

# Best Practice Principles for Weight-inclusive Maternity Care: Outcomes of a national consensus process

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various

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## Research Article

**Keywords:** Weight Stigma, Weight prejudice, Preconception, Antenatal care, Birth, Postnatal care, Obesity maternal, participatory research, consumer involvement.

**Posted Date:** October 5th, 2026

**DOI:** <https://doi.org/10.21203/rs.3.rs-11214189/v1>

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**Additional Declarations:** The authors declare no competing interests.

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# Abstract

**Objective:** To co-create nationally agreed Best Practice Principles for Weight-inclusive Maternity Care in Australia.

**Design:** A multi-stage consensus study using a modified Delphi process and Nominal Group Technique. Candidate principles were generated from prior qualitative research with women with lived experience of weight stigma, interviews with maternity care providers, and relevant literature. These principles were ranked and shortlisted through two national surveys, followed by a face-to-face national consensus workshop. Peak interest-holder organisations were subsequently invited to provide feedback and formally endorse the final principles.

**Setting:** Australia.

**Participants:** Women with recent lived experience of weight stigma in maternity care, maternity care providers across disciplines, and representatives of maternity consumer, medical, and midwifery organisations. Consumers and clinicians contributed equally throughout the process.

**Results:** Five Best Practice Principles for Weight-inclusive Maternity Care were agreed and endorsed by interest-holder organisations. These focus on acknowledging the impact of weight stigma in maternity care; educating the maternity workforce about weight stigma and weight-inclusive practice; appropriately resourcing services to provide weight-inclusive care; partnering with women with lived experience in the development of policies, guidelines and service directives; and providing respectful, woman-centred, trauma-informed, and strengths- and evidence-based care. Consensus was readily achieved on principles addressing respect, communication and partnership, while more contested issues highlighted the need for individualised assessment and adequate resourcing rather than categorical exclusions based on weight or body mass index.

**Conclusions:** These nationally endorsed Best Practice Principles provide a shared, evidence-informed, and consumer-led framework to guide maternity care practice, education, and policy. By explicitly addressing weight stigma and moving beyond weight-centric approaches, the Principles offer an essential foundation for improving maternity care experiences and supporting respectful, individualised care for women with larger bodies.

## Summary

**The known:** Almost half of all Australian women accessing maternity care have larger bodies. They report regular experiences of discrimination and weight stigma during healthcare interactions.

**The new:** Through an iterative multi-stage consensus building process, five Best Practice Principles for Weight-inclusive Maternity Care were developed, agreed on, and endorsed by peak consumer, medical and midwifery interest-holder organisations.

**The implications:** With implementation, these Best Practice Principles outline a clear approach to addressing weight stigma in maternity care.

## Introduction

Approximately half of all Australian women of reproductive age live in larger bodies[1, 2] and are at increased risk of poorer maternal and neonatal outcomes. Limited improvements have been made in this space over the past two decades. To date, most research has focused on nutrition and physical activity interventions before and during pregnancy, leading to short-term changes in health behaviours and very modest differences in gestational weight gain; any impact on clinical outcomes remains questionable.[3, 4] Despite questions over the modifiability of gestational weight gain and its causal contribution to perinatal outcomes,[5] this focus has contributed to an increasingly weight-centric orientation in contemporary maternity care. Weight-centric approaches position body weight as a primary determinant of health, emphasising individual control over, and responsibility for, achieving and maintaining a “healthy weight.”[6]

Weight-centric care has also been linked with weight stigma,[7] a widespread form of social stigma characterised by pervasive bias, discrimination, stereotyping, and social exclusion when body weight deviates from social norms, with thinness typically idealised.[8] Weight stigma has been widely reported in maternity care, both in women's experiences[1, 9, 10] and clinician attitudes.[11-14] This stigma contributes to psychosocial harms for women, as well as disengagement from health services, delays in seeking care, and mistrust of healthcare providers.[15, 16] Weight stigma also diminishes the quality of maternity care, with less antenatal consultation time devoted to rapport building and inquiries about health behaviours,[17] and women afforded less involvement in decision making,[18] and less access to respectful maternity care.[19] Weight stigma has also been linked to behaviours that do not improve health, such as binge eating and exercise avoidance.[20, 21]

By contrast, weight-inclusive approaches hold that “everybody is capable of achieving health and wellbeing independent of weight, given access to non-stigmatising healthcare.”[6] Such approaches have delivered improvements in physical and mental health outcomes in the general adult population, through models such as Health at Every Size.[22] However, approaches that support the delivery of weight-inclusive maternity care have not been developed or agreed by interest-holders. The aim of this study was to address this gap, by working with women and maternity care providers to co-create Best Practice Principles for Weight-inclusive Maternity Care.

Best practice principles and consensus statements have been used internationally to advance respectful, person-centred, and trauma-informed maternity care,[23] and are particularly useful where clinical complexity and value-laden decisions limit the feasibility of directive guidelines.[24, 25] In such contexts, principles act as a normative framework, shaping professional culture, service design, and quality improvement rather than specifying procedural thresholds.

## Methods

### Study Design

This study is the culmination of a larger program of research, *From Preconception to breastfeeding: Co-creating weight-inclusive care with women and maternity care providers* (RADIANT). RADIANT is a consumer-led study, with six Lived Experience Experts (LEE) collaborating in all stages of the research process. Here, a modified Delphi process and Nominal Group Technique were used,[26] across four stages: (1) identifying candidate Best Practice Principles for Weight-inclusive Maternity Care (hereafter, BPP); (2) ranking and shortlisting surveys; (3) national consensus workshop, and (4) interest-holder engagement, minor modifications, and endorsement.

### Participants

People were eligible to participate in each stage of the study where they were able to read and respond to study activities presented in English, were at least 18 years of age, and:

- Had experienced weight stigma in their maternity care within the last 3 years, in Australia, *and/or*
- Were currently providing maternity care in Australia, *and/or*
- Were taking part as the endorsed representative of a:
  - maternity consumer organisation;
  - medical, midwifery or allied health professional college or society;
  - an industry or policy making organisation.

## Data collection and analysis

### Stage 1: Candidate BPP

From our earlier qualitative work with women with lived experience of weight stigma in maternity care,[7] interviews with maternity care providers who have adopted weight-inclusive approaches,[27] other existing anti-stigma programs,[22] and weight

stigma literature,[10, 28-30] we identified 71 candidate BPP (see Supplementary Table 1).

## **Stage 2: Ranking and shortlisting**

Two online surveys were conducted, via Qualtrics, to rank, refine and shortlist the 71 candidate BPP. All survey data was extracted into SPSS and analysed using descriptive statistics. All data were stored in the University of Queensland's secure Research Data Management system.

The Stage 1 survey collected demographic information and asked participants to rank each candidate BPP on a Likert scale (essential, important, somewhat important, not important at all; with the additional option of 'I don't agree with this as a principle'). For each principle, there was also a free text question to elicit feedback on the principle or its wording. Information about the study was sent to participants in our earlier qualitative studies, via paid social media adverts, and via email to the professional networks of the research team and to interest-holder organisations (see Table 1). Snowballing was also used. Completion of the survey was taken as consent to participate. The first 200 participants were offered a \$10 gift card as thanks for completing the survey.

[INSERT TABLE 1 ABOUT HERE]

The results of the Stage 1 survey were used to shortlist and refine the candidate BPP. Criteria to retain or exclude candidate BPP after the Stage 1 survey were prespecified,[31] as per Table 2.

[INSERT TABLE 2 ABOUT HERE]

A shortlist of 37 candidate BPP were then included in the Stage 2 survey, which asked participants to select and rank their top ten BPP. Information about the Stage 2 survey was sent to participants in our earlier qualitative studies and the Stage 1 survey, as well as to peak interest-holder organisations (see Table 2). Again, snowballing was also used, \$10 gift cards were offered as thanks, and completion of the survey was taken as consent to participate.

The results of the Stage 2 survey were used to identify the top 20 principles with the most support for discussion at the National Consensus Workshop. The mean ranking of each BPP was calculated from both consumer responses and maternity care provider responses.

## **Stage 3: RADIANT National Consensus Workshop**

In the Stage 1 and Stage 2 surveys, participants had the option to express interest in attending the RADIANT National Consensus Workshop in Brisbane on March 24, 2025. Each interest-holder organisation also endorsed a representative to attend the workshop on their behalf. The full-day workshop began with a presentation (by BJ and AG) of the findings of earlier qualitative studies, and the first two surveys. Other presentations were interspersed throughout the day, including a lived experience account of weight stigma in maternity care (TS), overviews of the evidence on weight, weight change, and health, including in pregnancy (LC, JD), and weight stigma (BH). Participants also engaged in two rounds of small group discussion, facilitated by a RADIANT investigator, to agree on the ranking of candidate BPP. Groups discussions were aided by index cards that reported each BPP and its ranking amongst both consumer and clinician participants in the Stage 2 survey (see example in Figure 1). Groups were pre-specified to ensure the intended participant mix (people with lived experience, medical doctors, midwives, and allied health professionals) and maximise co-mingling in each round.

After each round, the rankings agreed upon by each small group were entered into a data collection spreadsheet, and the mean ranking of each candidate BPP was reported back to the whole group to guide further discussions.

Following the second ranking activity, a reflective large group discussion was facilitated (by BJ and AG) to clarify the emerging consensus, clustering and wording of the BPP. The agreed BPP were finalised based on this discussion, and circulated by email to all workshop participants in the days after the workshop for final agreement.

[INSERT FIGURE 1 ABOUT HERE]

All workshop participants were provided travel funding. Local participants were offered reimbursement of reasonable mileage; others received airfares and overnight accommodation. Consumers who attended the workshop in a voluntary capacity also received an honorarium, aligned with Health Consumers Queensland guidance,[32] to acknowledge their time and contribution.

**Stage 4: Interest-holder engagement, minor modifications, and endorsement.**

Following the National Consensus Workshop, each represented interest-holder organisation was provided with the agreed BPP and formally invited to endorse (and agree to co-badge) them. Interest-holder organisations were also offered a brief presentation about the consensus process (from LC, BJ and AG) to support their deliberations. Minor feedback from interest-holder organisations regarding phrasing of BPP was also considered.

**Ethical approval**

This study received approval from the Human Research Ethics Committee at the University of Queensland (2023/HE002433).

**Results**

The Stage 1 survey received 244 responses from people with lived experience and maternity care providers (see Table 3, with detailed results from the Stage 1 surveys included in Supplementary Table 1). Of the 71 candidate BPP at Stage 1, 37 met our inclusion criteria and were retained for the Stage 2 survey. A further 126 responses were received to the Stage 2 survey, and the top 20 BPP were discussed at the National Consensus Workshop (detailed results of Survey 2 are included in Supplementary Table 2). Amongst the Top 20 BPP prioritised by consumers and maternity care professionals, 15 were common to both groups.

[INSERT TABLE 3 ABOUT HERE]

The National Consensus Workshop was attended by 54 delegates (see Table 3). During the workshop, delegates agreed on and defined five themes to organise the BPP: Acknowledge; Educate; Resource; Partner, and Care, see Figure 2 (see also Supplementary Material).

During the endorsement process, interest-holder organisations provided feedback which led to some minor editorial changes. These changes were made to address concerns around inclusive language and workforce safety. The agreed Best Practice Principles for Weight-inclusive Maternity Care have now been endorsed by consumer, medical, and midwifery organisations nationally (see Supplementary material).

[INSERT FIGURE 2 ABOUT HERE]

**Discussion**

Through a robust co-design and consensus building process, we achieved our aim of co-creating nationally agreed Best Practice Principles for Weight-inclusive Maternity Care. The close involvement of women with lived experience of weight stigma alongside clinicians and endorsed representatives of peak interest-holder organisations was an essential component of our process. It supported the relevance, legitimacy, and acceptability of the resulting principles, and facilitated subsequent endorsement by peak interest-holder organisations. To the best of our knowledge, ours is the first national co-designed and consensus-based effort to address weight stigma in maternity care.

Rather than producing prescriptive clinical rules, the consensus process generated principles capable of guiding education, policy, and service reform while allowing for contextual adaptation and clinical judgement. Where causal relationships are uncertain and ethical implications are significant, consensus methods such as the Delphi and Nominal Group techniques used in this study offer a rigorous approach to integrating multiple forms of knowledge.[26] This is particularly relevant in the context of limited evidence of intervention effectiveness and ongoing uncertainty and debate about the causal relationships that underpin routine practice in the care of larger-bodied women.[4, 5]

In our study, consensus was readily achieved on principles addressing acknowledgement of weight stigma, education and reflective practice for clinicians, respectful and trauma-informed care, and meaningful partnership with larger-bodied women. These areas align closely with prior qualitative research in which women describe valuing care that recognises them as whole people rather than defining them primarily by body size,[7] and with clinicians' expressed need for clearer guidance on providing non-stigmatising maternity care.[27]

More contested discussions emerged where weight-inclusive care intersected with potential clinical risk or service constraints, including access to water immersion during labour and birth or the feasibility of giving birth closer to home in smaller or rural units. These debates reflect longstanding tensions between risk management, workforce confidence, and resourcing, and are reinforced by the routine use of body size as a proxy for safety.[12, 13] The final BPP intentionally avoid categorical decisions based on weight. Instead, they emphasise individualised assessment, shared decision-making and adequate resourcing. This approach acknowledges legitimate safety concerns while resisting the conflation of body size with pathology.

Over the last two decades in Australia, maternity care has increasingly focused on weight, with an emphasis on BMI informing policy direction and content.[33] While clinical guidelines [34] are available for the maternity care of women with larger bodies, none of them address healthcare practices that support weight-inclusive care or adequately acknowledge the role weight stigma may play. Indeed, guidelines and policies often implicitly condone weight stigma through language choice, the pathologisation of larger bodies and the perpetuation of the myth of individualised responsibility for weight gain.[33] Despite longstanding recognition of inequities in maternal and neonatal outcomes for women with larger bodies, progress in improving maternity care experiences and outcomes has been limited.[3, 4] These BPP offer a new approach that addresses growing questions about the usefulness of current weight-centric approaches.[4, 5, 11]

Importantly, trials and systematic reviews of nutrition and physical activity interventions during pregnancy have concentrated predominantly on biomedical endpoints,[3] with limited attention to potential unintended harms, including experiences of stigma, shame, disordered eating, mood disturbance or negative impacts on body image. Weight stigma is well established as a determinant of poorer health outcomes,[16] and women consistently report weight-centric maternity care as undermining trust, safety and engagement with services.[7, 10, 35] In the context of sustained focus on weight-centric interventions and guidelines, without corresponding improvements in outcomes or experience, the development of BPP that explicitly orient maternity care towards reducing weight stigma and supporting respectful, individualised care is novel, timely and necessary.

Given its harms, urgent action to address weight stigma is a key component of the National Obesity Strategy (2022-32).[36] The concerns of the National Obesity Strategy are consistent with the concerns which gave rise to this study. Weight stigma undermines the capacity of women to engage in healthy nutrition and physical activity, and adversely impacts mental health during pregnancy, possibly explaining why weight stigma is also associated with unintended gestational weight gain and postpartum weight retention.[20, 21] Our BPP directly address these concerns, and provide a maternity-specific response to the call of the National Obesity Strategy.

These BPP also respond to persistently documented concerns about weight stigma in the literature, where larger bodied women report experiences of 'shame and blame' when interacting with maternity clinicians, which results in stereotyping, medicalisation, and depersonalisation of care, leading to unacceptable maternity care experiences.[7, 10] Endorsing organisations have agreed to assist with disseminating the BPP, through promoting their inclusion in education programs, conference presentations and social media engagement. Development of educational resources to support implementation will be key, and is underway. Future research should also examine how the BPP are operationalised in practice, and whether they contribute to improved maternity experiences and outcomes for larger-bodied women.

The BPP call for maternity services and individual maternity care providers to reconsider how they define safety, not only in a clinical sense, but also psychosocially. There are important considerations regarding body size that influence the provision of maternity care, particularly in regional, rural, and primary maternity care settings. However, the BPP recognise the need for weight and body size to be considered as part of a nuanced, holistic and individualised understanding of each woman's health, history, needs, preferences and care plan. A more detailed exploration of the priorities of consumers, clinicians, and maternity services in regional and rural Australia is needed and would underpin safe implementation of the BPP in such settings.

## Strengths and limitations

A key strength of this study is the robust, multi-stage co-design methodology and the explicitly equal weighting of consumer and clinician perspectives, both in the research team and at the National Consensus Workshop (which was co-facilitated by RADIANT LEE investigators). This approach supported the development of mutual understanding across the different interest-holder groups and contributed to clearer, more inclusive input into the final BPP. The involvement of peak national consumer, medical, and midwifery interest-holder organisations, and the achievement of formal endorsement, enhances both the credibility and potential impact of the BPP. As with all consensus processes, the final principles reflect negotiated agreement rather than unanimity. It was beyond the scope of this study to evaluate implementation or clinical outcomes.

Limitations include reliance on English-language participation, minimal representation of some groups (including First Nations, and culturally and linguistically diverse communities) and a lack of representation of gender-diverse birthing people. The intersection of weight stigma and people's diverse identities in maternity care warrants further study.

## Conclusion

These nationally endorsed Best Practice Principles for Weight-inclusive Maternity Care provide a shared framework to guide education, policy development, and service reform. Developed through a rigorous and inclusive co-design and consensus building process, grounded in both lived experience and emerging critiques of weight-centric care, these BPP represent an essential first step towards reducing weight stigma and supporting respectful, individualised maternity care for women with larger bodies.

## Declarations

## Acknowledgements

The authors sincerely thank the women with lived experience of weight stigma in maternity care, clinicians from across disciplines, and representatives of consumer, medical and midwifery organisations who participated in the consensus-building process. Their expertise, openness, and collaboration were integral to the development of these Best Practice Principles. We also acknowledge and thank these interest-holders organisations for their review and endorsement of the principles. Finally, we thank Tanya Cawthorne for her lived experience contributions in the formative stages of this study.

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## Tables

| Table 1: Interest-holder organisations formally represented in the RADIANT National Consensus Process |
|-------------------------------------------------------------------------------------------------------|
| Organisation                                                                                          |
| Australasian Diabetes in Pregnancy Society                                                            |
| Australian and New Zealand College of Anaesthetists                                                   |
| Australian Breastfeeding Association                                                                  |
| Australian College of Midwives                                                                        |
| Birth Trauma Australia                                                                                |
| Maternity Choices Australia                                                                           |
| Maternity Consumer Network                                                                            |
| Royal Australian and New Zealand College of Obstetricians and Gynaecologists                          |
| Royal Australian College of General Practitioners                                                     |
| Size Inclusive Health Australia                                                                       |
| Society of Obstetric Medicine Australia and New Zealand                                               |

**Table 2: Pre-specified criteria to shortlist and refine candidate BPP after Stage 1 Survey.**

| Inclusion criteria                                                                                                                      | Exclusion criteria                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| >70% of participants rated the BPP as very important or essential                                                                       | <ul style="list-style-type: none"> <li>&gt;15% of participants rated a candidate BPP as unimportant or did not agree with its inclusion as a principle;</li> <li>&lt;30% of participants rated a candidate BPP as essential or very important;</li> <li>&gt;1 point mean ranking difference between participant groups (people with lived experience, maternity care providers).</li> </ul> |
| Candidate BPP that fit none of these criteria were revised to make them more salient, based on responses to free-text survey responses. |                                                                                                                                                                                                                                                                                                                                                                                             |

**Table 3: Background of participants at each stage of RADIANT consensus process**

|                                                                 | Survey 1<br>(n=244) |      | Survey 2<br>(n=126) |      | Workshop<br>(n=54) |      |
|-----------------------------------------------------------------|---------------------|------|---------------------|------|--------------------|------|
| Participants                                                    | n                   | %    | n                   | %    | n                  | %    |
| People with lived experience of weight stigma in maternity care | 184                 | 75.4 | 86                  | 68.3 | 22                 | 38.6 |
| Maternity care providers <sup>#</sup>                           | 56                  | 23.0 | 36                  | 28.6 | 30                 | 52.6 |
| Midwifery                                                       | 18                  | 7.4  | 10                  | 7.9  | 8                  | 14.0 |
| Medical                                                         | 26                  | 10.7 | 16                  | 12.7 | 15                 | 26.3 |
| GPs                                                             | 9                   |      | 6                   |      | 3                  |      |
| Obstetricians                                                   | 7                   |      | 1                   |      | 6                  |      |
| Anaesthetists                                                   | 5                   |      | 6                   |      | 3                  |      |
| Obstetric physicians & endocrinologists                         | 5                   |      | 3                   |      | 3                  |      |
| Allied health                                                   | 18                  | 7.4  | 10                  | 7.9  | 7                  | 12.3 |
| Dietitians                                                      | 9                   |      | 4                   |      | 3                  |      |
| Physiotherapy                                                   | 1                   |      | 1                   |      | -                  |      |
| Lactation support                                               | 5                   |      | 2                   |      | 2                  |      |
| Childbirth education                                            | 2                   |      | 1                   |      | 1                  |      |
| Sonography                                                      | 1                   |      | 2                   |      | 1                  |      |
| Other interest-holders                                          | 4                   | 1.6  | 4                   | 3.2  | 5                  | 8.8  |

<sup>#</sup> Maternity care providers could self-identify multiple speciality/interest areas. Hence subgroupings total to more than 100%.

## Figures

**B**

Acknowledge that body weight is complex and impacted by many factors.

23 consumers (27%) put this principle in their Top 10.

18 professionals (50%) put this principle in their Top 10.

On average, consumers who put this principle in their Top 10, ranked it 3.4

On average, professionals who put this principle in their Top 10 ranked it 3.4

Overall, this principle ranked #15 amongst consumers.

Overall, this principle ranked #2 amongst professionals.

Figure 1

Example of an index card used in the ranking activities

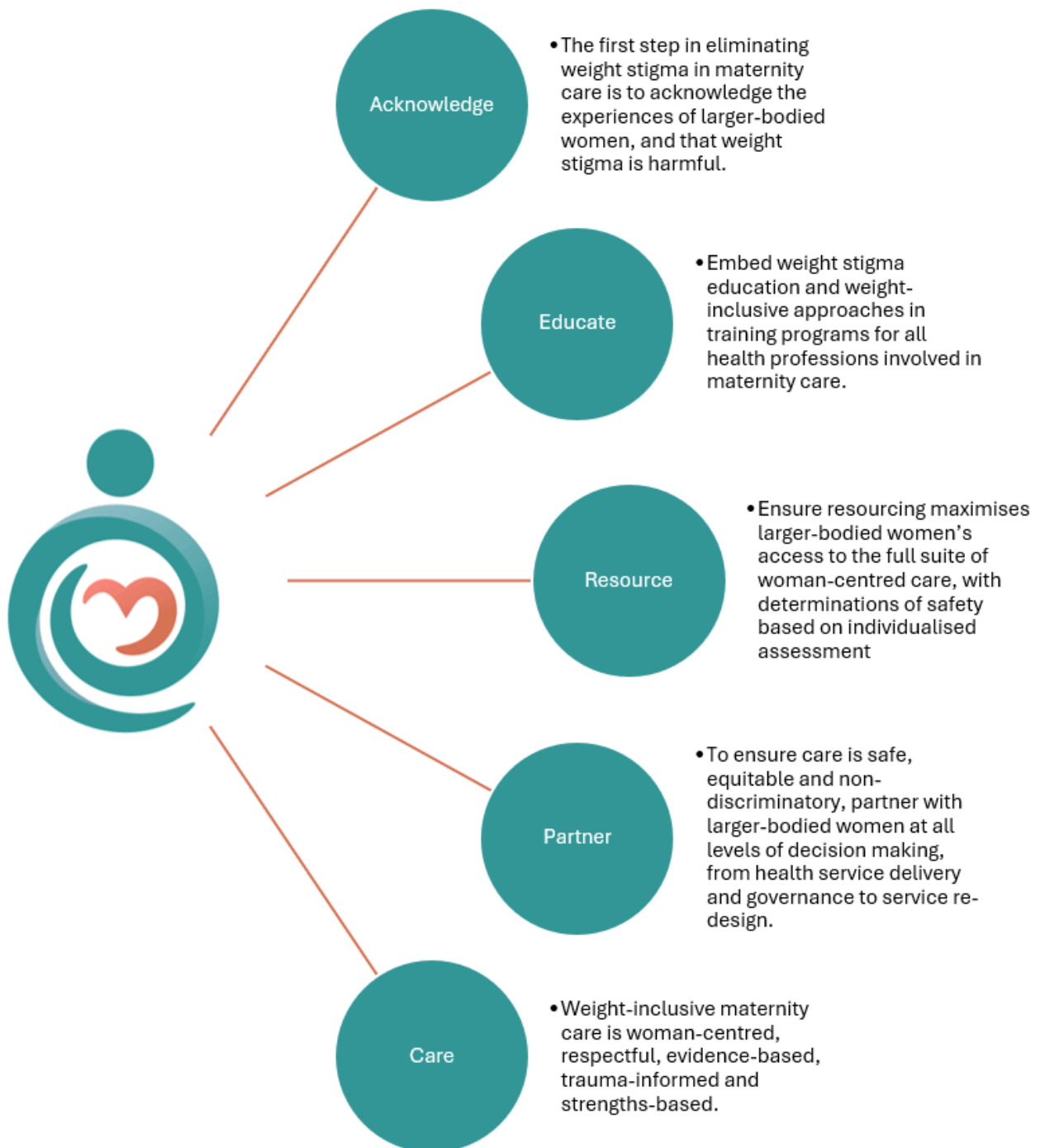


**Figure 2**

The RADIANT Best Practice Principles for Weight-inclusive Maternity Care

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [SupplementaryTable1FINAL.pdf](#)
- [SupplementaryTable2FINAL.pdf](#)
- [SupplementarymaterialRADIANTBPP.pdf](#)