Expert Working Group Secretariat
Review of the Pregnancy Care Guidelines
Maternity Services Policy Unit
Australian Government Department of Health
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Thank you for the opportunity to provide input to the Pregnancy Care Guidelines on Nutrition, Physical Activity and Weight.

HAES Australia is the representative body for health and fitness professionals, researchers and academics working from a Health at Every Size® paradigm. The work of HAES Australia and its members is underpinned by an evidence-based, weight-neutral, size inclusive, and body positive perspective. We make the following comments with regards to the draft guidelines to ensure women and trans, gender diverse and non-binary people who are pregnant receive high quality, evidence based and safe antenatal care.

Draft guidelines on physical activity

HAES Australia applauds the focus on health promoting behaviour, particularly in reference to the recommendation 'Advise women that regular moderate-intensity physical activity during pregnancy is associated with a range of health benefits and is generally not associated with adverse outcomes.'

HAES Australia advocates the use of weight-neutral and weight-inclusive paradigms in healthcare (Tylka et al., 2014) and policy (Hunger, Smith & Tomiyama, 2020), and particularly Health at Every Size (HAES)® approaches (ASDAH, 2020).

In physical activity, the use of HAES approaches can support sustainable positive health behaviours and fitness outcomes independent of weight loss (Souza, 2015) and can encourage physical activity participation among people who may have previously avoided or felt excluded from weight-focused exercise programs due to their body size (Pickett & Cunningham, 2017). Encouraging physical activity specifically in pregnancy has a wide range of benefits already outlined in the draft guidelines, and the use of weight-neutral and weight-inclusive approaches may reduce or eliminate barriers to participation.

HAES Australia recommends that practice points in the guidelines on physical activity include evidence for weight-neutral and weight-inclusive physical activity, as well as avenues for education for health professionals.

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Draft guidelines on nutrition

The guidelines on nutrition focus largely on intake of specific foods and nutrients and their impact on maternal and child outcomes. HAES Australia endorses a focus on health-promoting behaviours, though notes the following issues that the guidelines ought to address:

- Constant emphasis (i.e. at each antenatal visit) on eating patterns and exercise risks places additional pressure on pregnant people, who already experience pressure to eat well and exercise regularly throughout their lives.
- Particular care needs to be taken not to conflate these behaviours with weight status, which is influenced by a range of biological, behavioural, social, and environmental determinants.
- Deficit framing of nutrition knowledge and access to healthy food, especially for First Nations and migrant and refugee communities, which overlooks their cultural knowledges and strengths (Wilson et al., 2020; Wong et al., 2020)

HAES Australia recommends that the guidelines adopt a strength-focused, and trauma-informed perspective that empowers pregnant people, especially those from First Nations and migrant and regugee communities, to participate in health-promoting behaviours that are personally and culturally meaningful, while acknowledging and addressing structural issues that create barriers to access and participation.

- **Food insecurity**

The draft guidelines present introductory information about a range of populations who may experience reduced access to nutritious foods. These groups include people living in regional and remote areas, people in socioeconomically disadvantaged areas, First Nations Australians, and migrant and refugee populations. The guidelines present data about the increased cost of food in some areas, the proportions of diets that are made up of 'discretionary' foods, and some of the contributing factors to this food access disparity (e.g. social isolation and poor housing).

Beyond this, the guidelines offer nothing to guide a health professional who may be supporting a pregnant person facing food insecurity. Food insecurity is the experience of having inadequate physical, social or economic access to safe food of sufficient quantity and quality to meet dietary needs and food preferences (Gallegos, 2020). It affects four million Australians each year and rates are increasing (Foodbank Australia, 2019). Food insecurity is a result of structural and economic barriers to health, and is not something that people can be educated out of in the context of the practice directive to 'provide advice', as outlined in the draft guidelines. People facing food insecurity are likely to need different and more robust service responses (Begley, et al., 2019; Lindberg, et al., 2015).

While it may be beyond the scope of these guidelines to address the structural inequalities that give rise to food insecurity, it is imperative that health professionals charged with following these guidelines are adequately skilled and resourced to address food insecurity among their patients in tangible and effective ways.

HAES Australia recommends that the guidelines include specific practice recommendations to address food insecurity beyond standard nutrition education. Food and emergency relief organisations and their clients ought to be consulted in formulating these.

- **Social determinants of health**

Similar to the above, the draft guidelines note some of the social determinants of diet quality (e.g. higher education, smaller body) without examining the social determinants of health as they relate to pregnant people more generally. It is well documented that people in larger bodies are more likely to experience multiple forms of disadvantage (Bissell, et al., 2016; Moore & Cunningham, 2012), including access to employment and education (Roehling, et al., 2007). It is therefore important that the guidelines include consideration of the real-life contexts of people in lower socioeconomic positions and facing other forms of disadvantage, beyond simply noting that pregnant people from more advantaged positions follow a more 'health conscious' diet.

HAES Australia recommends that the guidelines include specific practice recommendations to address social disadvantage beyond simply noting that people of greater advantage are likely to be of lower weight. It is imperative that pregnant people in larger bodies are not blamed, stigmatised or held responsible for their body size and that their weight is not framed as a problem that they are responsible to fix.

Within the draft guidelines, the relationships between diet quality and, in particular, gestational diabetes miss out on this crucial connection to the social determinants of health. If diets higher in sugar-sweetened beverages and so-called 'fast food' are associated both with increased risk of gestational diabetes (as the guidelines note) and with increased disadvantage (as the wider literature notes (Backholder, et al., 2016), it is insufficient for the guidelines not to address this.

HAES Australia recommends that the guidelines include specific practice recommendations for the prevention and management of gestational diabetes. Any such recommendations ought to give reference to principles of weight-neutral care and not pathologize or stigmatize larger bodies, as well as support effective practice with disadvantaged populations.

HAES Australia has previously developed advice on weight-neutral diabetes care which may be adapted to suit these guidelines (Willer, 2020).

Draft guidelines on weight

HAES Australia notes that the current draft guidelines regarding pregnancy care are focused on Body Mass Index (BMI) and weight. However, the current guidelines include no discussion of weight stigma in pregnancy care.

Weight stigma may be defined as the expression of prejudiced attitudes (such as labelling people in a negative way, such as lazy, gluttonous, or unintelligent) and discriminatory actions (such as making snide comments, providing inferior education, health or other services) towards an individual based upon their weight and body size (Mulherin, et al., 2013). In addition to being inherently discriminatory, weight stigma results in profound negative impacts on psychological and physical

health. These include poor psychological functioning (Friedman, et al., 2005), body dissatisfaction (Puhl & Brownell, 2006), increased episodes of binge-eating (Puhl, et al., 2012) and exercise avoidance (Vartanian & Shaprow, 2008). Weight stigma reduces people's willingness to access health services (Mensinger, et al., 2018).

Weight stigma has been established as a major issue in Australian medical care generally, and is an emerging area of research within antenatal care. In a survey of 627 Australian women, Mulherin et al (2013) found that those with a higher BMI were more likely to report negative experiences of maternity care compared to lower weight women. In the same study, an online survey of pre-service maternity care providers reported that they perceived higher BMI women as having poorer self-management behaviours, and reported less positive attitudes towards caring for larger bodied women, than pregnant women of lower BMI ranges.

HAES Australia urgently recommends that a section on weight stigma be included in the guidelines, including discussions about the entrenched weight stigma apparent in medical professions, and the detrimental impact of weight stigma on patient care in antenatal environments.

The draft guidelines encourage frequent focus on weight with pregnant people. Speaking to this population at such a vulnerable time of life about their weight is an incredibly nuanced and sensitive area.

HAES Australia recommends that any medical staff engaging in BMI or weight discussions receive training on weight stigma and weight neutral care prior to engaging in such discussions.

It is evident that such training is needed: the draft guidelines noted that 76% of antenatal workers reported that they needed more training in counselling pregnant women regarding weight issues. The study by Brownfoot et al (2015) cited in the draft noted that "many women in our study stated that a focus on 'being healthy' rather than weight gain would have been more beneficial."

HAES Australia recommend that discussions about weight itself be abandoned in favour of discussions about how to help a pregnant person build health supportive behaviours regardless of weight status.

HAES Australia strongly disagrees with the assertion made in Section 2 of the draft guidelines that:

> "Weight and body mass index: Body mass index (prior to pregnancy or at the first antenatal visit) and weight gain during pregnancy are among the important determinants of the health of both mother and baby."

This statement is reductionist and misleading. Focusing on BMI alone erases numerous factors including race, social disadvantage, mental and physical health, access to quality health care and the pregnant persons' experience of weight stigma.

A singular focus on BMI is problematic as it reinforces stereotypical views about an individuals' ability to control their weight. Body weight is strongly influenced by genetic inheritance and a tightly regulated set of factors that are not within an individuals' conscious control. Setting targets for weight gain during pregnancy is unrealistic - data presented in the draft guidelines (Schumacher et al 2018) demonstrate that 86% of Aboriginal women experienced either inadequate weight gain or weight gain exceeding the guidelines. Data from Brownfoot et al (2015), also cited in the draft

guidelines, found that 73% of the women in their study gained weight above the recommended guidelines, in spite of regular antenatal weighing.

In addition to being ineffective, health care interventions which centre weight are inherently stigmatising. Weight stigma is entrenched within the medical system, which has been noted as a significant problem in Australia (Select Committee into the Obesity Epidemic in Australia, 2018). A focus on weight has been increasingly discouraged by several medical agencies, who are now advocating to help people optimise their health, regardless of weight status (RACP, 2018) and focus on health gain rather than weight loss (RACGP, 2019).

HAES Australia does not support the following recommendations contained in the guidelines on weight:

- **Measure women's weight and height at the first antenatal visit and calculate their body mass index (BMI) and give them advice about the benefits of gaining weight within the recommended weight gain range for their BMI.**

HAES Australia notes that the level of evidence ("CBR") to support this recommendation was not high quality. This is of great concern given the potential risk of harm detailed below.

At a minimum, a pregnant person should be asked whether they consent to be weighed as part of their antenatal care, and if they withhold consent this must be honoured. Healthcare consumers, including pregnant people, may have many reasons to request not to be weighed, including body image distress, eating disorder (past or current), and history of trauma. Moreover, there are clinically suitable alternatives for monitoring a pregnant person's and a baby's progress, including clinical interview, ultrasound, palpation, bloodwork and other standard measures in pregnancy care, which give a more accurate picture of the patient's biomarkers than their BMI.

HAES Australia recommends that the focus on BMI be removed from the guidelines and more sensitive and clinically accurate measures of patient and infant progress and wellbeing be adopted.

HAES Australia recommends that the guidelines include a practice point specific to asking consent of the pregnant person before weighing them, and explaining that other clinically appropriate options exist if they do not wish to be weighed.

- **At every antenatal visit, offer women the opportunity to be weighed so that low or high gestational weight gain is identified, and risk of associated adverse outcomes monitored.**

Again, pregnant people should always be asked their consent to be weighed, and offered alternatives to this.

The draft guidelines cite a study in which ten women expressed a view that being weighed regularly could be helpful or positive. Other evidence exists that offers a contrary view. A New Zealand study of 27 women who self-identified as fat (Parker, 2017) found that participants experienced weight-focused antenatal care as directly harmful, citing barriers to accessing care (such as assumptions that a higher weight patient is automatically more complex), negative assumptions on the part of healthcare providers in the absence of assessment (such as assuming a higher weight patient **will** develop diabetes or **will** need a caesarean section), and generally poorer care (such as fewer care

choices, offensive language, and a failure on the part of health professionals to see past body size and treat the whole patient). The participants described traumatic antenatal care and birth experiences as a result of care that was overly focused on their weight. This is consistent with other literature on weight stigma in healthcare (Puhl & Heuer, 2009).

HAES Australia recommends that weight neutral approaches be promoted in the guidelines as suitable for the antenatal management of patients across the weight spectrum.

- **At every antenatal visit, give women tailored advice on weight gain, including the benefits of a healthy diet, regular physical activity and self-monitoring.**

While HAES Australia supports the recommendation to give pregnant people tailored advice specific to their circumstances, and supports provision of advice about dietary patterns and physical activity that is safe during pregnancy, HAES Australia does not agree that this advice should be linked to discussions of weight. As mentioned above, a person's weight trajectory is not within an individual's control. It is critical that discussions about health behaviours are disentangled from discussions about weight, which at all times should be discouraged.

HAES Australia is concerned that this recommendation includes self-monitoring of weight in a patient population that is known to be at elevated risk for the development of disordered eating and eating disorders, which place both the pregnant person and the baby at risk.

Eating disorders affect people of all sizes and genders, and are characterised by severe and persistent distress related to body weight and/or shape and the need to control this through food and/or exercise (National Eating Disorders Collaboration, 2017). Eating disorders affect 9% of the Australian population (Butterfly Foundation, 2014) and are a leading cause of disability among females aged between 15-44 years (AIHW, 2019); pregnant and postpartum people are at risk of either continuation or emergence of disordered eating or eating disorders (Bulik, et al., 2007). This is partly due to the significant changes to the body that occur throughout and following pregnancy (Harris, 2010), and partly due to increased health hypervigilance (Tierney, et al., 2013), among other factors. This highlights the importance of sensitivity to the experience of the pregnant person and any concerns that they may have about managing their changing body and the health of their baby. Instructing a patient with significant body image distress, disordered eating or an eating disorder (whether identified or not) to regularly self-monitor their weight may trigger a significant deterioration in their mental health through increased weight preoccupation. This in turn may lead to or increase associated disordered eating behaviours which risk the physical health of both the pregnant person and their baby (Pasternak, et al., 2012).

HAES Australia recommends that advice to encourage pregnant people to self-monitor their weight be removed from the guidelines.

HAES Australia recommends that the guidelines include supplementary information for health professionals about the prevention, screening and management of eating disorders in this high-risk population as an accompaniment to any practice guidance or recommendations regarding weight, nutrition and exercise.

A note on language

Except when citing specific studies, this submission uses the term ‘pregnant person’ rather than ‘pregnant woman,’ ‘woman’ or ‘mother,’ in recognition that people of diverse genders experience pregnancy and require pregnancy care. This term is exchanged with ‘patient’ or ‘client’ where relevant.

In finalising the guidelines, similar language should be considered, in consultation with gender diversity organisations and the communities they support.

Medicalised terms that pathologise body size, such as “overweight”, “underweight”, “obese”, or “morbidly obese” are inherently stigmatizing and should be avoided.

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