Women and Birth 38 (2025) 101900

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.sciencedirect.com/journal/women-and-birth

Maternity care experiences of women with a BMI≥ 35 kg/m^2: An interpretive phenomenological analysis

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ARTICLE INFO

Keywords:
Pregnancy
Obesity
Maternity care

ABSTRACT

Problem: Maternity care of women with a Body Mass Index ≥ 35 kg/m^2 is driven by a biomedical approach, with limited inclusion of women's views or experiences.
Background: Body Mass Index ≥ 35 kg/m^2 in pregnancy is common. Women with a higher Body Mass Index are more likely to access medical care during their pregnancy owing to increased rates of obstetric complexity.
Aim: To understand experiences of care for women with a Body Mass Index ≥ 35 kg/m^2 accessing maternity care.
Methods: We conducted in-depth, semi-structured interviews with ten women with a Body Mass Index ≥ 35 kg/m^2 accessing maternity care in Australia. Data were analysed using Interpretive Phenomenological Analysis.
Findings: Women's experiential data were analysed and three superordinate themes were constructed: Women's knowledge and agency; Healthcare that harms; and Healthcare that heals. Participants recounted their own role in invoking knowledge and enacting agency, describing birth as a significant life event. Participants acknowledged that past life and pregnancy experiences informed present experience, including intuitive knowledge of their own bodies. Harm was experienced when care was discriminatory or stigmatising, in response to inadequate or inconsistent information or inadequate consent. Healing care was experienced when care was relationship-based, knowledgeable, kind and listening, and when adequate preparation was facilitated. Irrespective of the specifics of their maternity care experience, participants in this study rejected Body Mass Index as a measure of health and expected more nuanced and detailed individual health assessment from their maternity carers.
Discussion: Women described variable experiences of maternity care. A woman's knowledge and agency are central to her pregnancy care experience. Delivery of healthcare that heals minimises harmful care experiences. Harms such as stigma, discrimination, inadequate consent, and difficulty gathering and sharing information can be avoided with maternity care that was relationship-based, kind and knowledgeable, and affords adequate preparation.
Conclusions: Previous experience informs personal agency. Body Mass Index was rejected as a marker of health. Women want personalised care.

Introduction

Every year, approximately 39 million pregnancies may be complicated by Body Mass Index (BMI)≥ 30 kg/m^2 [1]. Increasing population BMI is an epidemiological driver of maternal and neonatal morbidity [2,3]. Women with higher BMIs experience increased rates of maternal hypertension, pre-eclampsia and gestational diabetes, caesarean section rates, postpartum haemorrhage and postpartum depression [3]. For the neonate, increasing maternal BMI is associated with higher rates of macrosomia, preterm birth, special care/neonatal admission and perinatal death [2,3], though preterm birth is often iatrogenic [4].

Not all women with higher BMI have the same odds of developing adverse pregnancy outcomes [5]. Some associations may reflect iatrogenic factors [4] or the influence of weight stigma rather than being solely attributable to maternal BMI [6]. Medical language, particularly when used to describe individuals with higher body weights, can

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https://doi.org/10.1016/j.wombi.2025.101900
Received 13 November 2024; Received in revised form 5 March 2025; Accepted 7 March 2025
Available online 22 April 2025

sometimes contribute to stigmatization, reinforcing negative stereotypes [6]. In this paper, we adopt the terminology of BMI≥ 35 kg/m^2 or 'higher BMI', as this language is more widely accepted and less likely to perpetuate stigma [6].

More than 50 % of maternity care in Australia is provided as public hospital maternity care [7]. In this model, women with a BMI≥ 35 kg/m^2 are more likely to be recommended specialised care with an obstetrician due to associated health complexities [8]. A multidisciplinary approach to maternity care is often taken, with the inclusion of a midwife, obstetrician, anaesthetist, obstetric physician and other allied health professionals [8]. Public hospital maternity care is more fragmented, and associated with lower levels of satisfaction for users [7,9]. Alternative models include shared care, in which a general practitioner (GP) or community midwife provides maternity care in collaboration with the public hospital using a schedule of visits [7]. GP shared care shows no improvement in outcomes when compared to hospital care except for higher satisfaction scores from women accessing that model [9].

Midwifery Continuity of care models, such as midwifery group practice caseload care, and private midwifery care have been shown to offer significant benefits [10,11]. These models emphasise the establishment of a continuous, trusting relationship between the woman and their care provider, which can improve both satisfaction and outcomes [10,11]. For women with a higher BMI, these models may offer enhanced support, better communication, and a more personalised approach to care, addressing both physical and psychological needs [10, 11].

Arguably women's experience of their care is as important as the associated maternal or neonatal clinical outcomes. The World Health Organization (WHO) guidance around pregnancy care, attributes equal importance to *both* physical and psychological outcomes [12]. Understanding consumer experience is a crucial component of quality health care delivery [2]. While much of the existing research focuses on maternal and neonatal outcomes, there is a lack of focused research on women's perspectives on the maternity care they receive. This study therefore seeks to address this gap by exploring the experiences of women with a BMI≥ 35 kg/m^2 within the contemporary maternity sector, examining their interactions with healthcare providers, the care models that best meet their needs, and the impact of having a higher BMI on their overall care experience.

Methods

We employed an Interpretive Phenomenological Analysis (IPA) methodology, a qualitative approach that explores how individuals understand their lived experience [13]. Major life events, such as pregnancy, birth and early motherhood are suited to this method of enquiry [13], being significant and transformative times for women [14]. Women were invited to participate if they were currently pregnant, had a BMI ≥ 35 kg/m^2 and were receiving maternity care in Australia. Social media, clinician referral (with participant consent) from the lead investigator's maternity unit, and snowballing techniques were used to inform potential participants about the study. The use of small purposeful samples is recommended when using IPA [13,15] and was considered appropriate for this research owing to narrow study aims, the density of the sample specificity, and the strong quality of the dialogue [16]. BMI was collected from the medical record, or self-reported.

Following informed consent, women were invited to attend a single semi-structured interview. Ten interviews were conducted either online or in person. Basic demographic data were collected, and an interview schedule was used to ensure all relevant areas were covered. Key topics included experiences of maternity care during pregnancy and understanding of BMI as a marker of health. The interview guide (Appendix 1) was piloted with a woman who met the inclusion criteria to check for clarity and acceptability. Interviews were flexible, allowing the researcher to follow-up discussion points from participants not originally included in the interview schedule. Interviews lasted 20–40 minutes, were audio recorded, transcribed verbatim, and pseudo-anonymised. Interview length was guided by the principle of data saturation, that is the researcher felt they had a full understanding of the participant's perspective [17].

Qualitative research acknowledges the position of the researcher as a key influencer of the analytical process [18]. The first author consider their roles as obstetricians [RN, CdC], obstetric physician [LC] midwife [LK], to inform their understanding of current delivery of maternity care in a large regional hospital to be an advantage during data analysis. None of the authorship team was involved in the clinical care of the participants. Similarly, the acknowledgement of the entire team as maternity care providers [RN, LK, LC, CdC] and researchers [RN, LK, LC, CdC], as well as mothers may have influenced interpretation of participant accounts. To account for these potential biases, a reflexive diary was kept by the first author [RN]. The first author [RN] was involved in data collection, allowing a truly systematic approach to be carried out by other authors [LK, LC] regarding coding, analysis, and interpretation of transcripts by those removed from the participants.

Data were analysed using IPA [13,15], incorporating a dual analytic focus: both a thematic orientation across cases, and an individual idiographic approach [13,15]. After each interview, the first author [RN] made detailed notes regarding the interview, including the content of the discussion, body language, pauses, and experience of tension or ease during the interview. Each transcript was reviewed and coded [RN, LK], and emergent themes from each interview were noted. Following this, connection across emergent themes led to the development of superordinate themes. Within each superordinate theme, 'subthemes' were developed from within each interview, and linked across interviews. Providing the finalised results was discussed and agreed upon by all participants. Therefore, member checking was not undertaken.

Ethics

Ethical approvals were granted by the Queensland Prince Charles Hospital HREC number HREC HREC/18/QPCH/91, UQ 2024-RD000781.

Results

IPA produced a final thematic structure consisting of three superordinate themes, each comprised of several subthemes. Theme 1: Women's knowledge and agency; Theme 2: Healthcare that harms; Theme 3: Healthcare that heals. Fig. 1 presents each theme and subthemes. Each thematic code was supported and explained by quotations using participant pseudonyms. Quotes are presented as tabulated themes in Appendix 2. All women were born in Australia, in heterosexual partnerships, and no women identified as First Nations. There was a mix of nulliparous and multiparous women, and average age of the group was 32 years of age. Table 1 describes characteristics of each woman interviewed. Women's BMI ranged from 35 to 53.

Women recounted their own role in invoking knowledge and enacting agency, describing birth as a significant life event. Participants acknowledge that past life and pregnancy experiences informed present experience, several women stating 'women know their bodies'; 'Irrespective of the specifics of their maternity care experience, participants in this study reject BMI as a measure of health and expect more nuanced and detailed individual health assessment from their maternity carers. Overall, women described variable experiences of maternity care, ranging from 'great' to 'traumatic.' Women experienced harms, such as stigma, discrimination, inadequate consent, and difficulty gathering and sharing information related to weight in pregnancy. Women also described healing experiences associated with maternity care that was relationship-based, kind and knowledgeable, and affording adequate preparation.

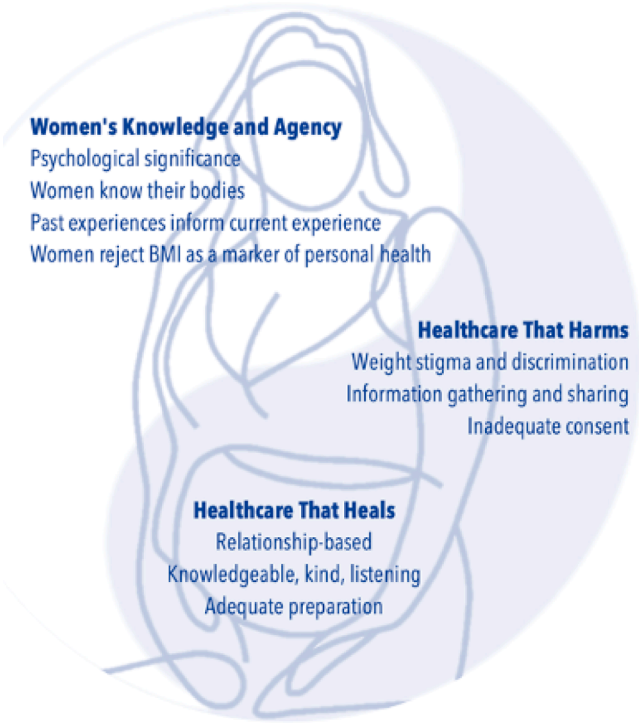

Fig. 1. Thematic diagram.

Table 1
Characteristics of women interviewed.

Pseudonym	Age	GxPx,	Gestation	Model of care as per Maternity Models of Care in Australia report [1]	Prior pregnancy mode of birth
Belinda	38	G3P0M2	26	GP Shared care	n/a
Jennifer	24	G1P0	16	Public hospital maternity care	n/a
Rose	25	G1P0	35	Public Hospital maternity care	n/a
Genevieve	31	G5P3M1	27	Public Hospital materntiy care	SVBx2, Elective CS
Vivien	32	G3P1	23	Midwife – privately practicing	Em CS
Maria	35	G4P3	26	Public hospital maternity care	SVBx3
Adeline	35	G6P1	29	Public hospital maternity care	SVB
Bea	28	G2P1	36	GP Shared care	Forceps with episiotomy
Liesl	37	G4P2	18	Public hospital maternity care	P1: Emergency CS, P2: Elective CS
Belle	32	G2P1	26	Midwife – privately practicing	SVB with episiotomy

Theme 1: women's knowledge and agency

Women identified their own role within their maternity care interactions. This theme included four sub-themes: 'psychological significance'; 'women know their bodies'; 'past experience informs current experience'; and, 'women reject BMI as a marker of personal health'.

Psychological significance

Women described birth as an intense physical and sometimes deeply psychological experience. Terms such as 'significant' and a sense of reverence were used to describe their lived journey of birth, as a social phenomenon – not just something that 'happens to them'.

> *You know, people, I think invariably feel like they're just the tick box and they have been churned through a system. But the reality is you're dealing with pregnancy. You're about to give birth to a human. These are not generic experiences, and I feel like without that element, that personal care and really specific care we're not really supporting people very well. - Belinda*

> *…[Its] a pretty significant experience[…] women carry their birth experiences for the rest of their life. You know a woman in their 90 s will still recall how she was treated in her birth and her pregnancy. - Belle*

Women know their bodies

Participants shared their life course understanding and experience of their own bodies. Some women described the lifelong experience of living in a larger body, or of coming from a family where their BMI was a health issue.

> *Mum's side of the family are all a bit bigger. So, I feel like I've been blessed with that. – Rose*

Other women had gained weight with pregnancy and parenting, or due to a medical condition.

> *I have Hashimoto's. So, that also has always been a big thing with weight loss for me because it affects my weight loss. It slows it down if I wanna go on a diet and lose weight and go to the gym and stuff that I've gotta take my thyroids into consideration because it slows everything down. - Genevieve*

Women shared their understanding of other complex conditions they were experiencing in pregnancy – including the experience of pregnancy post gastric sleeve.

> *It's a lot harder having a pregnancy post gastric sleeve[…]. I don't know if it's because of I'm a bit older […] I feel the effects of pregnancy more so. - Maria*

Past experiences inform current experience

Past maternity care experiences of women were described, and these informed their current perspective. Belinda experienced significant bruising following an obstetric ultrasound and discussed anticipatory anxiety for future ultrasounds required in the current pregnancy.

> *I think there's more anxiety for me and it's really around that. I think one thing that probably stood out most to me was when I've had ultrasounds, obviously my weight has impacted how they did ultrasounds and I found them quite uncomfortable and painful because they're kind of working around my body shape* - Belinda

Maria had 3 normal births previously, which gave her a sense of autonomy and empowerment, and the impression that modern medicine was unnecessarily intervening in a natural and effective process. Her past experience informed her current perspectives.

> *I think our bodies are design to naturally give birth without intervention… I think women's bodies are designed to have childbirth and just because we have all this newfound technology and medicine, I don't think we necessarily need it just in case.* - Maria

Women reject BMI as a marker of personal health

Some participants rejected BMI as a relevant marker of individual health, challenging its scientific validity.

> *Especially when my weight might have been 100 kilos for example. […] 100 kilos before I started weightlifting - I was unfit, couldn't do anything. But if in six months' time I would still weigh 100 kilos, but I can I do*

100 kg squat or move the weight or do all of those things? How can my BMI… if my weight hasn't changed, but my capabilities have, how can this information that is based solely on my weight and not my body composition be indicative of the care that I need? – Vivien

I think [BMI] is terrible as a measure of health and it really damaging. … When you pigeonhole people based on 2 numbers that have so many different influences, ethnicity hormones, muscle mass, age like and, and when you consider when you read and hear that it's been discredited widely as a measure of health it really hurts that that is the one thing that has put me in that high risk category and[…] it did impact the way that I was cared for. - Belle

Others recognised its use as a population health measure, but rejected it as a measure of personal health, comparing their self-assessed health as a comparator to their 'unhealthy BMI'.

I'm not an unhealthy person I certainly didn't have any problems falling pregnant…I just reframe it too. You know this is based on population studies. I try not to take it personally because I don't think it necessarily directly reflects my experience with respect to those risk factors obviously, they're still there and it's going to be aware of them. But you know, the direct relevance is really hard to calculate. - Belinda

Repeatedly women requested more nuanced health assessment than is afforded by BMI.

[They should say,]"*so can we just talk about your diet?… or can we talk about your health" and … if I then said "Oh look I'm not getting much exercise as I would like or I'm not getting I'm not eating as good as I could be… They can then go… "oh, can we suggest this, or we're just going to run some routine tests because of this…"*

- Genevieve

Theme 2: healthcare that harms

Women reported a range of harmful experiences of care, though they would often describe these experiences within the context of overall being satisfied with their care in pregnancy. Within this theme three key areas were discussed: 'Weight stigma and discrimination'; 'Information gathering and sharing'; and 'Inadequate consent'.

Weight stigma and discrimination

Experiences of weight stigma while accessing maternity care included fixated counselling regarding weight loss, test results such as glucose tolerance tests being disbelieved and repeated, and assumptions about women's lifestyle based on body shape. Liesl reported her doctor focused on her activity levels, rather than addressing her main concern of syncope. She felt dismissed without any recognition that syncope might impair the capacity to exercise. Liesl highlighted how a fixation on weight gain in pregnancy prevented a holistic assessment of the situation.

I remember […] every, every appointment I was on the scales and there'd be something to say if I was gaining weight. […] even the other day when I was at the doctor, she's like, ohh, [are] you getting exercise in? And I was like, I've literally come in here twice and been at the hospital twice in the last […]2 weeks because I can't stand longer than 10 minutes. Yet, you're telling me to exercise, like going for a walk is gonna make me skinny. - Liesl

Genevieve described judgment while accessing maternity care over the course of four pregnancies.

I don't like that a doctor can take one look at you and go 'you're overweight'. Like… I am physically capable of doing anything else that someone else who's skinnier than me can do. - Genevieve

Women experienced discrimination, based on their body size. The two key areas identified by participants were waterbirth and midwifery continuity of care, exclusion understood by women to be based purely on their weight or BMI.

I particularly wanted to use the bath and in the classes, it was 'you can't have a bath if you're over 100 kilos' or whatever it was. - Adeline

I was locked out of the model of care that I wanted based solely on my BMI. [At] *my 12-week appointment at the local hospital and the first check in appointment, I was asked what I wanted in terms of model of care and I opted for continuity of care with a midwife. […]They said I was too high risk due to my BMI - Belle*

Information gathering and sharing

Women reported shorter consultation times and the 'tick and flick' nature of many appointments resulting in depersonalized care or being 'churned through a system'. Shorter consultations were considered unsatisfactory experiences of care.

I think invariably it feels like they just the tick box and they have been churned through a system. – Belinda

I had waited two hours in the waiting room, and I spoke to him for a minute. And then I was out. I was like, 'What?' - Genevieve

Some women reported discomfort with being weighed or being asked about their weight in front of their partner.

I feel like the only time that I was uncomfortable, not made uncomfortable, but I was uncomfortable is when I was asked my weight in front of my partner. I said to my partner… 'block your ears.' - Rose

Adeline found national guidelines [19] for weight gain in pregnancy helpful but reported inconsistent information from her care providers. Despite guidelines recommending a five-to-nine-kilogram weight gain in pregnancy, she was advised that no weight gain in pregnancy was healthy.

[The guidelines] keeps me accountable for my weight progressions during my pregnancy. [*The doctor] said 'you've got plenty of room to move and babies gonna be fine if you don't put on weight'. …. [It helps] understanding being healthy and aware of what I'm eating. And if I lose a bit of weight, that's not that bad thing.*

- Adeline

Belle was frustrated by recommendations and counselling that lacked detail. She was advised to have growth scans to monitor the progress of her pregnancy and an induction for a large for gestational age fetus. She was angered and disappointed by her experience.

Don't just say we think you should have a growth scan. Tell me why I need to have a growth scan and what the evidence is behind that. I shouldn't have to prompt. You know, as a woman with a BMI above this level, the evidence suggests that you've got an x% higher chance of having a baby in this weight category. - Belle

Rose was recommended to commence enoxaparin (Clexane) due to her cumulative risk factors for thromboembolism, including BMI. She described feeling ignored by her care providers after twice questioning the impact of Clexane on her intrapartum analgesia. Women want individualized information to aid decision making.

I'm really hoping for an epidural. From my research, I think you […] stop taking Clexane like 24 hours before, or whatever… And I feel like [they're not listening] cause I've asked twice now when I'll kind of stop and no one has really said. - Rose

At other times women found counselling to be excessively concerned with risk and inflexible. Maria described counselling related to her blood sugar management as 'pushy and 'adamant'. She was concerned regarding the adoption of different blood glucose targets in Queensland when compared to previous maternity care received in Sydney. When Maria highlighted the inconsistency of GDM therapeutic targets to her

treating doctor, she described the response to her concerns as 'preachy'.

> *…the doctors were very pushy to get me onto insulin… Metformin wasn't an option because I had nausea. So, they wanted to put me straight on insulin, but I said, can you just let me do diet control and we'll take it from there. And they were really adamant that you need to be on insulin because baby can't live in a sugar state. But if you're preaching that, then how is it not the same in Sydney? - Maria*

Inadequate consent

Two women reported intrapartum examinations in which consent was omitted or coerced. Bea reported an examination without adequate consent in labour.

> *She wanted to check how dilated I was and I asked her to wait[…] She didn't, and I told her, "Stop. You're hurting me." And she said, "Well, if you can't handle this how are you going to have a baby." That was our first little moment together and then she broke my waters after that, without asking me. So that was really bad experience. But that was one person, whereas everyone else that I came across was really lovely. – Bea*

Belle consented for her episiotomy but felt that it was coerced in a moment of vulnerability.

> *I had to argue I didn't want the episiotomy… that I ultimately ended up having. And we were having discussion while I'm up in stirrups, she was saying that she felt I needed one, and I was like, I would rather tear naturally. And then she threw the line, 'I don't want you to be incontinent for the rest of your life.' And so you know, when you're trying to push out a baby and you're feeling pretty vulnerable, I kind of just threw my arms in the air and said 'do what you like' which was not great. You know, I look back on that and I regret that. - Belle*

Theme 3: healthcare that heals

Women reported a range of healing experiences of care. Within this theme there were three key areas discussed: 'Relationship-based'; 'knowledgeable, kind, listening'; and 'adequate preparation'.

Relationship-based

Relationship-based care was associated with a positive pregnancy experience. A range of models of care were reviewed positively including midwifery group practice, private practice midwife and a known/named doctor or nurse practitioner. Women described an ongoing relationship with their care provider as being central to facilitating woman-centred weight related discussions. Women also valued access to a known care provider when discussing more complex pregnancy care.

> *I was case loading […] so I could have my midwife come to the house after work to do checkups, which is awesome.* - Maria

> *My private midwife is also a lactation consultant of course […]so I got really good post-birth care. I think I had three visits in home with the midwife post birth, so I got good advice on getting a good latch.* - Vivien

Women find a known provider more equipped to understand their specific needs. Belinda describes 'being listened to' as a major contributor to her preference for a GP shared care model, even with its recognised limitations.

> *I chose that model because that particular GP saw me through the previous two miscarriages and I found her to be quite responsive. And so that was, I guess the main thing I was looking for in the maternity care to have someone who was responsive to my concerns. I mean it's GP, so they're only going to spend so much time with you. But I feel like I can give suggestions and I can make comments and she'll listen to what I say. I thought that was a better choice for me overall. – Belinda*

Adeline describes the benefits of a known provider when caring for her complex pregnancy needs.

> *So yesterday I called up cause my migraines kicked back in and no one I've seen was there yesterday and it was just kind of telling the story all over again. We're revisiting some of the things that were already investigated. Whereas, I think, if I had just talked to Gaye (nurse practitioner) or the consultant it would have just been 'here do this' and off you go. - Adeline*

Knowledgeable, kind, listening

Women described healing experiences with care that was 'responsive' and 'honest' – often tied to continuity models. Outside of continuity models, ease of communication shaped experience of care positively.

> *I feel like the thing what's stood out is how kind everyone has been[…] I actually haven't had a bad experience. Everyone's been really easy to talk to.* - Rose

Women described mindful but unbiased delivery of information, a non-judgmental approach and being listened to as positive experiences of care. This is healthcare that heals.

> *Yeah, they were very mindful about how they brought up weight related issues. They always make sure that they've got the larger cuff or your blood pressure monitoring. They give me the information. Unbiased. So it's just 'this is the information.' - Vivien*

> *I just think holding no judgment and like you can tell if someone holds judgment towards your reaction or how you ask for something in their body language, in their tone. And I feel like I haven't experienced that. So it just, you know, [BMI is] a passing comment almost, which is nice.* - Bea

Feeling listened to and respected was a positive care experience for Belle.

> *The obstetrician that I actually spoke to was respectful and did listen. And I talked about some of my experiences of having not been listened to in the past and she held that space for me and listened to me and apologized, even though it was not her place to need to apologize.* - Belle

Adequate preparation

Adequate preparation for care episodes was experienced as healing. Genevieve reflected positively on the communication around procedure during the birth of her third child by caesarean section.

> *I just think the C. section for me, was a lot easier because everyone explained to you what you were going through, what happens next, each step, where when I was having my baby both of the boys [vaginal births] no one was telling me what was going on.* - Genevieve

Liesl noted language used by the sonographer, which centred on the fetal pictures as the focal point of the ultrasound scan, rather than referencing her weight, as healing. Her sense of 'refreshment' is echoed by Belinda's experience of being weighed during pregnancy.

> *I know with my last two, they [said], "Oh, we're probably not gonna see anything because you're so big"[…], whereas this one[…] She did say it might not be a clear picture[…] It was quite refreshing not to make it about my weight.* - Liesl

> *I was […], expecting her to get on the scales […] I guess I was expecting all the questions about you gotta lose weight… You gotta do this, but nothing was actually mentioned, which was quite good.* - Belinda

Overall 'Women's knowledge and agency' emerged as a central theme, surrounded by both 'Healthcare that harms'; and 'Healthcare that heals'. See Fig. 1.

Discussion

Participants in this study had varied experiences of maternity care, themed as harmful or healing. Central to each woman's experience of her pregnancy care was the knowledge and agency brought by that woman to the pregnancy. Recognising a 'woman's knowledge and agency' is the foundation of a health consultation [20], and is sought after by women accessing maternity care [21]. Several women in our cohort described birth as a significant life event, with the psychological and social transformations considered just as important as the physical aspects of parturition [14,22]. Birth was described as a locus for their autonomy and personal power. Participants described how 'women know their bodies' and shared their lived experience of navigating the health system expressing their health needs, including for complex medical conditions. Our findings align with systematic review evidence which suggests women from high-income countries have adequate health literacy around pregnancy and childbirth [23].

The theme 'Prior experience informs current experience' relates to the additional knowledge and mindset conferred by multiparity. A positive childbirth experience can have a long-lasting effect on women's self-efficacy and self-esteem [24,25]. A negative childbirth experience may lead to negative outcomes, such as fear of childbirth, maternal distress, depression, and post-traumatic stress disorder (PTSD) [24,26]. This highlights the significance of previous experiences in shaping how women approach each pregnancy, and reinforces the importance of supportive, woman-centred care.

Participants did not consider BMI as a valid marker of individual health or pregnancy health, aligning with international maternity consumers and providers who challenge its use as a health predictor [27–29]. Guidelines published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, state that 'BMI is not a good measure of health, given it does not take into account age, ethnicity or body fat percentage and distribution'[19]. Regardless, its use remains pervasive in maternity care.

The theme 'Healthcare that harms' describes women's experiences of stigma and discrimination while accessing maternity care. Overt discrimination caused by weight stigma pervades society, health and maternity care [27,30–33]. Weight stigma is defined as "social devaluation and denigration of individuals because of their excess body weight [34]". It leads to negative attitudes, stereotypes, prejudice, and discrimination, and is propagated by explicit (conscious) or implicit (unconscious) weight bias [30,31,34]. Women in our study outlined incidents of implicit weight bias which have been previously described – test results not being believed or being repeated, shaming or blaming the woman for weight/body shape, repetitive diet/exercise counselling [27], or passing assumptions regarding lifestyle of the woman based on her body shape [28]. Experiences of explicit weight bias in maternity included exclusion from services such as waterbirth or continuity models [27], and offensive or discriminatory language use, notably related to ultrasound examination [27]. Weight bias and stigma may contribute to allostatic load in pregnancy which has been associated with an increase in hypertensive disease of pregnancy and pre-term birth [35]. The growing evidence examining weight stigma in obstetric care [27,28,36]suggests this as an urgent issue in need of translatable action.

Women in our cohort reported inconsistent information regarding weight management in pregnancy, which they experienced negatively [37]Women wanted high quality information, relevant to their circumstances [21]. However, information gathering and sharing around weight and weight related issues are potentially triggering as a source of shame and stigma and may benefit from employing a trauma informed approach [38,39].

Inadequate consent for intrapartum procedures were reported as healthcare that harms. For women with a history of trauma, procedures such as vaginal ultrasounds, physical examinations of breasts and genitals, and other invasive procedures can trigger painful memories, and trigger PTSD symptoms (flashbacks, hyperarousal, avoidance) [40]. Many sexual violence survivors experience trauma-related distress during pregnancy, childbirth and perinatal care [41]. Global estimates suggest that 27 % of ever-partnered women aged 15–49 years have experience trauma of the genitourinary system [42] and these rates are significantly higher for women with a higher BMI [43]. This finding underscores the need to minimise both primary trauma, and re-traumatisation in maternity care.

The theme 'Healthcare that heals' highlights the therapeutic potential of relationship-based care. Women with a known care provider are more likely to report a positive birth experience[44]. Midwifery continuity of care models are associated with increased vaginal births, increased breastfeeding rates, reduced complication rates and improved maternal anxiety and depression and overall satisfaction during the perinatal period [11,44]. There is emerging research on the effectiveness of relationship-based care models for women with complex needs in Australia, but more research is necessary [45]. Women in our study called for better access to continuity models, a preference echoed globally [46].

Care that is knowledgeable, kind and listening reflects quality information sharing which supports decision making. Quality information was valued on issues commonly arising in pregnancy such as gestational weight gain, oral glucose tolerance testing, venous thromboembolism prophylaxis, large for gestational age, induction of labour, mode of birth and episiotomy. Healthcare provider kindness and competence was widely reported as a healing experience of care. Warm, competent care has been demonstrated to account for a significant proportion of healing in many conditions [47]. Healthcare providers' facial appearance can help modulate top-down regulation of painful stimuli [47]. A supportive care provider-recipient relationship is a robust component of the placebo effect: boosting participants' expectations towards the treatment can enhance therapeutic effects in large single-blind randomized clinical trials [48,49]. Healthcare providers' behaviour and cognitive mindsets affect clinical interactions and participant outcomes [50]. Nonverbal empathic behaviours increase participant perceptions of clinician empathy, warmth, and competence [51].

Adequate preparation before procedures, and when making decision in pregnancy improves women's experience of care. Providing women with choices about whether they receive certain information as well as outlining expectations around procedures such as ultrasound or vaginal examinations, reflects the key trauma-informed care principles of choice, collaboration and empowerment [52]. Large scale validation of trauma-informed care principles in maternity settings are yet to be validated, though this work is underway [40].

'Healthcare that heals' outlines simple but potent variations to 'healthcare that harms'. Care with a known provider who is knowledgeable and kind negates many difficulties associated with information gathering and sharing. Issues with inadequate consent are prevented when women are adequately prepared. Our findings align with international systematic review evidence which found experiences during childbirth were reported as more satisfactory when they included quality care promoting wellbeing with a focus on individual needs; unrushed caregivers who provide continuity of care and communicate effectively; involvement in decision making about care and procedures; and kindness and respect [53].

Strengths and limitations

This study contributes to our understanding of the experiences of women with a BMI$\geq$ 35 kg/m^2 in Australian maternity care and echoes recent reports of the experience of weight stigma and discrimination for women accessing maternity care in Australia. A strength of this paper is its inclusion of women from various models of care, which allows for a broader perspective on the diverse maternity care systems and their impact on women's experiences. However, the sample lacks cultural and ethnic diversity, with a dominance of White women in heterosexual partnerships. This reflects a well reported underrepresentation of

vulnerable populations in research [54].

Conclusion

Women's experience of maternity care are influenced by their own knowledge and agency. Many women view birth as a deeply significant event, and prior experience shapes their current expectations and preferences. Women reject BMI as a marker of health and seek care that is relationship-based, kind, thorough and responsive. Harmful experiences such as stigma, discrimination, inconsistent information and inadequate consent should be eliminated wherever possible. Expanding access to continuity of care models and adopting trauma informed principles in maternity care may enhance maternal experiences and outcomes [34]. Recommendations for maternity care providers include:

1. Examination of the impact of training maternity care providers in using trauma-informed care principles is warranted.
2. Relationship-based care models for women with a BMI$\geq$35 kg/m^2 should be prioritised.

Ethical statement

Ethical approvals were granted by the Queensland Prince Charles Hospital HREC number HREC HREC/18/QPCH/91, UQ 2024-RD000781.

Funding

Dr Rachael Nugent was supported to conduct this research by a Clinician Researcher Fellowship Grant from the Study Education Research and Training Fund. Grant ID: 202108CRF.

CRediT authorship contribution statement

Conceptualization [**RN, CdC**]; Data curation [**RN**] ; Formal analysis [**RN, LK**]; Funding acquisition [RN]; Investigation [**RN, LK**]; Methodology [**RN, LK, CdC**]; Project administration [**RN, LK**]; Resources, Supervision [**LK, CdC, LC**]; Validation [**LK,LC, CdC**]; Visualization [**RN, LK, CdC, LC**]: Writing – original draft [**RN**]; and Writing – review & editing [**LK, CdC, LC**].

Declaration of Competing Interest

The authors have no competing interests to declare.

Acknowledgements

The authors would like to acknowledge the support of the Wishlist Health Foundation and Study, Education and Research and Training Fund, Sunshine Coast Hospital and Health Service for their financial support for this study.

Appendix 1. Question Guide

NAME:
Preamble

- All of your information is kept private and confidential (participant info sheet)
- We plan to record the interview is that ok?
- We will publish this but you will be de-identified.
- The purpose of this interview is for me to understand your experiences, if you have any clinical concerns I can't act in that role today.

Demographics
Contact details, email:
Share results when complete? [Y/N]
Age
G
P
Birth history:
Gestation:
Indigenous – Y/N
Country of birth –
Height and weight (from medical record Y/N) ir uf or self-reported - Weight: Height:
Partner - Y/N
Planned hospital of birth
Model of care
Occupation:
Questions – listen for cues regarding experience of care
'You just mentioned this can you tell me more about that?'
'The purpose of this interview is to talk to you about your experiences,'
Can you tell me about your pregnancy journey so far?
What did you hope your pregnancy care would look like?
How has your care matched up to that so far?
What is important to you in your pregnancy?
Ask about BMI if not come up yet – do you think this leads care?
'Reflexivity' - reflective writing after each interview.

Appendix 2. Tabulated Themes

Theme 1: *Women's knowledge and agency*	
Psychological Significance	*You know, people, I think invariably feel like they're just the tick box and they have been churned through a system. But the reality is you're dealing with pregnancy. You're about to give birth to a human. These are not generic experiences and I feel like without that element, those personal care and really specific care we're not really supporting people very well. - Belinda* *[Its] a pretty significant experience[…] women carry their birth experiences for the rest of their life. You know a woman in their 90 s will still recall how she was treated in her birth and her pregnancy. - Belle* *Completely different, but my eldest is type one diabetic and one of the important things from very first was they said it's not anybody's fault… It's pure bad luck[…] And I think that's a little things like that is that it sticks in your head cause it's like alright, it's not my fault. I didn't do this. - Liesl* *Friends who are also of higher weight and they had told me so many stories that made me very anxious about medical care during pregnancy because of that… - Belinda* *So far its been great. I feel like I've had a pretty easy pregnancy so far, so that probably plays into it. My anxiety with medical things has gotten better. I feel prior to this I haven't had any instances where I've \needed to go to the doctor, or the hospital, or whatever. And the only time I ever have needed to go to the hospital is like when a family member is sick so I always had that anxiety around being in a hospital, and like, it's not so scary. So., Yeah. Like the first day I remember crying in the carpark and I'm like oh my gosh I have to go in? Then it's been fine, so my anxiety around medical things has reduced. – Liesl*
Women know their bodies	*I have Hashimoto's. So, that also has always been a big thing with weight loss for me because it affects my weight loss. It slows it down if I wanna go on a diet and lose weight and go to the gym and stuff that I've gotta take my thyroids into consideration because it slows everything down. - Genevieve* *For me, it was a massive thing when I had my first child that I put on weight. And then I put on more weight when I had my second child. And then it's kind of always been since I got diagnosed with Hashimoto's after my second child. It was already a struggle after that to lose weight. - Genevieve* *Mum's side of the family are all a bit bigger. So, I feel like I've been blessed with that. - Rose* *[My weight] changed mostly between or probably ending uni and then starting my new job. I put on a bit of weight , then I lost it and then we had George. And then I never lost [the weight of the pregnancy] - Bea* *Its a lot harder having a pregnancy post gastric sleeve[…]. I don't know if it's because of I'm a bit older […] I feel the effects of pregnancy moreso. I think our bodies are design to naturally give birth without I'm intervention. - Maria* *[I'm] not very fit, but I think it's more just a general level of activity like usually walk everywhere. I don't own a car. I just walk everywhere. I used to do a lot of yoga[… I] generally have quite a busy lifestyle. So [I've] always being kind of out doing things, being social and active – Belinda*
Past experiences inform this experience	*I think there's more anxiety for me and it's really around that. I think one thing that probably stood out most to me was when I've had ultrasounds, obviously my weight has impacted how they did ultrasounds and I found them quite uncomfortable and painful because they're kind of working around my body shape - Belinda* *And then you just said how wonderful it was that I birthed a nearly four and a half kilo baby. You've just told me how good that is. I can do it. So this time around I'm much more able to, I think advocate and a bit more fiery about it I think. – Belle* *But with her I had a C section and they let me out the next day. Because through the night I was feeding her like a breeze, no problems. She was… it was easy as and I got up the next morning I could walk around, walking in the hallway, showered myself and everything[…]* - Genevieve *I've never had blood clots, I've never had the… I've never had the glucose issue but they still will go: 'Ohh you know your BMI is high we need to do it. And as soon as its… what's your weight or what's your height… like, I haven't put on any weight this pregnancy. Meaning I've lost it. I haven't put on anything… I have always been active throughout my pregnancies… if anything I've always eaten healthy when I've been pregnant because of that issue. But yeah, they always do harp on about your weight… - Genevieve* *Everything just feels really cruisy this time around. I don't know… less anxious. Maybe I'm just too busy with my other kid. I know what's happening? […]I've had a dream run. I haven't missed out on anything and I don't think I've been unfairly treated or mistreated due to my weight. So for me, I don't need to change it.[…] I know that there are certainly women out there that don't have the same experience. - Vivien* *The second pregnancy was an element [of] confidence or cockiness? I'm not sure what the answer to the word for that is. So then I don't need to be seen so much[…] Which this time around I think I fell heaps better, even though there's way more complications. - Adeline*
Women reject BMI as a marker of personal health	*Especially when my weight might have been 100 kilos for example. […] 100 kilos before I started weightlifting - I was unfit, couldn't do anything. But if in six months' time I would still weigh 100 kilos, but I can I do 100 kg squat or move the weight or do all of those things? How can my BMI… if my weight hasn't changed, but my capabilities have, how can this information that is based solely on my weight and not my body composition be indicative of the care that I need? – Vivien* *I thought, well, what a load of shit, because if it doesn't matter if you're a healthy BMI, you could still have pre-eclampsia gestational diabetes, a host of other issues that would prevent you from doing that [waterbirth], but in your little pamphlet thing it singled out by that. - Jennifer* *I'm not an unhealthy person I certainly didn't have any problems falling pregnant…I just reframe it too. You know this is based on population studies. I try not to take it personally because I don't think it necessarily directly reflects my experience with respect to those risk factors obviously, they're still there and it's going to be aware of them. But you know, the direct relevance is really hard to calculate. - Belinda* *Where the BMI, the measurement of BMI came from and how it actually translates into the general population for individualized care compared to like… herd health, community care. I'm a vet. It's for… for me, that's what I'm looking at… I wanna give information to a group of people and I'm looking at the averages within that group. I'm not looking at an individualized person at that point, because there's so much variation between the individuals, but when you're looking at a large group of people, you're going to have less variations between this group and that group. – Vivien* *I think [BMI] is terrible as a measure of health and it really damaging. … When you pigeonhole people based on 2 numbers that have so many different influences, ethnicity, hormones, muscle mass, age like and, and when you consider when you read and hear that it's been discredited widely as a measure of health it really hurts that that is the one thing that has put me in that high risk category and[…] it did impact the way that I was cared for. - Belle* *[They should say,]"so can we just talk about your diet?… or can we talk about your health" and … if I then said "Oh look I'm not getting much exercise as I would like or I'm not getting I'm not eating as good as I could be… They can then go… "oh, can we suggest this, or we're just going to run some routine tests because of this…" - Genevieve*
Theme 2: *Healthcare that harms*	
Stigma and discrimination	*I think it's because as soon as your BMI hits a certain amount it's 'This is the way we're going to treat you' and it's like… Why? I can imagine that the amount of exercise I do every day, even when pregnant at work, is the same as one customer who is half my size. But I still get treated as 'Oh no… Your BMI is high, you have a thyroid condition, you're automatically in that fat category'…Like you walk in you speak to women professionally trained to give help with babies and birth and stuff like that but are they gonna either a) judge or b) go oh you're fine like I understand where you're coming from […] I don't like that a doctor can take one look at you and go 'you're overweight'. Like… I am physically capable of doing anything else that someone else who's skinnier than me can do. - Genevieve* *I was locked out of the model of care that I wanted based solely on my BMI.* [At] *my 12-week appointment at the local hospital and the first check in appointment, I was asked what I wanted in terms of model of care and I opted for continuity of care with a midwife. […]They said I was too high risk due to my BMI - Belle* *I remember […] every, every appointment I was on the scales and there'd be something to say if I was gaining weight. […] even the other day when I was at the doctor, she's like, ohh, [are] you getting exercise in? And I was like, I've literally come in here twice and been at the hospital twice in the last […]2 weeks because I can't stand longer than 10 minutes. Yet, you're telling me to exercise, like going for a walk is gonna make me skinny. - Liesl*

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(*continued*)

	Like because I'm I've got a higher BMI, its just assumed I'm not healthy or I don't look after myself or that type of thing that goes hand in hand… But and then there's always that assumption. Whether I actually keeping track of what I'm eating. Or am I just writing down what I should be writing down? Umm yeah, there was a lot of judgment. - Liesl *Or yeah, like and I actually come from a family like we're all obese according to BMI and we'll all go to the doctors and it could all be for the same bloody infection. But we'll all get our have you thought about losing weight?* *In the ultrasound I found really interesting like it apparently had nothing to do with where the baby was or anything like that. It's all my faultthat they couldn't say [the gender]. Not that, like even if I wanted to know the sex of the baby, I wouldn't have been able to cause it's legs were crossed, would have that been blocked on my BMI as well. I feel like things could be missed because I'm just put in the fat pile. – Jennifer* *I really do feel like I was […] lying about it, like I'm making it up. No the test results are there. Look them up. I didn't have it. [Gestational diabetes]. Don't just assume that I'm going have pre-eclampsia and gestational diabetes because I have a bigger body. - Belle* *I particularly wanted to use the bath and in the classes, it was 'you can't have a bath if you're over 100 kilos' […] but then it comes round…They [said] 'nah do what you want. Whatever you're comfortable with.' So the little bit of inconsistency there - Adeline* *So my first pregnancy, I felt I had to do a lot of self-advocacy for myself because I was locked out of the model of care that I want to base solely on my BMI. So at my 12 week appointment at the local hospitals and the first check in appointment, I was asked for what I wanted in terms of model of care and I opted for Continuity of care with a midwife. – Belle* *At that point, I just felt like you're not going to be happy until I'm diagnosed with gestational diabetes. That was what I've said to people. 'They're not gonna be sastisfied until I tick that box'. I didn't have GD in my first pregnancy, but by god, do people just assume and I've been asked, 'are you sure you didn't have it?' Like I was asked multiple times. – Belle*
Information gathering and sharing	I think invariably it feel like they just the tick box and they have been churned through a system. – Belinda *I feel like the only time that I was uncomfortable, not made of comfortable, but I was uncomfortable is when I was asked my weight in front of my partner. I said to my partner… 'block your ears.' - Rose* I didn't love those [phone appointments], I don't know. I didn't love those because that was kind of felt quite tick and flicky… and I don't know if it's just because it was over the phone or what. - Adeline I had waited two hours in the waiting room, and I spoke to him for a minute. And then I was out. I was like, 'What?' - Genevieve They took my weight […] I think they measured my weight. There was some discussion that if my BMI went over 40, then I can't even remember what the discussion was. But there was something bad. If my BMI went over that 40, it triggers, see, there'd be things that would happen or that I might have more appointments or something. Didn't leave a big enough effect for me to [remember]. And then this time around, it's. Just been… I don't know any different. Yeah, like I had a high BMI the first time I had a high BMI I this time, so. Yeah, I just, that's the experience. Yeah. I don't have anything different to compare to. - Vivien I'm really hoping for an epidural. From my research, I think you […] stop taking Clexane like 24 hours before, or whatever… And I feel like [they're not listening] cause I've asked twice now when I'll kind of stop and no one has really said. – Rose *But I don't know if that's just because, like, maybe they just see how I go I don't really know […]I feel like actually that's really the only thing that I would say I haven't had a lot of communication about like I don't know when I'm stopping it. I don't know. I haven't had my, like education for it[…] its on next week, which I have already been having the injection for six weeks by then. So is it really worth it?… - Rose* [The guidelines] keeps me accountable for my weight progressions during my pregnancy…[The doctor] said 'you've got plenty of room to move and babies gonna be fine if you don't put on weight'. …. [It helps] understanding being healthy and aware of what I'm eating. And if I lose a bit of weight, that's not that bad thing. - Adeline Don't just say we think you should have a growth scan. Tell me why I need to have a growth scan and what the evidence is behind that. I shouldn't have to prompt… You know, as a woman with a BMI above this level, the evidence suggests that you've got an x% higher chance of having a baby in this weight category. - Belle *It just always comes back to the weight and they've actually diagnosed me with gestational diabetes. I've got a session with the diabetes clinic […] tomorrow. – Jennifer* *The doctors were very pushy to get me onto insulin… Metformin wasn't an option because I had nausea. So, they wanted to put me straight on insulin, but I said, can you just let me do diet control and we'll take it from there. And they were really adamant that you need to be on insulin because baby can't live in a sugar state. But if you're preaching that, then how is it not the same in Sydney? - Maria* *I had decreased movement and I couldn't feel baby move.[…] So I came in and it was at 38 [weeks and five days] and they said I could induce that day. Then I was told 'no, we have to send you home because there's twins coming in and that was higher priority. Unless you're worried' and I said yes, I am worried. I can't feel my baby[…] and that was a whole show and dance because they basically told me I was a nurse and I should have known better." – Adeline*
Inadequate consent	*I knew I was gonna bruise cause this particular area that you'd put a bit of pressure on [during the ultrasound]. And I thought, yeah, that's gonna bruise later. It wasn't huge, but it was noticeable. - Belinda* *I had to argue I didn't want the episiotomy… that I ultimately ended up having. And we were having discussion while I'm up in stirrups about, she was saying that she felt I needed one, and I was like, I would rather tear naturally. And then she threw the line, 'I don't want you to be incontinent for the rest of your life.' And so you know, when you're trying to push out a baby and you're feeling pretty vulnerable, I kind of just threw my arms in the air and said 'do what you like' which was not great. You know, I look back on that and I regret that. - Belle* *And then when I said to him like can we book and elective C Section and I said to him, these are the dates that I prefer. He goes, 'well you don't get what you want, you get what I give you'. - Genevieve* *She wanted to check how far along. Like how dilated I was and I asked her to wait. And she didn't, and I told her. "Stop. You're hurting me," and she said. "Well, if you can't handle this how are you going to have a baby. That was our first little moment together and then she broke my waters after that, without asking me. So that was really bad experience. But that was one person, whereas everyone else that I came across was really lovely. – Bea*
Theme 3: *Healthcare that heals*	
Relationship-based care	*I was case loading […] so I could have my midwife come to the house after work to do checkups, which is awesome. - Maria* *I trust her, whereas I don't feel like I had a lot of trust previous in in my previous pregnancy. - Belle* *And I've had very regular checks in. I think I'm very lucky that I've got the doctor. Dr G…. I think again, having a nurse practitioner is particularly great because there's no 'let me just quickly check with the Doctor'[…]she just [carries] the confidence about her that makes me feel very comfortable. - Adeline* *My private midwife is also a lactation consultant of course […]. So I got really good post-birth care, I think I had three visits in home with the midwife post birth, so I got good advice on getting a good latch. And breastfeeding care in that first week. I got mastitis twice in the first four weeks. It was not ideal, but after that, breastfeeding was fine. I think I got some, I got some mild case of mastitis… i don't know he might have been 12 months of age or something and he might have just been… I was breastfeeding up until I was about four months pregnant. So I think he was maybe 16 months when I weaned him. There was not much left. - Vivien* *I chose that model because that particular GP saw me through the previous two miscarriages and I found her to be quite responsive. And so that was, I guess the main thing I was looking for in the maternity care to have someone who was responsive to my concerns. I mean it's GP, so they're only going to spend so much time with you. But I feel like I can give suggestions and I can make comments and she'll listen to what I say. I thought that was a better choice for me overall. - Belinda* *Umm, I was actually really set on the MGP program and I didn't find out till I was almost 8 weeks, 7 or 8 weeks […]Having gestational diabetes doesn't rule me out of the program as high risk, which is good, nor does my BMI, as far as I'm aware. Yeah, that's the reason it was done like that a*

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	gazillion years ago. - Jennifer
	So yesterday I called up cause my migraines kicked back in and no one I've seen was there yesterday and it was just kind of telling the story all over again. We're revisiting some of the things that were already investigated. Whereas, I think, if I had have just talked to Gaye (nurse practitioner) or the consultant it would have just been 'here do this' and off you go. - Adeline
Kind, knowledgeable, listening	*I feel like the thing what's stood out is how kind everyone has been[…] I actually haven't had a bad experience. Everyone's been really easy to talk to. - Rose*
	I think I really appreciate the communication. I think everyone's very… I don't know they don't make you feel bad for asking questions up here which is nice. I like it that they just took notice of my pregnancy last time and automatically filled in like the extra scans. I don't want to give birth to a ten pounder… you know. Knowing that it was coming would be nice[…]
	I don't think that's been an issue at all (BMI-led care). I think, people like acknowledge where we're at and that's kind of it… Completely professional and needed and all that. You get made aware of like, you know, if it's a risk factor for this, that and whatever. But, it's not done like in a derogative way or anything like that. - Bea
	I've had her through Annabelle's pregnancy. And I managed to somehow get her again and she has always been very honest with me. Look if I've said to her,'this is what I'm worried about.' She's always told me exactly what she thinks about that or you know, how they, medically should react to. - Genevieve
	I was having some cramping and I called and […] they were so quick to [say] come in. [So I] come in and everyone's really patient and nice. So […] I think just the care you get[…]reduces that anxiety. Its not so scary. - Rose
	Yeah, they were very mindful about how they brought up weight related issues. They always make sure that they've got the larger cuff or your blood pressure monitoring. They give me the information. Unbiased. So it's just 'this is the information.' And are just very […] mindful of the way that they talk about it, because obviously it can be quite a difficult thing for some people to discuss… I think you could. See the midwife thinking about how she's going to phrase this to be mindful. So not a super smooth. delivery, but still trying her best to be very mindful, with how she's coming across. You can see that she's making the effort, to just not make it a problem, does that make sense?…I could see her choosing her words. So that she didn't say something inappropriate or something that might be triggering, because obviously, yeah, when you're pregnant you can be in a sensitive place - Vivien
	I just think holding no judgment and like you can tell if someone holds judgment towards your reaction or how you ask for something in their body language, in their tone. And I feel like I haven't experienced that. So it just, you know, it's a passing comment almost, which is nice. - Bea
	The obstetrician that I actually spoke to was respectful and did listen. And I talked about some of my experiences of having not been listened to in the past and she held that space for me and listened to me and apologized, even though it was not her place to need to apologize. - Belle
	Yeah. I will say I have like a bit of anxiety coming into pregnancy already being like on the higher end of BMI, but I feel like I've never been made to feel bad. Everyone's just been chill about it and even like I don't necessarily care about being weighed at all but even the last appointment I said 'I don't really wanna know' and they were fine with that. - Rose
	Afterwards when I said just chop him out and this poor OB was like "I spent years perfecting this surgery". And then apparently there was a comment made when we got up to the theater as well. "Apparently we're chopping this baby out." I thought, 'this is perfect.' - Vivien
Adequate preparation	*I just think the C. section for me, was a lot easier because everyone explained to you what you were going through, what's gonna happen next, each step, where when I was having my baby both of the boys [vaginal births] no one was telling me what was going on. - Genevieve*
	I know with my last two, they [said], "Oh, we're probably not gonna see anything because you're so big"[…], whereas this one[…] She did say it might not be a clear picture[…] It was quite refreshing not to make it about my weight. - Liesl
	I was […], expecting her to get on the scales […] I guess I was expecting all the questions about you gotta lose weight… You gotta do this, but nothing was actually mentioned, which was quite good. - Belinda
	I saw a female after him four weeks later and she was very thorough with me, explained everything with me like booked in my C section then and there, like was very much open because it was the first time I'd ever had a C section so I had no idea what I was going into. - Genvieve
	If I was more prepared that, you know, even going in and saying, OK, so you know, it [the ultrasound] might take a bit longer. You know, we might have to do some odd positions. You need to let me know if it's hurting you. You know, I think that kind of prior discussion and consent is really important because otherwise then you're left with this kind of like, is it normal feeling? The concern around you know, when does this end? - Belinda

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