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Research Article
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Excess weight and gestational self-care in primary care: a qualitative analysis according to Orem

Excesso de Peso e Autocuidado Gestacional na Atenção Primária: análise qualitativa segundo Orem

Sobrepeso y autocuidado gestacional en Atención Primaria: un análisis cualitativo según Orem

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ABSTRACT

Objective: to analyze the views, barriers, and facilitators related to self-care in overweight pregnant women, based on Orem's Theory, in Primary Health Care. Method: qualitative, descriptive, and exploratory study, conducted with 17 overweight pregnant women in a health unit in northern Brazil, between November 2023 and January 2024. Data collected through semi-structured interviews and subjected to thematic content analysis, guided by Orem's theoretical framework. The research protocol was approved by the Ethics Committee. **Results:** Three categories emerged: " Universal self-care deficits: dietary routine during pregnancy", "Universal self-care deficits: physical activity and leisure during pregna", and " Developmental self-care deficits: the implications of gestational obesity". **Final considerations:** The perceptions reveal barriers and potential facilitators of self-care, reinforcing the need for strategies in primary care that support overweight pregnant women.

Descriptors: Nursing; Primary Health Care; Pregnant People; Overweight; Self Care.

RESUMO

Objetivo: analisar as visões, barreiras e facilitadores relacionados ao autocuidado em gestantes com excesso de peso, com base na Teoria de Orem, na Atenção Primária à Saúde. **Método:** estudo qualitativo, descritivo e exploratório, realizado com 17 gestantes com excesso de peso em uma unidade de saúde do norte do Brasil, entre novembro de 2023 e janeiro de 2024. Dados coletados por entrevistas semiestruturadas e submetidos a análise de conteúdo temática, orientada pelo referencial teórico de Orem. Protocolo de pesquisa aprovado por Comitê de Ética. **Resultados:** emergiram três categorias: "Déficits de autocuidado universal: rotina alimentar na gestação", "Déficits de autocuidado universal: atividade física e lazer no período gestacional" e "Déficits de autocuidado de desenvolvimento: as implicações da obesidade gestacional". **Considerações finais:** as percepções revelam barreiras e potenciais facilitadores do autocuidado, reforçando a necessidade de estratégias na atenção primária que apoiem gestantes com excesso de peso.

Descritores: Gestantes; Excesso de Peso; Autocuidado; Enfermagem; Atenção Primária à Saúde.

RESUMEN

Objetivo: analizar las perspectivas, barreras y facilitadores relacionados con el autocuidado en mujeres embarazadas con sobrepeso, según la Teoría de Orem, en Atención Primaria de Salud. **Método:** estudio cualitativo, descriptivo y exploratorio, realizado con 17 mujeres embarazadas con sobrepeso en una unidad de salud del norte de Brasil, entre noviembre de 2023 y enero de 2024. Los datos se recopilaron mediante entrevistas semiestructuradas y se sometieron a un análisis temático de contenido, guiado por el marco teórico de Orem. El protocolo de investigación fue aprobado por el Comité de Ética. **Resultados:** surgieron tres categorías: ""Déficits universales de autocuidado: rutina alimentaria durante el embarazo", "Déficits universales de autocuidado: actividad física y ocio durante el embarazo", y "Déficits de autocuidado en el desarrollo: implicaciones de la obesidad gestacional". **Consideraciones finales:** las percepciones revelan barreras y facilitadores potenciales del autocuidado, reforzando la necesidad de estrategias en atención primaria que apoyen a las mujeres embarazadas con sobrepeso.

Descriptores: Enfermería; Atención Primaria de Salud; Personas Embarazadas; Sobrepeso; Autocuidado.

INTRODUCTION

Obesity is a chronic and complex condition of the endocrine-metabolic system, resulting from various factors, characterized by the excessive accumulation of adipose tissue, causing a negative impact on people's health[1]. The diagnosis of excess weight is initially made by calculating the Body Mass Index (BMI), which uses weight and height parameters. BMI scores between 25 and 29.9 kg/m² are considered overweight, and BMI ≥ 30.0 kg/m² is considered obesity[2].

In 2022, approximately 2.5 billion adults were overweight, including 890 million adults experiencing obesity, representing a significant threat to public health and increasing the risk of chronic non-communicable diseases[2]. About 44% of these individuals were women of reproductive age, negatively impacting the gestational phase[3].

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Maternal obesity is associated with comorbidities such as diabetes, dyslipidemia, and cardiovascular diseases, increasing the risk of gestational complications such as pre-eclampsia, eclampsia, surgical delivery, and perinatal mortality[4]. Effective actions are needed to promote and monitor adequate gestational weight gain. Therefore, healthcare professionals should encourage women to manage their gestational weight in a healthy manner through new lifestyle interventions, considering the clinical context[5].

During pregnancy, encouraging self-care is fundamental, as knowledge about the gestational process promotes the adoption of healthy practices. Health literacy is a central tool for empowering women as leading actors of their own care and promoters of health.

In this context, during the first prenatal visit, preferably before the 13th week, it is recommended to identify pre-pregnancy weight for BMI calculation and classification, classifying BMI as underweight (<18.5 kg/m²), normal weight (18.5–24.9 kg/m²), overweight (25.0–29.9 kg/m²), or obese (30 kg/m²), and defining the appropriate weight gain monitoring curve, according to the Ministry of Health guidelines[6]. This approach is relevant given the evidence that obesity compromises maternal, fetal, and neonatal health, as well as female fertility, and lifestyle changes and weight loss are safe strategies to improve reproductive outcomes, reduce pre- and perinatal complications, healthcare costs, and the transgenerational transmission of cardiometabolic diseases[7].

In this context, the Food and Nutrition Surveillance System (*Sistema de Vigilância Alimentar e Nutricional*) records a high frequency of excess weight among pregnant women monitored in Primary Health Care (PHC). In 2025, 818,680 pregnant women were assessed, of which 237,030 presented obesity, corresponding to 28.95% of the total. In addition, 241,775 (29.53%) were classified as overweight, while 246,263 (30.08%) presented adequate nutritional status and 93,612 (11.43%) were underweight. These data demonstrate that more than half of the pregnant women monitored in the country are overweight, obese, or have excess weight, highlighting the need for nutritional surveillance and health promotion actions during prenatal care[8].

Self-care is defined as the performance of activities initiated and executed by a person for their own benefit, aiming at the maintenance of life, health, and well-being. This is a learned behavior, resulting from cognitive, cultural, and social experiences, that guides choices related to diet, physical activity, rest, and seeking healthcare[9]. In this sense, the development of self-care skills becomes fundamental during pregnancy, especially among overweight women, as it promotes the adoption of healthy behaviors and the prevention of complications.

Adverse outcomes associated with postpartum diabetes, such as hypertensive disorders, gestational diabetes mellitus (GDM), large-for-gestational-age fetuses, prematurity, stillbirth, cesarean section, and postpartum hemorrhage, reinforce the need for proactive action by healthcare professionals, not only in monitoring weight gain but also in strengthening health literacy and self-care as structuring strategies for maternal care. Thus, an integrated approach that articulates nutritional surveillance, health education, and timely prenatal interventions is necessary. Early anthropometric assessment, continuous monitoring, and encouragement of sustainable lifestyle changes constitute basic measures to reduce immediate and future risks, breaking the intergenerational cycle of cardiometabolic diseases and improving care for women of reproductive age[10,11].

The various cases of pregnant women with obesity associated with unfavorable outcomes, both for the woman and the newborn, highlight deficits in the universal self-care described by Orem[9], which are human needs common to all individuals, related to the maintenance of life, physiological functioning, and well-being.

It is noteworthy that the object of study is relevant because it addresses the self-care of overweight pregnant women in PHC, in light of Orem's Theory, considering the perspectives, barriers, and facilitators that influence this process. This approach contributes to the promotion of maternal health and the prevention of gestational complications, aligning with the Sustainable Development Goals (SDGs), especially regarding health and well-being improvement, mentioned in the third SDG of the United Nations (UN), the reduction of inequalities in access to care, contemplated in the tenth SDG, and the empowerment of women through health education, included in the fourth and fifth SDGs of the UN[12].

Given this, the importance of promoting self-care actions during pregnancy in PHC is highlighted. Based on this premise, the following research question was formulated: "What knowledge do overweight pregnant women have about self-care?".

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The objective was defined as analyzing the views, barriers, and facilitators of self-care in overweight pregnant women in PHC based on Orem's Theory.

METHOD

This is a descriptive and exploratory study with a qualitative approach, guided by the COnsolidated criteria for REporting Qualitative research (COREQ)[13], developed in a Family Health Strategy Unit in a municipality in northern Brazil, between November 2023 and January 2024. Participants were pregnant women who were receiving prenatal care at this unit.

The invitation to participate in the study was made at the end of the prenatal consultation, exclusively for pregnant women who were overweight adults, with a BMI of 26-40 kg/m², in the first trimester of pregnancy, aged 18 years or older. Those with twin pregnancies and those who, even with overweight, started prenatal care after the first trimester were excluded.

Data collection was initially carried out by identifying participants' socioeconomic data and then through semi-structured interviews with open-ended questions, totaling five questions supported by Orem's theoretical framework[8], with questions about their daily routine, diet, physical activity, leisure, and rest. The questions in the interview guide were always conducted in a conversational tone, in order to provide a welcoming and comfortable environment for pregnant women. The interviews were conducted by the researcher-nurse herself, who is trained in interview techniques and has experience in dialoguing with pregnant women.

To conclude data collection, it was considered that consecutive interviews should be conducted without the emergence of new categories, at which point data saturation was observed, i.e., when no new element emerged and the addition of information did not alter the understanding of the object of study[14].

The interviews took place in a private place in the health unit, lasting an average of 20 minutes, and were conducted by the main researcher. During the recruitment process, there were three refusals to participate in the study. Most interviews were carried out only with the presence of the pregnant woman and the researcher. In some cases, the participant was accompanied by her partner at the time of the service.

All interviews were recorded with prior authorization from the participants, transcribed in full and subjected to Bardin's thematic content analysis. As a data validation strategy, the transcriptions were made available to participants at the end of the collection process, enabling checking and confirmation of the recorded information[15].

Data were processed in three stages: in the pre-analysis, an exhaustive reading of the transcribed interview material was carried out, seeking to order and classify the content without discarding information; in the material exploration, the main topics, categories and core meanings emerging from statements were identified; and, in the final phase, the analysis was carried out jointly by the researchers, through successive readings and grouping of content with convergent meanings guided by the adopted theoretical framework and relevant and up-to-date literature.guided by the adopted theoretical framework and by relevant and up-to-date literature[8,15].

The research protocol was approved by the Research Ethics Committee with Human Beings and respected current ethical standards. All participants signed the Informed Consent Form. To guarantee anonymity, participants were represented by the letters "PW" (for pregnant woman), followed by cardinal numbers in ascending order.

RESULTS

Seventeen overweight pregnant women participated in the study. Concerning the women's profile, their BMI ranged from 28 to 40 kg/m², 13 were between 19 and 29 years old, and four were between 30 and 40 years old. As for employment status, six had formal employment, one identified as self-employed, and ten declared themselves "housewives". Concerning the receipt of government benefits, 12 reported receiving no assistance, four received a Family Allowance (*Bolsa Família*), and one received assistance for sick leave. In relation to education, one participant had completed higher education, ten had completed high school, two had incomplete high school, one had completed elementary school, and three had incomplete elementary school. Six women reported, at the time of the interview, that they lived with a partner. Regarding parity, three were experiencing motherhood for the first time. The others already had children, with one experiencing motherhood for the eighth time.

Through the successive analysis of the interviews and the grouping of content with convergent meanings, according to the assumptions of thematic analysis, recurring core meanings were identified, allowing for the synthesis of the findings. The coding and categorization process resulted in three thematic categories: "Universal self-care deficits: dietary routine during pregnancy"; "Universal self-care deficits: physical activity and leisure during pregnancy"; and

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"Developmental self-care deficits: the implications of gestational obesity". These categories encompassed themes related to nutrition, physical activity, leisure, rest, excess weight, and their repercussions for maternal and fetal health, including complications such as hypertension and gestational diabetes mellitus

Universal self-care deficits: dietary routine during pregnancy

The category "Universal self-care deficits: dietary routine during pregnancy" concentrated the greatest diversity of reports related to eating habits, consumption of ultra-processed foods, weight control strategies, and concerns about maternal and fetal health, with 11 codes identified for the units of meaning and grouping of content.

When participants reported on their eating habits, it was observed that some did not maintain an adequate diet. Others presented insufficient self-care practices, reporting consumption of ultra-processed foods and foods high in sugar. Only a few statements showed satisfactory eating habits, although some pregnant women expressed concern about improving the quality of their diet during pregnancy.

Most of the pregnant women (nine pregnant women) who were overweight reported consuming ultra-processed foods and foods high in sugar:

> *I eat everything, bread, cake, lunch, soft drinks, lots of junk food [...] (PW1)*
>
> *[...] I really like lunch, mostly rice and beans, sometimes mixed dishes, I don't really like it when there are too many vegetables in the beans [...] (PW4)*
>
> *I eat a lot of fried food. I eat very little rice and beans [...] (PW9)*
>
> *Sometimes a very cold Coke, with a sweet biscuit [...] (PW2)*
>
> *[...] I usually eat a lot of junk food, like soft drinks and savory snacks. (PW8)*

Some pregnant women, however, sought to maintain a more balanced diet and demonstrated concern for healthier eating practices:

> *I like rice, beans, meat, salad, fruit, yogurt, and crackers. I also drink plenty of water. (PW11)*
>
> *For a snack, I like to eat tapioca with egg. (PW17)*
>
> *Rice, beans, fried or boiled meat, and salad too. I like cabbage, lettuce, tomato, beetroot, carrot, and there are some others that I'm not a big fan of eating. (PW8)*
>
> *I usually eat salad, carbohydrates, and protein. (PW15)*

Other pregnant women linked their food concerns to the issue of weight control during pregnancy:

> *I like to eat vegetables, for dinner I have soup because of my weight, I can't keep eating junk food. (PW16)*
>
> *I eat well, I have breakfast, lunch, everything done the right way. Dinner is a little difficult because of the nausea, but I try much more than before the pregnancy. (PW10)*
>
> *I don't drink soda anymore, I don't eat junk food anymore, I eat more food, salad and things like that. (PW7)*

Nutrition was shown to be directly related to the phenomenon investigated, since excess gestational weight is associated with outcomes such as gestational diabetes mellitus and hypertensive syndromes of pregnancy. The statements describe the diversity in the dietary routines of pregnant women, demonstrating both gaps in self-care regarding food intake and efforts by some to improve their practices, highlighting the importance of professional guidance and health literacy.

Universal self-care deficits: physical activity and leisure during pregnancy

The category "Universal self-care deficits: physical activity and leisure during pregnancy" was obtained from the manual grouping of reports with convergent meanings related to the practice of physical activity and leisure activities, originating from 11 identified codes.

Regarding the practice of physical activity, some pregnant women reported that they performed activities before pregnancy, but interrupted them during pregnancy, mainly due to insecurity, doubts about the safety of exercise during this period, or changes in routine resulting from pregnancy.

Among the main thematic areas identified are interruption of physical activities after the start of pregnancy, fear or insecurity regarding the practice of exercise, beliefs about possible risks to the fetus, physical limitations, recognition of the benefits of physical activity, performance of adapted activities, and difficulties in experiencing leisure time due to domestic overload and childcare.

> *I used to play soccer, but now I've stopped. (G11)*

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I used to play, I don't anymore, and now I've stopped completely during my pregnancy. (G9)

I stopped playing because I was worried about the pregnancy. (G1) or formal quantification of codes.

Other participants reported not engaging in physical activity due to personal disinterest or because they believed that the practice might be inappropriate during pregnancy:

I don't do any physical activity, I don't like it, I think you can't do it during pregnancy. (G2)

Before pregnancy I did a lot of functional training, functional training that uses body weight, but now that I'm pregnant I don't know if I can continue. (G16)

Others reported believing that physical activity would be contraindicated during pregnancy:

I don't do any physical activity, I don't like it, I think you can't do it during pregnancy. (PW2)

Before pregnancy I did a lot of functional training, functional training that uses your own body weight, but now that I'm pregnant I don't know if I can continue. (PW16)

Some pregnant women did not engage in any physical activity for various reasons:

I can't do anything, I feel pain in my legs, back, arms, I feel pain everywhere. (PW6)

Even though I'm taking care of my diet, I'm lacking exercise. In my first pregnancy I didn't have any of this because I went for walks, but I already had a much better level of physical fitness. (PW10)

On the other hand, some pregnant women recognized the importance of physical activity and engaged in adapted practices:

I walk a lot during the week, there are some days when I slip up, but I try to keep up the routine. (PW7)

During the week I go for a walk in the morning, and three times a week I do water aerobics. (PW15)

Oh, we live in the countryside. Just a walk, because walking is good. (PW12)

I used to go to the gym, but I stopped. Now I like to dance. (PW3)

Regarding leisure activities, most pregnant women reported not having any systematized practices, limiting themselves to sporadic activities, such as:

I like listening to music at home. (PW8)

I like going outdoors, I like going to the Skatepark. (PW13)

I like going to the playground. (PW17)

So, I like going out to a relative's or friend's house. (PW7)

Some women did not associate leisure time with self-care, as they were immersed in household chores and childcare:

I'm a housewife, I always have something to do. (PW2)

I spend most of my time taking care of the children and the house. (PW9)

The housewife's routine is heavy, we never stop, always taking care of the house or taking care of the children. (PW4)

It is therefore observed that there is a contrast between the desire for moments of well-being and the daily demands of domestic life, which often limit the time and physical availability for broader self-care practices.

Developmental self-care deficits: the implications of gestational obesity

The category "Developmental self-care deficits: the implications of gestational obesity" was constructed from a grouping of reports that expressed limited understanding of the risks of excess weight during pregnancy, perception of the impacts on maternal and fetal health, concerns related to weight gain, experiences of guidance received during prenatal care, and difficulties in recognizing complications associated with gestational obesity, themes originating from eight codes.

Although the topic of excess weight is frequently addressed by health professionals during prenatal care, the testimonies revealed different levels of understanding among pregnant women regarding the risks associated with gestational obesity. Reports emerged related to limited knowledge about possible maternal and fetal complications, concern about weight gain, and guidance received during prenatal care:

I think it's a little dangerous for the baby's development. It can cause several complications. (PW1)

Which is not good. It's bad for both us and the baby. (PW2)

It says it can even cause illness, right? That's the basics I know. (PW16)

I don't have much of an idea about that. I can't explain it. (PW6)

It can aggravate health problems, such as hypertension and diabetes. (PW5)

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I'm very sad to be at this weight, at this stage of pregnancy that I'm in now, I know it's not good for me or for the baby. (PW13)

When questioned about weight gain, some expressed subjective concerns:

My weight is very high; I gained a lot of weight. (PW2)

Ah, my weight, I think it's good, right? But I should lose some weight. I feel a little more obese, chubby. (PW8)

[...] 13, 15... I think up to 20 kilos. I think that's what I gained. (PW1)

I think it's terrible, because I'm 21 years old, I weigh 94 kilos. (PW12)

So, from what I saw on social media, they said that you can gain up to 12 kilos during pregnancy. (PW11)

Regarding the guidance received during prenatal care about the risk of excess weight, there was variation in the responses. The majority (nine pregnant women) reported not having received specific guidance; the others (eight pregnant women) stated that they had received it:

The doctor saw me and talked to me at length about obesity. (PW5)

Yes, the nurse. (PW3)

No, I didn't receive it. (PW12)

The steatments presented reveal different levels of understanding regarding the repercussions of excess weight during pregnancy. While some participants recognized risks such as hypertension and gestational diabetes, others demonstrated superficial knowledge or difficulty in identifying possible complications, in addition to reporting a lack of or insufficient guidance received during prenatal care. These findings reveal a heterogeneous perception of the impacts of excess weight on maternal and fetal health.

DISCUSSION

Pregnancy is a complex period in a woman's life, involving physical, emotional, and social transformations, generating doubts and uncertainties that demand qualified guidance for self-care[16]. This study highlighted difficulties and challenges in the development of self-care practices among overweight pregnant women, revealing cultural, institutional, and individual factors that limit the adequate management of obesity during pregnancy.

Universal self-care deficits related to nutrition are implicit in cultural and social aspects that contribute to inadequate dietary routines, food insecurity, lack of information and knowledge, and easy access to ultra-processed, sugary, and fatty products. Inadequate dietary routines during pregnancy reflect the importance of awareness about a balanced diet and self-care, which are fundamental aspects for promoting a healthy pregnancy.

Studies show that low levels of health literacy during pregnancy are associated with inadequate health behaviors, less involvement in preventive care, and non-adherence to medical recommendations, which can negatively impact maternal and neonatal outcomes. In other words, women with little health education are more likely to exhibit unhealthy behaviors during pregnancy, such as poor nutritional quality, weight gain, and less adherence to prenatal care guidelines[17–19].

In the context of pregnancy, dietary routines are a universal need, fundamental for meeting the nutritional demands of both mother and baby, thus preventing obstetric complications and promoting healthy development. Therefore, understanding the dietary practices adopted by overweight pregnant women allows for the identification of deficits in meeting these basic needs and guides targeted educational interventions.

Inadequate dietary routines, with high consumption of ultra-processed, sugary, and high-fat foods, were recurrent among the participants. Scientific evidence demonstrates that this dietary pattern is associated with an increased risk of adverse outcomes, such as gestational diabetes mellitus, hypertension, premature birth, and macrosomia[20-22]. This dietary pattern reflects the influence of socioeconomic and cultural factors, as well as easy access to low-cost, high-calorie processed foods[23,24]. Inadequate consumption during pregnancy compromises not only maternal health but also fetal development, making early encouragement of healthy eating practices essential[25,26].

Nutrition encompasses not only the foods themselves, which provide essential nutrients for the body, but also how these foods are combined, prepared, and consumed. Furthermore, nutrition involves cultural and social aspects, reflecting the specific dietary practices of a community or group[23]. Dietary intake during pregnancy is crucial for promoting the neurodevelopment of the child, highlighting the importance of maintaining a healthy lifestyle even before the start of gestation[26].

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Orem's theory[9] posits that self-care is a learned behavior, dependent on knowledge, skills, and motivation. However, pregnant women frequently demonstrated informational weaknesses and difficulties in understanding the risks associated with excess weight and inadequate nutrition, as well as reporting insufficient guidance during prenatal care. These findings suggest challenges in the health education process during pregnancy monitoring and corroborate studies that identify similar difficulties in communicating information related to weight control and the adoption of healthy habits during pregnancy[27].

Professional support is essential for self-care, particularly regarding the importance of nutrition during pregnancy. This type of support can help pregnant women overcome barriers and commit to changes in their eating habits. Raising awareness among pregnant women about the importance of a balanced diet and providing nutritional education strategies and emotional support are fundamental steps in strengthening their role as caregivers of themselves. In this way, it is possible to promote maternal-fetal well-being, aligning appropriate dietary practices with the principles of self-care proposed by Orem[9].

Gaps in professional support have favored the search for information from informal sources, such as family, friends, and social networks, which do not always provide well-founded and reliable content[28]. This becomes even more evident when we associate it with Orem's Self-Care Deficit Theory, regarding the need to strengthen the support-education system in PHC. One of the nurse's roles is to act as a facilitator of care, empowering pregnant women to make conscious and autonomous decisions about their health and that of their child[9,29], contributing to health literacy, since when women know the risks and benefits they can consciously decide on their actions.

Physical activity and leisure are also part of universal self-care requirements, as they contribute to pregnant women's physical and emotional well-being. However, during pregnancy, aspects such as misconceptions, insecurity, lack of guidance, and an overload of domestic activities can hinder the regular practice of exercise and the enjoyment of leisure and rest time; these are some of the difficulties reported by pregnant women. Many suspended their exercise routines upon becoming pregnant, mainly due to fear and insecurity about possible risks to the pregnancy, demonstrating a lack of knowledge about the benefits already well established in the literature[30,31]. It is important to emphasize that adapted physical activity is safe and promotes metabolic, psychological, and obstetric benefits, including better glycemic control, reduction of gestational hypertension, prevention of excessive weight gain, and a decrease in neonatal complications[32–35].

This concern is understandable, but it may be the result of a lack of clear and reliable information about the benefits and limitations of exercise during this period and points to the need for specific professional guidance, which implies the educational and supportive role of nursing professionals, aiming to promote safe and adapted practices that favor women's well-being.

On the other hand, physical factors, such as pain and discomfort, and emotional factors, such as fear and anxiety, also hinder adherence to exercise practices[32,35]. Such barriers indicate the need for individualized programs, conducted by interdisciplinary teams, that consider the particularities of each pregnant woman and promote continuous, supportive and clarifying guidance[36,37].

Some pregnant women recognize the benefits of physical activity for a healthy pregnancy and mention walking, water aerobics, and dancing, reflecting the understanding that movement can contribute to physical and emotional well-being during pregnancy. Lifestyle also plays a key role in exercise. In this sense, Orem highlights as a central focus the support for the individual in carrying out and managing self-care[9].

Regarding leisure and rest, participants described an overloaded routine of domestic chores, childcare, and work, leaving little time or energy for self-care and emotional well-being. This scenario exacerbates the risk of stress, exhaustion, and negative impacts on both maternal and fetal health[32-34]. Recognizing and valuing the invisible work performed by these women, through public policies of social support, strengthening community networks, and redistribution of family responsibilities, is a necessary strategy to expand opportunities for self-care[28].

This reality highlights the importance of creating spaces and opportunities that allow women to better balance their responsibilities and self-care. This can include community initiatives for leisure and well-being, support networks that facilitate the division of household chores, and, above all, greater social recognition of domestic and care work. Recognizing these needs and promoting inclusive solutions is essential to improving the quality of life and well-being of these women.

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The lack of understanding, information, or adequate follow-up regarding the risks of excess weight during pregnancy was recurrent among study participants. This highlights self-care deficits related to addressing needs arising from specific events or health conditions that require adaptations on the part of pregnant women. Despite robust scientific evidence on the deleterious effects of pre-gestational and gestational obesity, such as increased risk of pre-eclampsia, GDM, cesarean sections, postpartum hemorrhage, and neonatal complications[3,4,8], pregnant women are still found with uncontrolled weight gain. Therefore, careful monitoring of weight gain during prenatal care, combined with individualized educational interventions, is fundamental to preventing adverse outcomes[24,43]. These factors reflect the self-care deficits found in the women in the study, including difficulty understanding the potential implications of excess weight during pregnancy.

Thus, the operationalization of Orem's support-education system in PHC requires professionals skilled in identifying self-care deficits and intervening through ongoing educational approaches[9]. In this respect, digital patient education tools, which vary in educational strategies such as text, videos, and social media platforms, are widely accepted, facilitate knowledge, and can positively influence health behaviors[23].

Health education groups, extended nursing consultation times, culturally adapted educational materials, and the use of remote support technologies can be valuable strategies for promoting the empowerment of pregnant women[29].

Furthermore, it is essential that healthcare professionals combine science and empathy, fostering bonding, support, and safety in their relationship with pregnant women, in order to reduce anxiety, strengthen self-confidence, and promote sustainable healthy practices aligned with the principles of self-care theory[27,28].

The self-care deficits presented by the women in the study highlight the importance of nursing care, making it indispensable when a person is unable to care for themselves, either due to physical disability or lack of specific knowledge. It is assumed that people can develop the capacity for self-care, with nursing professionals playing a fundamental role as educators and managers of this process, especially in situations of disability or when significant doubts arise about how to proceed.

In this context, the findings of this study also directly relate to the 2030 Agenda SDGs, especially SDG 3 (Good Health and Well-being), by highlighting the need for effective health promotion actions during pregnancy, and SDG 5 (Gender Equality), by emphasizing the overload of responsibilities that impacts women's self-care. Furthermore, strengthening the support-education system in PHC, as proposed by Orem's Theory, aligns with SDG 4 (Quality Education), insofar as it promotes health literacy and empowers pregnant women to make informed decisions about their well-being and that of their child. Therefore, understanding and addressing the self-care deficits identified in this study is an essential strategy to reduce inequalities (SDG 10) and promote comprehensive, equitable, and sustainable care for overweight pregnant women[12].

Study limitations

The study was limited by its restricted geographic scope, as it was conducted in only one health unit, which limits the generalizability of results, as well as by a sample of pregnant women with obesity. Another aspect that may limit the generalizability of the inferences presented is that only women in the first trimester of pregnancy were interviewed.

FINAL CONSIDERATIONS

The knowledge of overweight pregnant women regarding self-care practices is limited and needs reinforcement from healthcare professionals and Brazilian public policies. During pregnancy, an approach focused on self-care can be a way to empower women to understand their own bodies and the gestational process, clarifying doubts regarding proper nutrition, physical activity, rest, and leisure, highlighting gaps that can be filled with appropriate guidance from healthcare professionals, especially nurses.

The importance of nurses' role in PHC is highlighted. By developing effective strategies that involve women in self-care, with a focus on health literacy, nurses truly play a central role as educators, encouraging, guiding, and empowering women to adopt self-care practices during pregnancy. This study reinforces the importance of using solid theoretical frameworks, such as Orem's Theory, in the field of nursing, as it allows for the search for scientific evidence to support the actions and care strategies developed in professional practice, promoting autonomy, empowerment, and safety for pregnant women and their babies.

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In terms of nursing practice, findings of this study reinforce the need to strengthen support-education actions aimed at overweight pregnant women in Primary Health Care. Strategies that promote health literacy, promote autonomy and support the adoption of self-care practices can contribute to addressing identified deficits and qualifying prenatal care. Furthermore, the results point to the importance of developing educational interventions adapted to the sociocultural context of pregnant women and carrying out new studies that evaluate innovative strategies for promoting self-care during pregnancy.

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Use of artificial intelligence tools

Authors declare that no artificial intelligence tools were used in the composition of the manuscript *Sobrepeso y autocuidado gestacional en Atención Primaria: un análisis cualitativo según Orem*".