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How Pregnant African-American Women View Pregnancy Weight Gain

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Abstract

Objective—To gain insight into how low-income, pregnant African-American women viewed their weight gain while pregnant and how they managed their weight during pregnancy.

Design—Descriptive study using three focus groups.

Setting—Women were recruited from urban prenatal care sites and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services in a medium-sized urban Northeastern city.

Participants—Twenty-six adult, low-income, pregnant African-American women, aged 18–39; the majority were within the first 20 weeks of pregnancy.

Methods—Three focus groups were conducted utilizing open-ended questions related to pregnancy weight gain. Content analysis was used to analyze the verbatim transcripts. Analysis focused on meaning, intention and context. Groups were compared and contrasted at the within and between group levels to identify themes.

Results—Four themes were identified that provided insight into how women viewed their pregnancy weight gain and managed weight gain during pregnancy: (a) pregnancy weight gain: no matter how much means a healthy baby; (b) weight retention: it happens; (c) there is a limit: weight gain impact on appearance; and (d) watching and waiting: plans for controlling weight.

Conclusion—Low-income African-American women, though cognizant of the likelihood of retention of weight following pregnancy, are not focused on limiting their gestational weight gain. The cultural acceptance of a larger body size along with the belief that gaining more weight is indicative of a healthy infant present challenges for interventions to limit excessive gestational weight gain.

Keywords

pregnancy; gestational weight gain; African-American women; focus groups

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Excessive gestational weight gain contributes to postpartum weight retention (Chu, Callaghan, Bish, & D'Angelo, 2009; Mamun et al., 2010) and to long-term obesity (Davis & Olson, 2009). Women who gain excessively are at increased risk for cesareans (Jain, Denk, Kruse, & Dandolu, 2007; Rodrigues, de Oliveira, Brito Ados, & Kac, 2010; Savitz, Stein, Siega-Riz, & Herring, 2011; Viswanathan et al., 2008) and their infants are at risk for problems such as macrosomia, hypoglycemia and hyperbilirubinemia (Hedderson et al., 2006). Excessive gestational weight gain is an independent contributor to maternal obesity (Davis & Olson, 2009) and obesity in the offspring (Crozier et al., 2010; Fraser et al., 2010). Furthermore, if women become obese, they are at risk for unsuccessful breastfeeding due to reduced initiation, early cessation, and delayed lactogenesis II (Jevitt, Hernandez, & Groer, 2007; Oddy et al., 2006; Rasmussen & Kjolhede, 2004).

Excessive gestational weight gain is defined as gaining more weight than the Institute of Medicine recommendations, which vary depending on pre-pregnant body mass index (BMI) (Rasmussen & Yaktine, 2009). More than 45% of women gain more than the IOM recommendations (Rasmussen & Yaktine), and interventions to prevent this excessive gestational weight gain are essential for limiting the obesity epidemic in women. Certain demographic groups also are at increased risk for excessive gestational weight gain. In particular, women who are economically disadvantaged (National Heart, Lung, and Blood Institute [NHLBI], 1998) or have a lower level of education (Mokdad et al., 2001) have higher rates of gestational weight gain and obesity (Olson & Strawderman, 2003). In addition, racial disparity is evident in gestational weight gain. African-American women have a high risk of weight gain and retention with pregnancy (Boardley, Sargent, Coker, Hussey, & Sharpe, 1995; Davis & Olson, 2009; Smith et al., 1994) and also have a tendency to gain additional weight in the 3–12 months following pregnancy (Walker et al., 2004), further compounding the risk for obesity. Excessive gestational weight gain has a deleterious effect on long-term obesity and therefore the risk of chronic disease in African-American women.

Little is known about the attitudes of pregnant African-American women toward pregnancy weight gain. Most published studies have focused on the postpartum period (Carter-Edward et al., 2010; Morin, Brogan, & Flavin, 2002) or on White women (Devine, Bove, & Olson, 2000; Dipietro, Millet, Costigan, Gurewitsch, & Caulfield, 2003; Mehta, Siega-Riz, & Herring, 2011; Wiles, 1998). In postpartum studies, researchers assessed body image or satisfaction with body size several months out from delivery and reported that overweight and obese women were dissatisfied with their current body sizes (Boyington, Johnson, & Carter-Edwards, 2007). Researchers in one study assessed body image in 45 African-American women 24–48 hours after delivery (Morin et al., 2002). Thus, the study results may be more in line with pregnant women. These authors concluded that women who were overweight had less positive views of their bodies than those who weighed less. However, this finding was not statistically significant.

It has been reported that White women were less concerned about weight during pregnancy than the non-pregnant state (Davies & Wardle, 1994), although there appears to be a goal to return to pre-pregnancy weight after delivery (Wiles, 1998). However, low-risk predominantly White pregnant women (N=130) had negative attitudes toward gestational weight gain, even when weight gain was within the recommended range (Dipietro et al., 2003). In White women attitudes toward body weight prior to pregnancy have been found to be a primary influence on pregnancy weight gain and postpartum weight (Devine et al., 2000). It is not known if African-American women also experience concerns about pregnancy weight gain or if similarly, they have negative attitudes are toward pregnancy weight gain.

A factor that could affect the attitudes of African-American women toward pregnancy weight gain is their acceptance of a larger body size; their culture is more accepting of being “thick” than other cultures (Befort, Thomas, Daley, Rhode, & Ahluwalia, 2008; Thomas, Moseley, Stallings, Nichols-English, & Wagner, 2008). Even though non-pregnant African-American women believe they can be attractive and healthy when a large size, they still report dissatisfaction with personal weight (Baturka, Hornsby, & Schorling, 2000; Befort et al., 2008; Davis, Clark, Carrese, Gary, & Cooper, 2005). Of interest, in a recent study the authors found that the acceptance of a larger body size and less body dissatisfaction may not be as relevant to the newest generation of African-American women (Davis, Sbrocco, Odoms-Young, & Smith, 2010). In this study of 160 women (80 African-American, White), body ideals and body dissatisfaction were similar for both the African-American and White women. The women who are currently becoming pregnant would be members of this younger generation of African-American women.

Given the number of women who gain more than the IOM recommendations and the lack of literature that informs how pregnant African-American women view pregnancy weight gain, it is essential to gain an understanding of their views so that effective interventions can be developed to limit excessive gestational weight gain. The purpose of this study was to conduct focus groups with pregnant, low-income, African-American women to elicit how they viewed their pregnancy weight gain with a goal of informing the design of effective interventions to prevent excessive gestational weight gain and thus decrease the risk for long term weight retention and obesity.

Methods

Focus groups were held with low-income pregnant African-American women to elicit their views of pregnancy weight gain because detailed descriptions of attitudes and beliefs of individuals can be obtained with focus groups (Morrison-Beedy, Cote-Arsenault, & Feinstein, 2001). Focus groups capitalize on group interactions to obtain rich detailed experiential data of participants (Asbury, 1995), and the data obtained are credible, valid, and useful for assessing thoughts, feelings, and experiences of the participants (Morrison-Beedy et al.).

Setting and Participants

Purposive sampling for adult, low-income, pregnant African-American women was used to obtain a sample of women who agreed to discuss weight gain during pregnancy in small groups of similar women. Women were recruited from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) services and urban prenatal care sites that provide care primarily to low income women in a medium-sized urban Northeastern city in the United States.

Procedures

Participants were limited to adult (18 years or greater) pregnant women who self-identified as African-American. Overrecruiting to ensure adequate numbers of participants (Morgan, 1995) resulted in three focus groups ranging from 7–10 participants each. A group of 6 to 12 participants is considered the ideal size of a focus group (Krueger, 1994).

Pregnant women with a wide range of BMIs were approached by research assistants trained in the responsible conduct of research and provided with flyers containing information about the study. Women who were interested in participating were given information on when the next focus group would be held and attendance at the focus group was considered consent to participate. Focus groups were held by study team members in a conference room located in

a facility near the local WIC office. Childcare was not provided. When women arrived they were asked to complete a brief demographic form that collected age range, race/ethnicity, and education, type of insurance, gestation (range), and approximate pre-pregnant weight and height. No personal identifiers were collected. Parity was elicited as women introduced themselves during the focus groups. Participants were provided with snacks during the meeting, and each woman was paid \$40 for participating.

Following standard protocols for interview guide development (Krueger, 1998), questions related to gestational weight gain were created to gain insight into participant views of weight gain in pregnancy and identify how these pregnant women managed their weight changes while pregnant. Questions opened with introductory neutral questions and then moved from less to more sensitive topics. Questions such as “what are your feelings or thoughts about you gaining weight while you are pregnant” and “what have you been told about weight gain during pregnancy and by whom” were used. Probes such as “help me understand better” or “tell me more about that” were used to elicit in-depth responses. All questions were determined clear, relevant, and culturally sensitive for African-American women by a doctorally-prepared individual recognized for expertise in research with minority populations. Following each focus group, modification and refinement of interview questions took place and were incorporated into the interview guide prior to the next focus group (Cote-Arsenault & Morrison-Beedy, 1999). All audio-tapes were transcribed verbatim for analysis. Data collection was considered complete when enough groups had been conducted to answer the formulated research questions, and the topics and viewpoints expressed by participants in subsequent groups were redundant (Cote-Arsenault & Morrison-Beedy, 2005).

We used strategies that are considered effective for focus groups including a moderator familiar with the topic and matched in terms of race and gender, creation of a focus group guide, audio-taping for verbatim transcription, and integration of field notes (Morgan, 1998b; Morrison-Beedy et al., 2001). The moderator provided guidelines that stressed the importance of confidentiality and reminded the participants that the session was being audio taped (Morgan, 1998a). Only first names were used to protect participant identity and participants had the option of using aliases. All focus groups were lead by the same moderator. A note taker recorded impressions, non-verbal behaviors, and group interactions. The study was approved with exempt status by the Institutional Review Board because no personal identifiers were collected.

Data Coding and Analysis

Using content analysis to identify themes, analysis focused on meaning, intention, and context and included between-group and within-group analysis of the common responses (Krueger, 1997). Individually, two study team members read the participant responses, selected exact words from the text that depicted key concepts, and wrote notes on first impressions and initial analysis (Hsieh & Shannon, 2005). Transcribed text and field note data were then reviewed by the team for overall impressions, followed with line-by-line review for extraction of significant statements. Meaning was formulated from these statements and then organized into themes by the authors (Ayres, Kavanaugh, & Knafl, 2003). Consensus was sought for all coding differences with attention to the retention of the perspectives of the women in the context of their lived experiences. Immersion in the data and discussion were used to refine themes and descriptions. Trustworthiness of the analytic process was optimized in several ways: (a) debriefing after each focus group, (b) independent and team approaches to analysis, and (c) providing an audit trail of how and why things were done (Koch, 2004).

Results

A total of 36 women were invited to participate. Of those, five refused and five did not attend the focus groups, resulting in a sample of 26 women. The sample consisted of pregnant women who ranged in age from 18–39 years old, with the majority (50%) in their twenties. Women were at different points in their pregnancies, but the majority (61%) was in the first 20 weeks (See Table 1). Approximately one-third of the sample was primigravida. Although participants were asked to indicate approximate prepregnant weight and height on the demographic form, 35% did not provide this information. All focus groups were held for 60–90 minutes. Women in the focus groups were fully engaged in the conversation about pregnancy weight gain and all of them shared in the discussion. They appeared to enjoy the opportunity to talk about their pregnancies and the topics that were introduced by the moderator.

During analysis, four themes were identified concerning pregnancy weight gain: (a) pregnancy weight gain: no matter how much means a healthy baby, (b) weight retention: it happens, (c) there is a limit: weight gain impact on appearance, and (d) watching and waiting: plans for controlling weight.

Pregnancy Weight Gain: No Matter How Much Means a Healthy Baby

The majority of women expressed a desire for a healthy infant and assumed that weight gain during pregnancy was central for that:

I'm like whatever, I'm not trying to watch how much weight I gain or lose while I'm pregnant. I just pray that my baby is healthy and after I have this baby I plan to go work out as much as I can get [weight] off in the gym and so be it, but I'm not going to make a big deal out of it."

Another woman indicated, "I'm going to eat normal and I'm going to stay healthy and make sure my baby's healthy."

Women who were concerned they were not gaining enough weight were especially focused on this theme. They felt they were not gaining as much weight as they should, whether that was because their pregnancy experience was different from a prior pregnancy, or whether they were women who did not gain weight easily. As one woman expressed it, "I'm gaining weight! I'm gaining weight, and me personally I'm loving it because with my daughter, my first pregnancy, I couldn't keep nothing down." Another woman stated: "...like I said I am kind of nervous about not having gained weight."

Some of the women who discussed the importance of pregnancy weight gain for a healthy infant indicated that their thinking and behaviors were influenced by other people:

My significant other, the baby's father, he wants me to gain weight because he feels like...his baby will be healthy. So he's like, eat! And stop complaining about that! Eat it! You're pregnant, what do you expect?"

Another woman referred to her mother: "...she [the mother] said I'm getting' fatter—she said at least I'm having a big, healthy baby...she said that's good."

Weight Retention: It Happens

The theme weight retention: it happens reflected that the women believed they would retain weight following pregnancy. The participants provided a variety of reasons supporting why they believed weight retention would happen following pregnancy. The women did not always differentiate between weight that was specific to pregnancy and weight that was retained after pregnancy, and they often mixed the two together.

The women indicated that for them, being “thicker” was acceptable within their culture: “And the fact that Black women [I] mean, in our culture we’re not perceived as being overweight but thicker.” This concept was reinforced by another woman:

And then I was saying that you know, outside of being pregnant, I don’t think we view being um maybe a little thicker as being a bad thing. You know, voluptuous is, in our culture, its more attractive you know in some ways.

In addition to verbalizing that it was culturally acceptable to carry extra weight, the women indicated that they anticipated they would gain extra weight while they were pregnant and likely retain it. Therefore, they were not going to get overly concerned about it. As one woman put it, “I don’t care about getting big. I mean, you supposed to get fat when you pregnant. Enjoy all the good food that you want to eat, enjoy everything, and can’t nobody say nothing!” Another woman said:

Weight gain for me is, it has always been like on my mind like before I got pregnant, especially before I got pregnant, because I wasn’t pregnant I just use to eat and people would be like, “Oh, you’re gaining weight, are you pregnant?” I’m like, “No, no, I’m just fat.” But, umm, now it’s like, it’s going to happen and I can’t help the swelling of the belly part, so I might as well just eat, so I just let it go.

The women indicated that heritability was a factor in what happened with weight both during and after pregnancy: “Yeah ‘cause to me, weight gain is depressing. To me, because genetics doesn’t make it any better, you know, I wasn’t made to be small anyway, I’ve always been a hefty, a hefty chick, you know?”

The women considered age to be a contributing factor in pregnancy weight gain and post pregnancy weight retention: “I’ve always been small but now...with my other kids it just kinda, fell right off and now I’m like 31, and it might not fall off of me.” Or as another woman suggested, “Just ‘cause my age, you know metabolism slows down a little bit, so, you know. I still think I’m like really big!” Another woman indicated:

When I was 18 having one [a baby] I came across you on the street three weeks later, you never knew I had a baby. I was 26, having twins, I had to do a little work to get that back off. This time...I’m still active but it’s coming a little faster, and I’m hoping it is going to come off.

There is a Limit: Weight Gain Impact on Appearance

Women were comfortable with the idea of their weight increasing during pregnancy and believed that some of the weight gained was likely to be a permanent change. At the same time there was an apparent limit or point at which weight gain, while pregnant and non-pregnant, was no longer acceptable, and that point was reached if the weight affected one of two things: their appearance, or (b) their ability to do what they wanted to do. Appearance was the factor that received the most emphasis.

Women suggested that there were advantages that could be gained in terms of appearance from pregnancy weight gain. There could be weight gain in the “right places” that would enhance their appearance:

I don’t like gaining weight; I just wanted a little booty!” This was further supported by another woman: “When I was pregnant with my daughter, I just gained. I was a size 3, and I went to a size 9. And everybody was like, “Oh you look better that way, you look better that way!” But then when I had my son, I lost it. So I don’t want to get big, real big.

For women the limit came during pregnancy if they reached what to them was an unacceptable weight: "I'm just hoping that I won't get no bigger because I'm close to being, soon I be 300 lbs!" Along the same lines, another woman stated, "I'm ready to hit the last 35, 30...I don't know what I'm going to do when I hit 200--I just want to be the same size!" The limit to weight gain that continued beyond pregnancy was reached for some of the women when it had a negative effect on their appearance:

I don't want all that extra flab and stuff...I can't be like this! You know I don't want to be the one that's got to keep wearing sports bras and busting out on the sides and stuff like I got to double up.

Women expressed concern that too much weight after pregnancy could affect their activities, and there seemed to be an underlying fear that they would end up weighing too much, changing not just their appearance but also their ability to function:

Umm I mean I, my thing that messes with me is that I'm too short to be fat and everybody have their own opinion but 5 ft, 5ft 1 inch, I don't want to have so much weight until I need someone wheeling me around or I can't you know do my usual things.

Watching and Waiting: Plans for Controlling Weight

Some of the women reported plans for how they would control their pregnancy weight gain. Even though they deemed it important to gain for a healthy infant, they did not want their weight gain to be uncontrolled. Controlling weight during pregnancy was one way to prevent having to deal with losing it later.

Women changed how they ate as a means to cope with their worries about gaining too much weight:

I will see my nutritionist. I will try to take some of her advice, whatever she gives me, try to eat less fattening like umm always frying food. That's the only thing I am going to watch, but everything else I'm going to eat normal and I'm going to stay healthy and make sure my baby's healthy...I'm really not going to watch how much I eat but I am going to watch like I was saying how much fattening food I eat.

Another woman expressed her plans this way:

I fear that I'm not going to wait like I had done before, so that's why I'm really trying to watch what I eat, so, that's my fear so after the baby is born--I don't want this baby weight on me, you know. I want to exercise so that's my fear about weight gain during pregnancy.

Other women were focused on what they were supposed to gain based on their care provider's advice or on what they understood the pregnancy weight gain guidelines:

When I found out I was pregnant, I was really focusing on the guidelines cause me being overweight, I really had to focus on gaining a certain amount of weight. So for me, my opinion about weight gain is just follow the guidelines.

For other women their plans were to control their thinking:

I try not to think about weight because for me I think that it's a mind thing. If I think about how much I eat and what I want. I want this. I want this and I will eat a lot of it and I'll go back the next day and the next day for it. But if I just eat normal and eat until I'm full and not until this big plate, I think I'll be fine.

Being active was also seen as a means to control weight: “I’m active! I walk miles and miles, I always run up and down the stairs. I wash clothes and take care of other children every day.”

Planning to manage weight in the future was an approach adopted by many of the women, for example, if they planned to breastfeed:

They say after you have the baby if you breastfeed, if you nurse your baby it helps you to lose weight faster...So I was thinking about breastfeeding [and] losing weight at the same time. I don’t want to have all that extra flab and stuff, ‘cause I said next time I can’t be like this!

Discussion

Women provided insight into how they thought about pregnancy weight gain, weight itself, and the retention of weight after pregnancy. As identified in the first theme women recognized that gestational weight gain was important to ensure a healthy baby. Support persons for these women lent credence to the idea that higher weight gain meant the baby would be healthier as evidenced by the partner who encouraged eating more to gain weight for a healthy infant. The requirement to gain weight during pregnancy is reiterated in the IOM recommendations that are based on the best outcomes for mother and infant (Rasmussen & Yaktine, 2009). Gaining too little can result in low birth weight and increased risk of obesity, metabolic syndrome, type 2 diabetes and coronary heart disease later in life for the infant (Rasmussen & Yaktine). Similarly, gaining too much can result in large for gestational age, stillbirth, birth defects, obesity, and metabolic risk later in life. Maternal effects of gaining too much during pregnancy include pregnancy associated hypertension, labor complications, breastfeeding difficulties, and weight retention.

The women acknowledged that gestational weight gain likely had an impact on long term obesity. This was apparent by their reports of some plans to control their weight gain, either while they were pregnant or afterwards. This is similar to what has been found in pregnant White women (Wiles, 1998) but has not been reported for pregnant African-American women. The decision to wait until after pregnancy to address any excessive weight gain was common to many of the women, and their primary rationale was to ensure they delivered a healthy baby.

Although we did not specifically address health risks with a question, we noticed that women did not bring up that excessive gestational weight gain posed health risks to their infants, nor did they comment on health risks to themselves, other than gestational diabetes. If women do not recognize the risks that excessive gestational weight gain and obesity cause for them and their infants, this is a knowledge gap that requires bridging because it has major ramifications for the health of the women and their children. Providing concrete information about health risks to infants such as macrosomia, hypoglycemia, and obesity, as well as risks to the woman herself in terms of the long-term consequences of chronic disease is a means to bridge that knowledge gap.

The participants indicated that in general their culture was accepting of women being “thicker.” This is consistent with literature that suggests African-Americans accept larger body sizes as attractive compared to other racial groups (Befort et al., 2008; Morin et al., 2002). This approach to body size as part of culture results in an environment where weight retention following pregnancy does not have negative ramifications on a social level. The women assumed that they would retain weight. This finding is consistent with what happens with Black women following pregnancy (Rosenberg et al., 2003), especially if they gained above the IOM recommendations (Chu et al., 2009; Mamun et al., 2010). It also is consistent

with reports that African-American women indicate pregnancy as a main antecedent to weight increase (Befort et al., 2008).

The participants attributed weight retention to heritability and the role of genetics as well as to older age. These are both biological, uncontrollable mechanisms with some basis in the literature. There is support for weight being heritable (Rasmussen & Yaktine, 2009), and as women age weight increases (Linne, Dye, Barkeling, & Rossner, 2004). However, a woman's prepregnant BMI and her gestational weight gain are stronger predictors for weight retention than age (Rasmussen & Yaktine, 2009). In addition, older women tend to have a lower gestational weight gain than younger women, although older women are more likely obese at the start of a pregnancy. It remains unclear what the contribution of gestational weight gain is to postpartum weight retention in older women (Rasmussen & Yaktine).

It was clear that there came a point when current weight, be it while pregnant or after pregnancy, was deemed unacceptable, whether it was a specified weight, interfered with desired activities, or caused them to look different than they preferred. There was a complexity in terms of pregnant African-American women's views of pregnancy weight gain and weight in general that has not yet been delineated. These women were accepting of being heavier, in fact, found it desirable, but there was a limit where a body size became undesirable and unacceptable. This is consistent with literature that indicates dissatisfaction with body size and discrepancies in body ideals in postpartum African-American women (Baturka et al., 2000; Befort et al., 2008; Boyington et al., 2007).

The women indicated that even while pregnant they set a limit on how much they wanted to gain based on a particular weight that seemed too high or anticipated weight effects on later appearance and function. This finding could be associated with their self-esteem and self-confidence as noted by Groth & David (2008) where African-American women indicated weight played a role in self-esteem and self-confidence. Furthermore, it points out that there can be dissatisfaction with personal weight as has been reported (Baturka et al., 2000; Befort et al., 2008; Davis et al., 2005), even during pregnancy.

Implications

The findings of this study have an impact on how clinicians and scientists think about how to assist low-income pregnant African-American women avoid excessive gestational weight gain to prevent health risks during the perinatal period, and future obesity. Approximately 50% of all women gain above the IOM recommendations. Although cognizant of the effects of excessive gestational weight gain these women did not focus to a large extent on controlling their pregnancy weight gain while they were pregnant. Rather, they focused primarily on a healthy infant, which is an appropriate focus for pregnant women. Their assumption of more weight is better for a healthy infant is a knowledge gap that requires attention. Plans to wait until after pregnancy to manage weight may be a challenge because African-American women tend to gain weight by 3–12 months after delivery (Walker et al., 2004). The optimal approach likely is to limit gestational weight gain rather than try to lose weight after pregnancy. Phelan (2010) indicated that intervention during pregnancy capitalizes on a “teachable moment” that stems from the life transition that naturally occurs at the time of pregnancy.

If women believe that weight retention after pregnancy is inevitable, that belief is a potential barrier for intervention and clinical practice both during and after pregnancy. The effects of this belief are further compounded by the cultural acceptance of a larger body size than is seen in other cultural groups. Yet the implications for obesity-related health issues are substantial in terms of effects on the women, their infants, and the health care system.

To date intervention studies have focused on a multiple methods to limit gestational weight gain using a variety of venues that range from provision of information about diet and physical activity to group sessions for dietary teaching and/or physical activity to weight tracking and goal setting (Dodd, Grivell, Crowther, & Robinson, 2010; Gardner, Wardle, Poston, & Croker, 2011; Ronnberg & Nilsson, 2010; Streuling, Beyerlein, & von Kries, 2010). The results have been variable, although findings suggest that monitoring weight gain and food intake, along with encouraging physical activity seem appropriate (Phelan, 2010). However, the number of randomized controlled trials (RCTs) to limit excessive gestational weight gain is few, and none are specific to African-American women. Given the unique cultural perspectives and beliefs about pregnancy weight and weight in general, it is clear there is a need for RCTs tailored to the specific needs of African-American women.

The findings of this study emphasize that we cannot assume that there is a desire to limit gestational weight gain. The participants wanted a healthy pregnancy and most importantly, a healthy baby and they considered pregnancy weight gain antecedent to that. Their determination of how much pregnancy weight gain is too much was not centered on infant outcomes, rather on the amount of weight they perceived to have a negative impact on their activity and appearance. Although they were aware of some of the risks posed by excessive gestational weight gain, their beliefs around what constitutes a healthy pregnancy weight gain and their belief that weight retention was inevitable shaped how they approached pregnancy weight gain.

Given that no randomized controlled trials (RCTs) to date have focused exclusively on gestational weight gain in African-American women there is no data to inform what types of interventions are most appropriate for them. The few trials that have included African-American women have not reported findings specific to this subgroup. Therefore, feasibility studies and then larger RCTs are needed to determine the most efficacious interventions to limit excessive gestational weight gain in pregnant African-American women. Based on the findings of this study it appears that emphasis on a healthy infant and what behaviors result in the best infant outcomes would be of import to these women. Additionally, capitalizing on a healthy pregnancy, as opposed to limiting gestational weight gain, would be of greater relevance to women who do not focus on maintaining a small body size. Shifting ideals and beliefs around the inevitability of weight retention so that women do not reach their outer limits of pregnancy weight gain or weight in general could also be integrated into interventions.

Limitations to this study should be noted. As with all qualitative studies the themes and descriptions described in this study are reflective of the participants and are not necessarily transferable to other populations. The results of the study are suggestive and based on a small sample of pregnant African-American women from one northeastern city. These women should not be assumed to be representative of all pregnant women. Over 60% of them were in the earlier part of their pregnancies and may not have had a sense of how pregnancy weight would affect them directly, although approximately two thirds of them had been pregnant before.

Conclusion

Low-income African-American women, though cognizant of the likelihood of retention of weight following pregnancy, are not focused on limiting their gestational weight gain. The cultural acceptance of a larger body size along with the belief that gaining more weight is indicative of a healthy baby presents a challenge for intervention to limit excessive gestational weight gain. An apparent knowledge gap regarding the risks of excessive gestational weight gain for both infants and mothers provides an opportunity for education

that has the potential to change behavior that promotes excessive gestational weight gain. Furthermore, recognition that these women set personal limits of what constitutes too much pregnancy weight gain or weight in general is another relevant piece of information that can be used for effective interventions.

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Callouts

1. African-American women are at risk for excessive gestational weight gain, yet little is known about how they view and manage weight during pregnancy.
2. Effective intervention with pregnant women to prevent excessive gestational weight gain requires an understanding of how women view weight while pregnant.
3. African-American women were comfortable with body size, but there was a limit when current weight became unacceptable.

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Table 1

Sample Characteristics (N = 26)

Characteristics	N (%)
Age ranges	
18–20	9 (35)
21–29	13 (50)
30–39	4 (15)
Race	
Black	24 (92)
Multiracial (including Black)	2 (8)
Ethnic group	
Hispanic	1 (4)
Non-Hispanic	23 (88)
Unknown	1 (8)
Gestation of pregnancy	
10–20 weeks	16 (61)
21–30 weeks	8 (31)
31–40 weeks	2 (8)
Completed education	
Grade 8	1 (4)
Grade 9–11	8 (31)
Grade 12	12 (46)
Grade 12+	1 (4)
GED	2 (7.5)
College	2 (7.5)
Health insurance	
Medicaid	15 (58)
Medicaid options	10 (38)
Commercial insurance	1 (4)
Weight range (pounds)	116–230
Body mass index (BMI)	
Underweight	1 (3)
Normal weight	5 (19)
Overweight	7 (27)
Obese	4 (15)
Unknown	9 (35)