Hafekost, K., Lawrence, D., Mitrou, F., O'Sullivan, T.A., & Zubrick, S.R. (2013). Tackling overweight and obesity: Does the public health message match the science? *BMC Medicine, 11*(1), 41.

Heslehurst, N., Moore, H., Rankin, J., Ells, L.J., Wilkinson, J.R., & Summberbell, C.D. (2011). How can maternity services be developed to effectively address maternal obesity? A qualitative study. *Midwifery, 27*(5), e170-e177.

Hill, B., McPhie, S., Moran, L.J., Harrison, P., Huang, T.T.-K., Teede, H., & Skouteris, H. (2017). Lifestyle intervention to prevent obesity during pregnancy: Implications and recommendations for research and implementation. *Midwifery, 49*, 13-18.

Huda, S.S., Brodie, L.E., & Sattar, N. (2010). Obesity in pregnancy: Prevalence and metabolic consequences. *Seminars in Fetal and Neonatal Medicine, 15*(2), 70-76.

Inhorn, M.C., 2006. Defining women's health: A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly, 20*(3), 345-378.

Institute of Medicine, & National Research Council. (2009). *Weight Gain During Pregnancy: Re-examining the Guidelines.* In A.L. Yaktine & K.M. Rasmussen (Eds). Washington DC, USA: National Academies Press.

International Confederation of Midwives. (2017a). Position Statement on Appropriate Maternity Services for Normal Pregnancy, Childbirth and the Postnatal Period. Retrieved from http://internationalmidwives.org/who-we-are/policy-and-practice/icm-position-statements-general/

International Confederation of Midwives. (2017b). Position Statement on Partnership between Women and Midwives. Retrieved from http://internationalmidwives.org/who-we-are/policy-and-practice/icm-position-statements-general/

Jarvie, R. (2017). Lived experiences of women with co-existing BMI≥ 30 and Gestational Diabetes Mellitus. *Midwifery, 49*, 79-86.

Kan, M.Y., & Lau, M. (2013). Comparing alcohol affordability in 65 cities worldwide. *Drug and Alcohol Review, 32*(1), 19-26.

Keely, A., Cunningham-Burley, S., Elliott, L., Sandall, J., & Whittaker, A. (2017). "If she wants to eat… and eat and eat… fine! It's gonna feed the baby": Pregnant women and partners' perceptions and experiences of pregnancy with a BMI> 40 kg/m². *Midwifery, 49*, 87-94.

Kohn, M.L. (1989). *Cross-national Research in Sociology.* Newbury Park, USA: Sage Publications.

Koniak-Griffin, D. (1993). Maternal role attainment. *Journal of Nursing Scholarship, 25*, 257-262.

Lashen, H., Fear, K., & Sturdee, D. (2004). Obesity is associated with increased risk of first trimester and recurrent miscarriage: Matched case-control study. *Human Reproduction, 19*(7), 1644-1646.

Leslie, W., Gibson, A., & Hankey, C. (2013). Prevention and management of excessive gestational weight gain: A survey of overweight and obese pregnant women. *BMC Pregnancy and Childbirth, 13*(1), 1-16.

Lindhardt, C.L., Rubak, S., Mogensen, O., Lamont, R.F., & Joergensen, J.S. (2013). The experience of pregnant women with a body mass index> 30 kg/m² of their encounters with healthcare professionals. *Acta Obstetricia et Gynecologica Scandinavica, 92*(9), 1101-1107.

Marchi, J., Berg, M., Dencker, A., Olander, E.K., Begley, C. (2015). Risks associated with obesity in pregnancy, for the mother and baby: A systematic review of reviews. *Obesity Reviews, 16*(8), 621-638.

McGlone, A., & Davies, S. (2012). Perspectives on risk and obesity: Towards a 'tolerable risk' approach? *British Journal of Midwifery, 20*(1), 13-17.

Medical Council of New Zealand. (2008). *Best Health Outcomes for Māori: Practice Implications.* Wellington: Author.

Ménage, D. (2016). Part 2: A model for evidence-based decision-making in midwifery care. *British Journal of Midwifery, 24*(2), 137-143.

Midwifery 2020. (2010). *Midwifery 2020: Delivering expectation.* Cambridge, UK: Author.

Mills, A., Schmied, V.A., & Dahlen, H.G. (2013). 'Get alongside us', women's experiences of being overweight and pregnant in Sydney, Australia. *Maternal & Child Nutrition, 9*(3), 309-321.

Mills, C.W. (1959). *The Sociological Imagination.* Oxford, England: Oxford University Press.

Ministry of Health. (2006). *Food and nutrition guidelines for healthy pregnant and breastfeeding women.* Wellington: Author.

Ministry of Health. (2012). *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).* Wellington: Author.

Ministry of Health. (2014). *Guidance for Healthy Weight Gain in Pregnancy.* Wellington: Author.

Ministry of Health. (2015a). *Annual Update of Key Results 2014/15: New Zealand Health Survey.* Wellington: Author.

Ministry of Health. (2015b). *Childhood Obesity Plan.* Retrieved from https://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan,

Ministry of Health. (2016). *New Zealand Health Strategy: Roadmap of actions 2016.* Retrieved from https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmapofactions-2016-apr16.pdf

Modder, J., & Fitzsimons, K.J. (2010). *Joint Guidelines for the Management of Women with Obesity in Pregnancy.* England: Centre for Maternal and Child Enquiries, & Royal College of Obstetricians and Gynaecologists.

Mooney, J.D., Jepson, R., Frank, J., & Geddes, R. (2015). Obesity prevention in Scotland: A policy analysis using the ANGELO framework. *Obesity Facts, 8*(4), 273-281.

Morad, S., Parry-Smith, W., & McSherry, W. (2013). Dignity in Maternity Care. *Evidence Based Midwifery, 11*(2), 67-70.

Mourtakos, S.P., Tambalis, K.D., Panagiotakos, D.B., Antonogeorgos, G., Arnaoutis, G., Karteroliotis, K., & Sidossis, L.S. (2015). Maternal lifestyle characteristics during pregnancy, and the risk of obesity in the offspring: A study of 5,125 children. *BMC Pregnancy & Childbirth, 15*(1), 1.

Musingarimi, P. (2009). Obesity in the UK: A review and comparative analysis of policies within the devolved administrations. *Health Policy, 91*(1), 10-16.

National Institute Health and Clinical Excellence. (2010). *Weight management before, during and after pregnancy.* Retrieved from https://www.nice.org.uk/guidance/ph27

Nursing and Midwifery Council. (2008). *The Code: Standards, Performance and Ethics for Nurses and Midwives.* Retrieved from *https://www.nmc.org.uk/standards/code/*

Pan, S., Dixon, L., Paterson, H., & Campbell, N. (2014). New Zealand LMC midwives' approaches to discussing nutrition, activity and weight gain during pregnancy. *New Zealand College of Midwives Journal, 50*, 24-29.

Pirkola, J., Pouta, A., Bloigu, A., Hartikainen, A.-L., Laitinen, J., Järvelin, M.-R., & Väärämäki, M. (2010). Risks of overweight and abdominal obesity at age 16 years associated with prenatal exposures to maternal prepregnancy overweight and gestational diabetes mellitus. *Diabetes Care, 33*(5), 1115-1121.

Poston, L. (2017). Obesity in pregnancy; Where are we, where should we go? *Midwifery, 49*, 4-6.

Ramachenderan, J., Bradford, J., & McLean, M. (2008). Maternal obesity and pregnancy complications: A review. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 48*(3), 228-235.

Room, R., Bloomfield, K., Gmel, G., Grittner, U., Gustafsson, N.-K., Mäkelä, P.,… Wicki, M. (2013). What happened to alcohol consumption and problems in the Nordic countries when alcohol taxes were decreased and borders opened? *The International Journal of Alcohol and Drug Research, 2*(1), 77-87.

Rowe, H.J., & Fisher, J.R.W. (2015). Do contemporary social and health discourses arouse peripartum anxiety? A qualitative investigation of women's accounts. *Women's Studies International Forum, 51*, 56-65.

Rowland, T., McLeod, D., & Forese-Burns, N. (2012). *Comparative Study of Maternity Systems.* Wellington: Ministry of Health.

Ryan, D. (2007). Obesity in women: A life cycle of medical risk. *International Journal of Obesity., 31*, S3-S7.

Scamell, M. (2016). The fear factor of risk--clinical governance and midwifery talk and practice in the UK. *Midwifery, 38*, 14-20.

Scott, C., Andersen, C.T., Valdez, N., Mardones, F., Nohr, E.A., Poston, L.… Abrams, B. (2014). No global consensus: a cross-sectional survey of maternal weight policies. *BMC Pregnancy & Childbirth, 14*(1), 167.

Scottish Government. (2010). *Preventing overweight and obesity in Scotland: A route map towards healthy weight.* Edinburgh, Scotland: Author.

Scottish Government. (2011). *Improving Maternal and Infant Nutrition: A Framework for Action.* Edinburgh, Scotland: Author.

Scottish Government. (2015). *The Scottish Health Survey 2014.* Edinburgh, Scotland: Author

Scottish Government. (2017). *The best start: A five year forward plan for maternity and neonatal care in Scotland.* Edinburgh, Scotland: Author.

Shield, K.D., Rylett, M., Gmel, G., Gmel, G., Kehoe-Chan, T.A., & Rehm, J. (2013). Global alcohol exposure estimates by country, territory and region for 2005—a contribution to the Comparative Risk Assessment for the 2010 Global Burden of Disease Study. *Addiction, 108*(5), 912-922.

Smith, D.M., Taylor, W., Whitworth, M.K., Roberts, S., Sibley, C., & Lavender, T. (2015). The feasibility phase of a community antenatal lifestyle programme [The Lifestyle Course (TLC)] for women with a body mass index (BMI)≥ 30 kg/m^2. *Midwifery, 31*(2), 280-287.

Stotland, N.E. (2009). Obesity and pregnancy. *BMJ, 338*, 107-110.

Sutherland, G., Brown, S., & Yelland, J. (2013). Applying a social disparities lens to obesity in pregnancy to inform efforts to intervene. *Midwifery, 29*(4), 338-343.

Swann, L., & Davies, S. (2012). The role of the midwife in improving normal birth rates in obese women. *British Journal of Midwifery, 20*(1).

Theodore, R., McLean, R., & TeMorenga, L. (2015). Challenges to addressing obesity for Māori in Aotearoa/New Zealand. *Australian and New Zealand Journal of Public Health 39*(6), 509-512.

Torloni, M.R., Betran, A.P., & Merialdi, M. (2012). Demography of Obesity. In M.W. Gillman, & L. Poston (Eds.), *Maternal Obesity* (pp.1-5). New York, USA: Cambridge University Press.

Warren, L., Rance, J., & Hunter, B. (2017). Eat Well Keep Active: Qualitative findings from a feasibility and acceptability study of a brief midwife led intervention to facilitate healthful dietary and physical activity behaviours in pregnant women. *Midwifery, 49*, 117-123.

World Health Organization. (2015a). *Interim Report of the Commission on Ending Childhood Obesity.* Geneva, Switzerland: Author.

World Health Organization. (2015b). *Overweight and Obesity Fact Sheet.* Retrieved from http://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

Yeo, S., & Logan, J.G. (2014). Preventing obesity: Exercise and daily activities of low-income pregnant women. *Journal of Perinatal & Neonatal Nursing, 28*(1), 17-25.

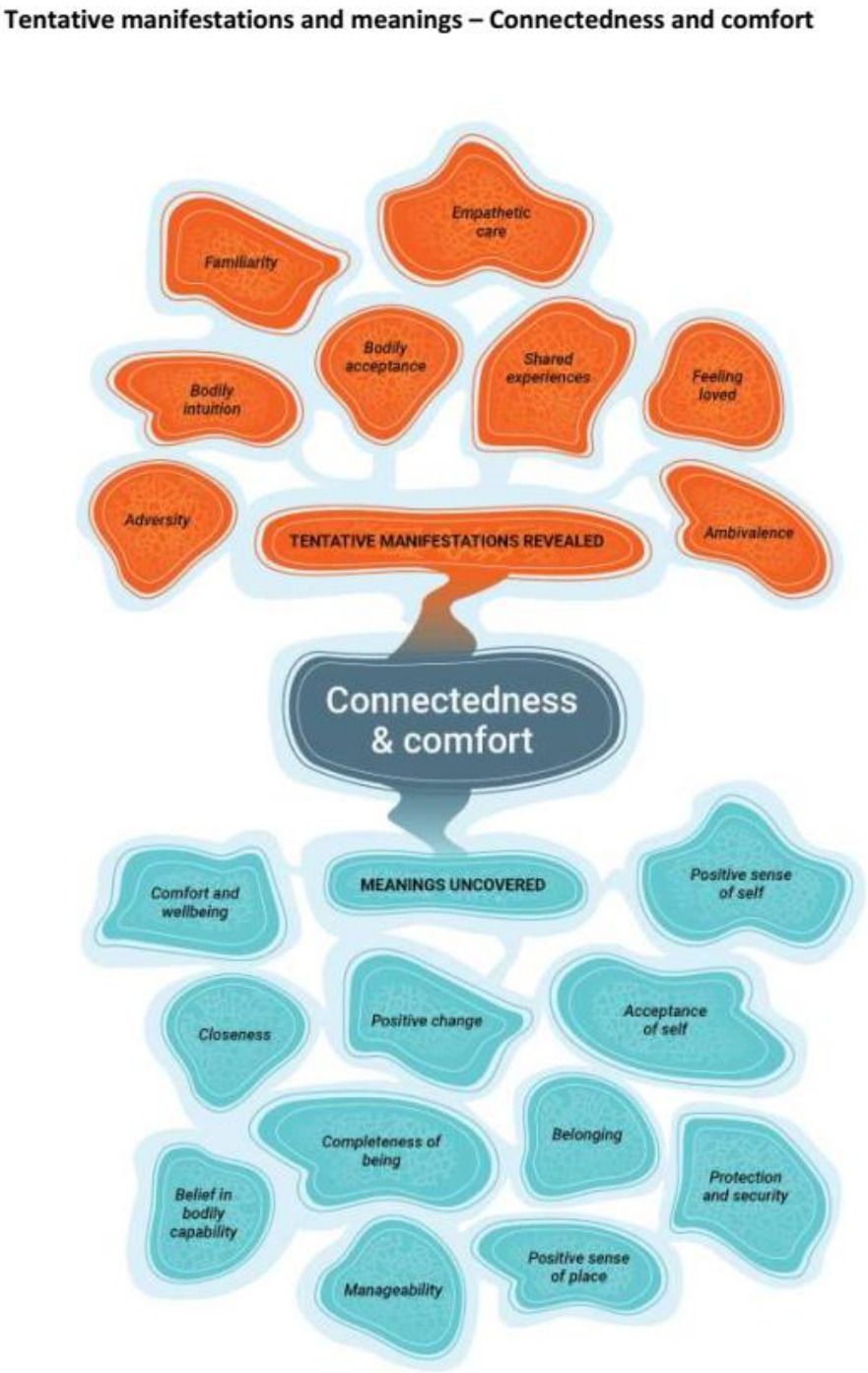
Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth. *Sociology of Health & Illness, 21*(3), 267-289.

Accepted for Publication June 2018

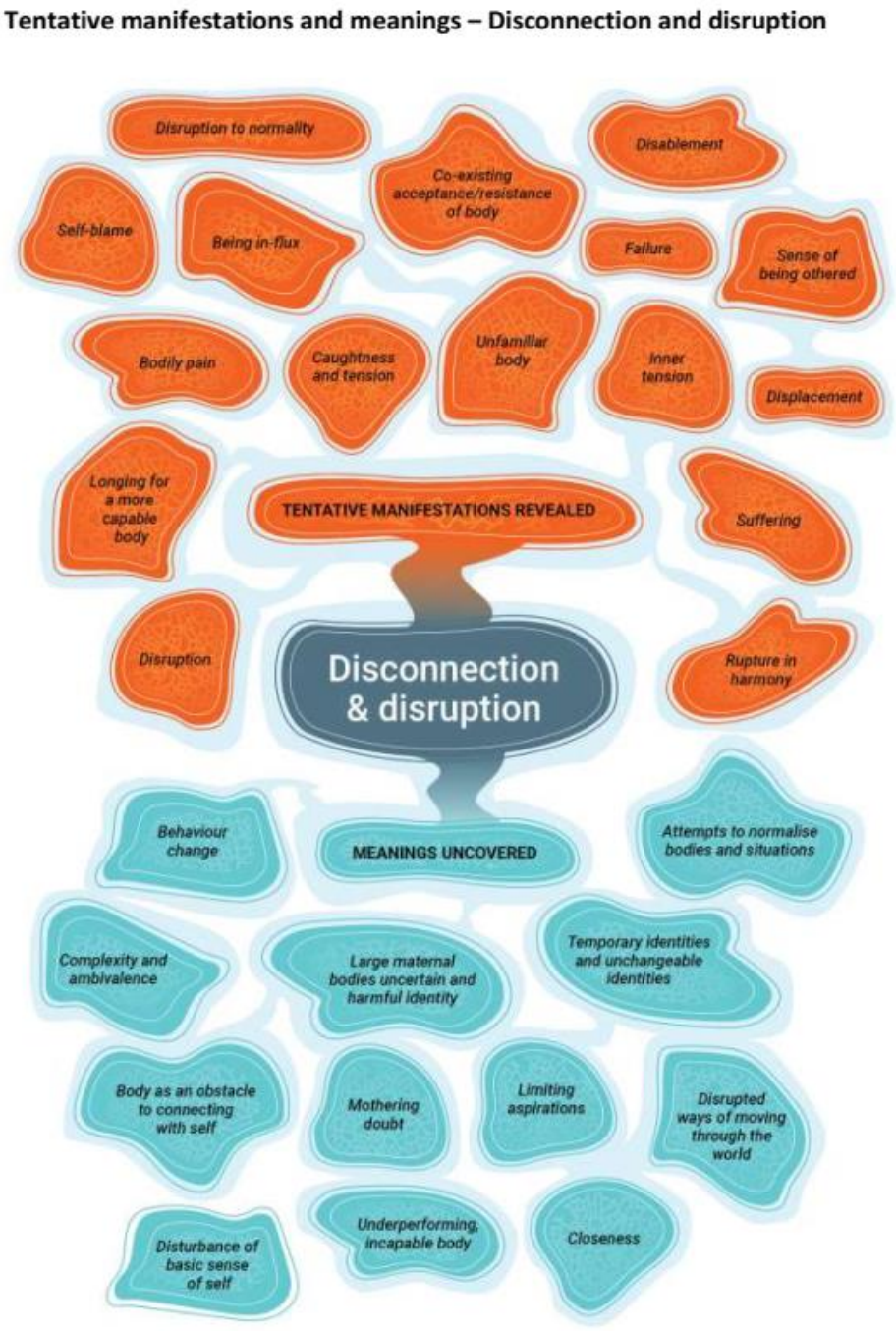
Knox, S., Crowther, S., McAra-Couper, J., & Gilkison, A. (2018). Health policy and its unintended consequences for midwife-woman partnerships: Is normal pregnancy at risk when the BMI measure is used? *New Zealand College of Midwives Journal, 54*, 30-37.

https://doi.org/10.12784/nzcomjnl54.2018.4.30-37

Appendix R: Tentative manifestations and meanings – Connectedness and comfort



Appendix S: Tentative manifestations and meanings – Disconnection and disruption



Appendix T: Tentative manifestations and meanings – Disruption to being-in-disease

Tentative manifestations and meanings uncovered – Disruption to being-in-disease