FOOD AND NUTRITION IN COLLECTIVE HEALTH

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Nutritional attention and food practices in the perspective of overweight pregnant women

Atenção nutricional e práticas alimentares na perspectiva de gestantes com excesso de peso

Abstract

Objective: The aim of this study is to investigate nutritional care and dietary practices, from the perspective of overweight pregnant women receiving primary health care in the town of Macaé, Rio de Janeiro state. ***Methods:*** This is a qualitative research study, based on the interpretive paradigm. In-depth interviews were conducted, and the data underwent thematic content analysis, adapted from Bardin. Twelve overweight pregnant women, over 20 years old, living in Macaé-RJ, were interviewed. ***Results:*** The study found the establishment of vertical relationships between the health worker-patient, discontinued nutritional care and non-adherence to dietary guidelines by some participants. There was greater acceptance of excessive gestational weight gain and the adoption of ambiguous eating practices, permeated both by the excessive intake of food and by the withdrawal of foods considered to be "bad and/or junk". The vertical discourse of health workers, which is often authoritarian, and the nullification of women as an active subject in the construction of care, were implicitly reported in the narratives. ***Conclusion:*** Naturalization of gestational excess weight, conceptions built in the social imaginary such as "eating for two" and "cravings" during pregnancy, the set of eating practices in this period and family support are relevant elements to be considered by health teams for the organization of nutritional care.

Keywords: Pregnant women. Overweight. Prenatal care. Eating Behavior.

Resumo

Objetivo: Este estudo tem como objetivo investigar a atenção nutricional e as práticas alimentares, na perspectiva de gestantes com excesso de peso assistidas na Atenção Básica de Macaé, Rio de Janeiro. ***Métodos:*** Trata-se de pesquisa de abordagem qualitativa, fundamentada no paradigma interpretativista. Realizaram-se entrevistas em profundidade, cujos dados foram submetidos à análise de conteúdo temática adaptada de Bardin. Foram entrevistadas 12 gestantes com excesso de peso, maiores de 20 anos, residentes em Macaé-RJ. ***Resultados:*** O estudo verificou o estabelecimento de relações verticalizadas entre o profissional de saúde-usuário, descontinuidade do atendimento nutricional e a não adesão às orientações dietéticas por algumas participantes. Houve maior aceitação do ganho de peso gestacional excessivo e adoção de práticas alimentares ambíguas, permeadas tanto pelo consumo exagerado de alimentos quanto pela retirada de alimentos considerados "ruins e/ou besteiras". O discurso verticalizado do profissional de saúde, frequentemente autoritário, e a anulação da mulher enquanto sujeito ativo na construção do cuidado se manifestaram, de forma implícita, nas narrativas. ***Conclusão:*** A naturalização do excesso de peso gestacional, concepções construídas no imaginário social como o "comer por dois" e "desejos" durante a gestação, o conjunto das práticas alimentares

nesse período e o suporte familiar constituem elementos relevantes a serem considerados pelas equipes de saúde para a organização da atenção nutricional.

Palavras-chave: Gestantes. Sobrepeso. Cuidado Pré-Natal. Comportamento Alimentar.

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INTRODUCTION

During pregnancy, nutritional needs are increased, and nutritional care is essential for maternal and fetal health. Pregnant women should eat foods in specific variety and quantity, based on the advice from dietary guidelines and local socio-cultural issues, in order to meet energy needs and weight gain recommendations. During this period, many women have excessive weight gain, which can compromise their future nutritional status. Pre-pregnancy weight and postpartum weight retention make pregnancy a risky period for development of obesity. Therefore, healthy eating practices should be advised and encouraged at this stage.[1-3]

Maternal nutritional status has a great impact on pregnancy prognosis, and healthy eating practices are associated with better embryonic development, prevention of pregnancy complications, better postpartum recovery and quality of breastfeeding.[1,4,5]

Despite a transition in the nutritional profile of Brazilians, characterized by increasing rates of overweight and obesity, the protocol of nutritional care in prenatal care, prepared by the Ministry of Health, is still focused on preventing the birth of low-weight newborns.[6] In addition, there remains a biological, fragmented and vertical approach to health care that affects the perceptions of Primary Health Care (PHC) workers, who fail to fully adopt the recommendations of comprehensive health care guidelines targeted at pregnant women at risk of excessive weight gain.[7] Brazil's National Primary Care Policy (PNAB) defines PHC as a set of individual, family and collective health activities, which involve promotion, prevention, protection, diagnosis, treatment and rehabilitation, so that comprehensive care can be offered to the population of a particular territory by an interdisciplinary team.[8]

However, according to Niquíni et al.,[9] there are factors that impair comprehensive prenatal care: e.g., health workers that are not prepared to deal with nutritional issues, which require competencies and skills that go beyond the specific qualification of such workers; difficulty in providing matrix support and maintaining referral and counter-referral flows; absence of nutritionists in health care teams.

Despite all these challenges, pregnancy can be a good time to promote healthy eating. As pointed out by Líbera et al.,[10] when women receive nutritional advice as part of comprehensive prenatal care, they adopt healthier eating practices that can be maintained after pregnancy. Such measure helps prevent overweight and obesity in women.

However, a critical point needs to be made, as raised by Poulain[11] and discussed by Oliveira,[12] about body-related issues, in a perspective in which the body is seen as one of the constituent elements of a wide and intricate universe of meanings, in which subjectivities are produced. In this sense, the author underlines the influence of social actors, whose divergent interests (or not so much) are placed in the (social and political) arena of obesity, which can transform it into a universal phenomenon in public health and, therefore, liable to be addressed by "anti-obesity activism" which, in turn, can bring back control policies over individuals. Thus, one must be careful about the process of medicalization of daily eating and the controversies over both the critical view on obesity and the health, social and cultural risks underlying it.

In light of the above remarks, the aim of the present study is to investigate nutritional care and eating practices, from the perspective of overweight pregnant women, assisted with Primary Health Care services in the town of Macaé, Rio de Janeiro state, Brazil.

METHODS

This is a qualitative study, with interpretativism as a theoretical framework, and thematic content analysis adapted from Bardin[13] as a technical reference. We sought to apprehend themes, categories and patterns of meanings, in order to understand the models behind the content expressed in the speech of informants, according to procedures proposed by Minayo.[14]

Fieldwork was carried out from February to August 2017, in two health units in the town of Macaé: *Estratégia de Saúde da Família (ESF) Cajueiros* ("Family Health Strategy") and *Núcleo de Atenção à Mulher e à Criança - NUAMC Visconde* ("Primary Health Care Center for Women and Children").

The town of Macaé is located in the northeastern region of the state of Rio de Janeiro, 180 kilometers away from the state capital. It has a population of nearly 244,000 inhabitants. There was an important change in the local food system after the establishment of factories in the region and the uncontrolled occupation of land by the population. The practice of fishing and subsistence agriculture has undergone changes with the advance of industrialization and oil exploration in the region, thus affecting eating practices. Such a phenomenon may be contributing to an increase in excess weight in the population, including pregnant women.[15,16]

The first step of the present research was to check the medical records in the two above-mentioned health units in order to identify pregnant women who met the inclusion criteria: living in the town of Macaé, being an adult (over 20 years of age) and diagnosed with excess weight, according to the body mass index (BMI) per gestational week (overweight or obesity). In addition to these data, socioeconomic and demographic information was also collected to characterize the study participants.

The short-listed pregnant women were invited to participate in this research on the days of their prenatal appointments or contacted by community health workers. The study participants signed an Informed Consent Form (ICF) and were taken to a separate room for the purpose of ensuring their privacy.

The saturation criterion was used to define the number of participants to compose the group to be investigated.[17] A total of 12 adult pregnant women diagnosed with excess weight were selected. Data were collected with semi-structured interviews that were audio-recorded and transcribed in full to ensure the registration of the speeches, as well as verbal and non-verbal cues, such as voice intonations, interjections and silences.

The study was approved by the Research Ethics Committee of the School of Nursing *Escola de Enfermagem Anna Nery (CEP EEAN) at* the Federal University of Rio de Janeiro, and of the Municipal Health Department of Macaé (protocol no. CAEE 6197.9416.7.0000. 5238), as provided in Section I of Resolution No. 466/2012 of Brazil's National Health Council, which establishes guidelines and standards for research involving human beings.[18]

RESULTS AND DISCUSSION

Four of the 12 pregnant women interviewed were from the town of Macaé, three were from the city of Rio de Janeiro, and the others were from other towns in the states of Rio de Janeiro (two), Bahia (two) and Minas Gerais (one). Eight women were multiparous and four were primiparous. One had completed elementary school; five, high school; another five had incomplete high school, and only one was studying in higher education. Eight were housewives, one was a student and three have a paying job. At the time of the interview, they all lived with their partners who, in most cases, were the primary wage earners of the family.

Regarding adherence to the minimum schedule of prenatal care, only four of the interviewees made six or more appointments (Brazil's Ministry of Health adopts a follow-up calendar until the 41st gestational week).[1] However, this parameter could not be assessed, since the gestational age of all respondents was below 41 weeks. Nutritional diagnosis indicated that half of the interviewees were overweight and the other half were obese, as shown by their BMI per gestational week.

Nutritional care in prenatal care was learned from the interviewees' statements through the category "Eating and nutritional advice in prenatal care: eating practices and experience of nutritional care".

Eating and nutritional advice in prenatal care: eating practices and experience of nutritional care

The nutritional status of pregnant women is recognized as an essential aspect for a healthy and uneventful pregnancy. In this sense, one should be attentive to eating practices, since dietary guidelines need to reconcile the nutritional demands of pregnancy with the typical symbols and rituals of motherhood, so that nutritional care raises pregnant women's awareness of the motivations of their food choices and, in this perspective, either have them change or maintain such choices.[19-22]

For some of the interviewees, the increase in nutritional needs was perceived to be linked to increased appetite and fetal movement, which increased their anxiety and compromised the performance of their daily activities, including sleep. Thus, the addition of several meals throughout the day and the act of "eating for two" were justified by the urgency to calm down the unborn baby and reduce the anguish of would-be-mothers.

> Oh, I'm eating twice as much, right? [laughs]. Oh, I don't know, it makes me hungrier. I'm not eating only for myself; I'm eating for the child too [...] So, twice as much food, right? [...] If I don't eat enough in the evening, when bed time comes, mind you, I can't sleep. My baby keeps moving all night. I can't sleep until I get to eat something. (GD02).

> Now, I eat three bread rolls early in the morning [laughs]. I eat later, before lunch [...] I eat whatever I have at home. I eat more bread or cake, it's crazy. At lunchtime, I eat like a horse, darling. I eat it all! [...] In the afternoon, I eat more cake, more bread [...] it's all messed up now [...] [lots of laughter]. (GA09).

Sociocultural and emotional factors associated with a pregnant woman's diet, e.g. the feeling of "food cravings", are still a part the daily lives of many women. They validate the indiscriminate consumption of food and / or preparations, which may further compromise their nutritional status, as happened to some pregnant women of this study.[23]

> [...] On TV, I saw a recipe for *moqueca* made with plantains and heart of palm. I saw that on TV and I was crazy about it. I made my husband buy plantains, heart of palm, and make the moqueca with plantains and heart of palm. And I ate it all. It was the only scary thing [...] I was trying to understand why I wanted to eat that, but I really wanted to eat that! (GC08).

> The only thing that I craved for, a huge craving that I had when I was at church - and it was the first time that I was angry about it because I left the church later, it was chicken drumstick. I kept dreaming about chicken drumstick and guarana. Then, I tried to find the exit door of the church but I couldn't find it. The other day, my husband bought them for me. But it was a terrible thing. My husband bought three of them and I ate all three! (GA09).

> [...] I had a craving for trifle. Cookie trifle, chocolate trifle. I had a huge craving! Then, I went on to make the trifle but it didn't come out the way I wanted [laughs]. It came out terrible, but I ate it all. I wanted it so bad that it came out terrible and I ate everything! [Lots of laughter] (GD02).

A study by Baião and Deslandes[24] pointed out that, during pregnancy, women distinguished "bad diet" from "healthy eating". Poor diet would be associated with "excess food intake" and the possible development of diseases, while healthy eating should be a choice required for fetal growth and development, aspects also observed in the present study:

> [...] I started eating more sweets. And I can't help it. But this is a problem. I can't do that; I have to control my blood sugar level! [...] (CC07).

> [...] Since I can't eat junk food, I go there and eat rice and beans, I have dinner, I eat a salad. I don't think this will be bad for me. Instead of eating a hamburger, I'm going to eat this. I try to look at the positive side, you know? That I'm cutting down on things, but it's for a good cause [referring to the baby] [...] (GC08).

Some interviewees reported having at least four meals a day - breakfast, lunch, afternoon snack and dinner - and when they were unable to eat "every three hours". They understood that a prolonged fast was not considered to be a proper practice:[25]

> [...] As soon as I wake up, I have coffee. Or, if I don't have coffee, I eat fruit. Then, I wait until lunchtime and then I have lunch. In the afternoon, I eat some fruit or have some yogurt. After that, I have dinner. I eat a piece of meat, a salad, rice and beans. (GN10).

In large meals (lunch and dinner), the predominant combination was rice, beans, animal protein (meat) and vegetables, in order to "sustain" the pregnant body and prevent the occurrence of iron-deficiency anemia. These eating practices were also found by Sato et al.[26] For these authors, pregnancy promotes changes in eating habits, especially the inclusion of dinner and the intake of iron-rich vegetables.

> If I eat only rice, it won't keep me going. I need to eat beans, potatoes, carrots, then it'll see me through. (GD02).

> So, I need to eat my rice and beans or something, a salad too. (GC08).

> [...] I started eating more beans, because I didn't use to eat them [she had anemia]. I started eating more broccoli, things I didn't use to eat before. (GD11).

For Junges et al.,[22] eating during pregnancy is a means for building a bond with the fetus, and it is perceived as important for its development. In this sense, the interviewees' partners and their family played an important role in their diet. With tender loving care, they helped those women to overcome typical gastrointestinal symptoms of pregnancy and ensure mother-child health, when buying, preparing and prioritizing the intake of foods considered to be healthy:

> Chicken stew [...] when I got really sick, my husband would make it often and so would my mother [...] (GG05).

> Now, we've been eating a lot of vegetables. [...] my husband's been eating them, and the same goes for my son, who didn't like it very much, who didn't care much about them before. Now, he [husband] is buying them and wants to cook them [...] [laughs] (GN10).

> There was a day when I felt like eating chocolate [...] then, you know what I had? My husband went out, bought 100 ml of açaí and we ate it together. And we no longer have chocolate [...] at least, it's not a chocolate bar. We try to balance things out, because it is not easy either (GC08).

From this perspective, other dietary rules were adopted during the pregnancy period. One of them was to recognize some foods as "bad" and/or "junk" and to stop eating them out of the realization that they are harmful:

> I only stopped eating junk food, like hamburgers, pizza [laughs and sighs]. [...] Because they're no good. I used to eat them and feel very ill. I used to throw up, feel sick, have a headache, because I ate them three or four times a week. And I didn't have any rice and beans so I could have a snack. I had a soda every day [...] the effect was quick. I started feeling sick right after I'd had it. And I decided to cut out on it. (GI01).

As pointed out by Oliveira et al.,[27] ultra-processed foods are more affordable, which increases their consumption and allows their sociocultural resignification, promoting changes in the population's taste and their inclusion in the daily diet, especially because they are easy to prepare.

According to one of the interviewees, it was only during the appointment with the nutritionist at the health unit that she realized that excessive intake of ultra-processed foods, rich in sugar, sodium and fat, was harmful to health and contraindicated during pregnancy. For her, nutritional orientation helped her think critically on the role of the food industry in encouraging the adoption of inappropriate eating practices and on the need to review such practices.[10]

> You acquire habits [...] you have a habit that you don't even notice. In the past, we used to buy a lot of canned goods, canned food, canned sardines, canned juices. Because it comes in handy, because we're lazy, the industry really gets you into it. When the nutritionist said: 'you can't eat canned corn', it was cool. You end up dropping some habits and acquiring others, right? [...] you change too, your mindset changes. (GC08).

Nutritional care in prenatal care is essential for planning appropriate weight gain in pregnancy, thereby preventing diseases, providing dietary orientation, treating gastrointestinal symptoms and, especially, promoting a successful obstetric outcome.

However, although the two health units have nutritionists - reference/matrix support (ESF Cajueiros) and traditional health care model (NUAMC Visconde) - and the 12 interviewees in the present study had been diagnosed with excess weight, only eight of them were referred for nutritional care by the health teams. Among those eight, six had only one appointment and two did not go to their appointment with a nutritionist:

> It was good [nutrition appointment]. She said, of course, that I couldn't put on too much weight, that I could eat protein and vegetables every day, that if I put on a lot of weight, I could increase my sugar blood levels, because I put on weight too quickly [...] I've only seen the nutritionist once. She said that if there were any changes in the outcomes of my tests, I was supposed to come back. But nothing's changed, so [...] (GA09).

For two other interviewees, nutritional care was not a comfortable moment. Although the health worker meant to advise the patient, her authoritarian tone of voice was received with distress, therefore, the patient felt embarrassed and discontent:

> She told me I mustn't eat a lot of things: beans at night, soda, sweets [...] but I won't be able to do that, no. I feel very hungry! [She speaks in a complaining tone] (GF04).

> She was very worried about the amount of cooking oil I use every month. She said that this amount is right for a household with 16 people, but there are only three people in my home. She chided me so I would cut down on it. She said that I have to spend only up to one liter of oil a month. I used to spend three to four liters per month. Then, she was angry and amazed at me. I brought my son over, and my son told her the things we eat: processed snack foods, lots of junk food [nervous laughter]. Right on spot, she cut things out from my diet (GN10).

Santos et al.[28] underlined the prevalence of the traditional biomedical model, in which a health worker "[...] unilaterally establishes what is right or wrong, adequate or inadequate, behaving as one who knows better about other people than the people themselves" [our translation] (p.778). In this perspective, the verticalization of knowledge, which is strict and critical of individual beliefs and experiences, nullifies the possibility of establishing equality relations and knowledge exchange between users and health workers, limiting the perception of women as active subjects in the health care process.

In another situation, two interviewees did not go to the nutrition appointment, even though they had been referred by the health team. One of them missed the appointment because she thought it was unnecessary, since she was at the end of her pregnancy. The other, because there was no one that could look after her underage child. Although the health team has recognized (even if only later) the need to refer patients to specialized nutritional care, appreciation of the importance of this monitoring and attention to the pregnant woman's living conditions, which are meant to facilitate assistance at the health clinic, were insufficient to promote comprehensive health care.

> I didn't [have any appointment]. I actually scheduled it, but then I canceled it. What for?! I'm at the end of pregnancy. (GT12).

> They [the health clinic staff] booked it. The girl at the reception desk scheduled the nutrition appointment. But then, it was hard because my son is hyperactive, so it was difficult for me to come (GA06).

As the pregnant women in this study had a nutritional diagnosis of excess weight, discontinuity of health care increased the risk of occurrence of health problems during pregnancy, during childbirth and in the postpartum period.[29,30] In addition, it impaired the control of gestational weight gain and prescription of dietary guidelines that are useful for promoting the health of the entire family, including the unborn child.

As noted by Líbera et al.,[10] the pregnancy period, even when permeated by beliefs that can compromise maternal-fetal health, is also marked by women's greater concern with behaviors that can negatively influence the health of the fetus. However, when analyzing the experiences relative to nutritional health care, this study found that such care was discontinued and some participants had not adhered to it.

In this perspective, it is worth mentioning that multiprofessional teams, by performing food and nutritional surveillance, can early detect pregnant women with excess weight, as well as unsafe eating practices. Another crucial point is timely referral to nutritional health care whenever necessary, with a view

to building a bond and prescribing nutritional therapy consistent with the economic and socio-cultural aspects of the pregnant woman, thus enhancing the likelihood of greater adherence and continued health care after the pregnancy period. Therefore, health teams need to be qualified so that they can offer comprehensive care in terms of food and nutrition.

Thus, continued education of the health team represents a feasible way for professionals to plan and develop high-quality prenatal nutritional health care.

CONCLUSION

The narratives of the women who participated in this study showed the strength of constructs of the biomedical model present in prenatal care, such as the verticalized and often authoritarian discourse of health workers, and the nullification of women as an active subject in the construction of health care.

It should be noted that the naturalization of excess gestational weight, "eating for two" and "cravings" during pregnancy, which are socially constructed, should be respectfully discussed between pregnant women and health care teams. In addition, the set of dietary practices and family/community support need to be considered as relevant elements for the organization of nutritional health care, as recommended by Brazil's National Food and Nutrition Policy.

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Contributors

Pires CC and Baião MR worked in all stages, from the conception of the study to the revision of the final version of the article. Capelli JCS, Rodrigues ML and Santos MMAS participated in the discussion of the results, writing and critical review of the article. All authors approved the final version of the article.

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