

Conflictive Matrescence: A Situation-Specific Theory of the Transition to Motherhood In Women With Obesity

Javier Alonso Bula Romero

Estudiante de Doctorado en Enfermería de la Universidad de Antioquia, Docente Tiempo completo Universidad de Córdoba, Email javierbula@correo.unicordoba.edu.co

ABSTRACT

The transition to motherhood in women with obesity is a complex and challenging process for comprehensive health care, and requires rethinking the theoretical and conceptual foundations that guide the Nursing professional work. This study sought to develop a situation-specific nursing theory for the care of women with obesity in the process of transitioning to motherhood. Grounded theory was employed through the application of a constant process of interactive and integrative comparison of data obtained from the documentary review, the investigative findings, and the theoretical foundations by Im and Meleis. The results demonstrate the development of a situation-specific theory of the transition to motherhood in women with obesity, where obstetric fatphobia is proposed as a key conceptual axis to understand this phenomenon. It is concluded that the “*Conflictive matrescence*” is a situation-specific, prescriptive theory derived from multiple sources, which describes the physical, psychological or emotional and social/relational changes experienced by women who are obese and go through motherhood. The ambivalent relationship between health risk and the desire to be a mother is recorded, as well as the change in expectations and the processes of emancipation and resistance against weight stigma and fatphobia.

KEYWORDS: motherhood, obesity, transition, fatphobia.

INTRODUCTION

For many women, transitioning to motherhood is considered a complex and challenging process. During this transition, a series of internal and external factors come into play that generate challenges for the woman, the family, and the care providers (1). Adapting daily life to pregnancy represents one of the biggest challenges for women at this stage, as it involves biological, psychological, and social aspects that either favor or hinder a satisfactory transition to motherhood. However, there are particular situations where the changes experienced take on greater significance for the woman, such as the case of a pregnant woman who is obese.

There are short-, medium- and long-term implications of obesity in a pregnant woman (2), (3), (4). For instance, having a high pre-pregnancy Body Mass Index (BMI) and gaining excessive weight during pregnancy would have a negative effect on maternal outcomes (5), (6), on perinatal effects (7), on gestation, on childbirth (8), (9), and on postpartum (10), (11). Obesity during this period also has intergenerational consequences when it helps to perpetuate the obesogenic cycle in subsequent pregnancies and in their offspring (12), (13).

Similarly, the existence of elements that facilitate or hinder this process in some women is recognized; therefore, to understand the transition to motherhood it is necessary to know the nature of this transition, the critical points or turning points, the barriers and facilitators of this process, as well as the strategies used by women and those who accompany them in the care of their health (14).

The constructs of motherhood and becoming a mother have been the subject of study for decades. However, the topics discussed show interest in the impact of obesity on maternal and perinatal outcomes, and the experiences of health providers in the care and treatment of pregnant women with obesity (15), as well as in the experiences of women in health services and their interactions with care providers, specifically focused on the processes of gestation, childbirth and postpartum, but not on the transition to motherhood, revealing the need to know and understand how this process occurs (16), especially in women who are obese.

The purpose of this research was to develop a situation-specific theory (SST) linked to the transition process to motherhood in women with obesity. This not only contributes to theoretical development in the area, which is linked to the emergence of lines of investigation that strengthen the scientific development of the nursing discipline, but also promotes standards for nursing practice that allow guiding the care of women with obesity who are transitioning to motherhood.

METHODOLOGY

There is an important group of nursing theorists who have proposed a variety of methods for the development of nursing theories (33); among them are Im and Meleis (34), who propose the integrative approach as a specific method for the development of theories of specific situations from the exploration of multiple sources.

According to Im et al. (35), situation-specific theories can incorporate the integration of qualitative and quantitative paradigms. This feature allows for a comprehensive and integrated view of nursing phenomena through description, explanation, prediction, or prescription, serving as a guide for research and practice in the discipline. In nursing, each phenomenon is unique and requires a different approach, so these theories are useful for understanding specific situations that require novel proposals to address them.

This research assumed the integrative approach proposed by Im and Meleis (34) for the development of a situation-specific nursing theory linked to the care of women who present obesity in the process of transition to motherhood. The beginning of the construction of this SST was based on the recognition of the assumptions put forward by Im and Meleis for the development of theories of specific situations. As a researcher, I recognized the existence of multiple truths and the need to support the development of this SST from the integration of the findings of Grounded Theory, the review of the literature, and the theoretical derivation from the theory of transitions proposed by Meleis. These elements became the raw material for the formulation of an SST related to the transition to motherhood in women with obesity.

The integration of the findings allowed for reflection and the use of internal and external dialogues that helped to build this SST. This process was made possible through constant comparison and the permanent use of theoretical thinking that facilitated a more organized and integrated theorizing process, as Im and Meleis set out in their methodological proposal (34). In this process, conceptual schemes were used to represent the emerging theory, and in this way, to have a visual and explanatory overview of the relationship of the concepts composing it.

RESULTS AND DISCUSSION

Exploring the transition to motherhood in women with obesity through multiple sources

To understand the transition process to motherhood in women with obesity, 52 people participated; 25 of them were women who had obesity during the transition process to motherhood and 27 nursing professionals who worked in different areas of maternal and perinatal care, including primary care services and specialized maternal care services such as delivery rooms, postpartum services, and obstetric care units in different regions of Colombia. The grounded theory method was used for data analysis, resulting in the substantive theory called: transitioning to motherhood in the shadow of stigma and fatphobia.

The findings of this substantive theory describe the transition to motherhood in women with obesity as a conflictive, complex, often confusing and critical process represented by three clearly defined stages. The first stage is the conflictual matrescence that defines the nature of this transition process. Here, women who are obese must make adjustments at the physical, mental or emotional level and at the social-relational level (50). Each of these dimensions represents a significant challenge for women with this condition. One of them is being able to move forward in the process of becoming mothers in the shadow of stigma and fatphobia, elements that are transversal throughout the spectrum of their reproductive continuum (51). Faced with this situation, many women encounter an oppressive system that constantly watches and punishes them (52). It is in this context that they are forced to emancipate themselves as a political act and an act of social justice, resisting and exposing themselves to being treated only from an obesogenic and weight-centered perspective (53). These elements help them raise their voice and disclose the way they receive care. Finally, after overcoming these first two stages, women who are obese can find the balance that allows them to make this transition to motherhood despite the circumstances and adversities faced.

For their part, nursing professionals are aware of this transition, but their approach to it is completely different from what women expect when they are cared for. The way care is provided to these women is framed within a particular deterministic vision, where the woman is reduced to an obese body that is considered threatening and which must be intervened upon. They consistently focus their attention on obstetric and perinatal complications (54), postponing the women's needs, because their priority is to avoid any adverse outcome for the mother and her unborn child, crossing that thin line that separates care from the woman's real needs, such as blaming her for maternal and perinatal results (55). The presence of prejudices or conscious or unconscious discrimination on the part of nursing professionals legitimizes fatphobia as a type of violence and oppression for women who are obese (56).

Care in the transition process to motherhood can be difficult for both women and nursing professionals and is recognized as a conflictive matrescence, which occurs in the shadow of stigma and fatphobia (57). Women who are obese during their transition to motherhood are viewed in terms of a threatening body and are considered "an imminent risk" that must be addressed before fatal complications occur for them and their unborn child; a situation that makes women feel uncared for, or not cared for, as they would really like (58).

This process occurs in multiple dimensions of the woman; the first dimension linked to this is the conflictive matrescence assumed as an ontological dimension; inhabiting a body that presents obesity places the woman at a disadvantage in relation to care, because she is

valued in terms of the risk and size of her body (58). Besides being a woman, she is obese and pregnant. The elements of being a woman, a woman in pregnancy, childbirth or postpartum, and being obese show the vulnerability to which they are exposed (59).

Another dimension linked to conflictive matrescence is the relational dimension, where the processes of interrelation with nursing professionals converge, generally laden with negative interactions, perceived by the women that are related to stigma (60), prejudices, stereotypes (61) and discrimination (62). It could be said that there are more negative than positive elements that direct the flow of interactions occurring between nursing professionals and women who are obese and transitioning to motherhood.

Nursing practice and the ethos of care are two core dimensions in the care of women with obesity during their transition to motherhood, dimensions that are visibly compromised. On the one hand, nursing practice shows the challenges that nurses face in the practice of care, challenges not only in structural terms such as having equipment and elements to provide safe care, such as the use of bariatric stretchers, and biomedical equipment, but also those related to direct care such as mobilization, the management of obstetric and perinatal complications, comfort, among others (63). Nursing professionals are expected to engage in reflective practice regarding issues involving the care of women with obesity during their transition to motherhood, as well as other significant aspects of the environment of women with this condition. Likewise, the ethos of care is found to be a transcendental element in the transitional care of women with obesity, a situation that becomes a paradigmatic issue, since it invites nursing professionals to review and reflect on how they are providing care to this group of women.

In this line of thought, there is the contextual dimension, since these processes cannot be seen in isolation. The process of transition to motherhood in women with obesity, as well as nursing care in this transition process, are situated within a specific sociopolitical context, which shows the reality of a specific population, with a specific health situation. The closest context for women transitioning to motherhood while experiencing obesity is the institutional context, the space where interactions with care providers occur. This is one of the spaces where conditions converge that can facilitate or hinder the transition to motherhood. Institutional policies play a fundamental role in creating safe ecosystems free from prejudice and discrimination for women with obesity, regardless of whether they are pregnant or not.

LITERATURE REVIEW

The literature review showed a set of facilitators of the transition process to motherhood in women with obesity, such as: having a partner committed to the woman during the transition process to motherhood (64) and family support (65).

The findings from qualitative studies describe negative interactions between women with obesity and care providers (66); many of these women report feeling judged (67) and stigmatized (68), which made the transition to motherhood conflictive for them. Challenging the stigma of obesity is a struggle they have to face in health services, as they are constantly singled out for their weight, a situation that leads them to live a complex, contradictory process opposite to what they expected to experience during the transition to motherhood, where women with this condition constantly express the desire to be understood and treated with respect (69), (70).

The nature of the transition to motherhood in women with obesity is situational and developmental, with a multiple, simultaneous, and related pattern that cannot be predicted. In this process, women who transition to motherhood while obese face many challenges, including the stigma surrounding obese female bodies that decide to become mothers and implicit or explicit fatphobia from care providers (71).

Scientific evidence has also identified barriers in the transition process to motherhood such as: unwanted or unplanned pregnancies (72), absence of the baby's father (73), lack of family support (74), sociocultural influences regarding food (75) and physical activity during pregnancy (76), and lack of knowledge and preparation to make this transition (77). Qualitative evidence also shows that identifying as a mother and adopting the maternal role, as well as having self-confidence and feeling competent to be a mother, are considered response patterns of the transition process to motherhood in women with obesity (78); similar to other response patterns of the transition to motherhood of other women, the difference with women with obesity lies in the way in which the meanings given by women to this process are understood (79). It could be said, then, that the condition of obesity requires space for the care needs and the transition approach to motherhood in women who present this condition to be different.

The findings of this review show how the transition to motherhood in women with obesity is also provided with a series of observable process and outcome indicators that allow us to assess whether this transition has been successful or not; among them we can mention the following: when the mother shows confidence in mothering (80), recognizes her new role, demonstrates competence in the care of her newborn, is secure, has self-confidence, gradually acquires skills and abilities for the care of her baby (81), feels satisfaction for it, recognizes the behavior of her newborn child and learns to identify his needs (82), makes adjustments at a physical, emotional and social level according to her maternal role and experiences a process of growth and transformation, it can be said that the woman has made a healthy or successful transition to motherhood (83).

The literature also points to outcome indicators that show when the transition process to motherhood is not successful, but difficult, among which the following were identified: the difficulty women have in seeing themselves as mothers, the lack of self-confidence (84), not knowing what to do or feeling overwhelmed, and not having clarity in her roles (85). These indicators allow nursing professionals to use their care interventions so that women who are experiencing a difficult transition or have not been able to successfully complete this process can achieve it.

THEORETICAL DERIVATION

From a conceptual standpoint, this situation-specific theory uses some central concepts from Meleis's theory of transitions, contextualized to the phenomenon under study, notably:

Nature of the transition

The pattern the transition obeys, which is characterized by being multiple and related, that is, it is most common for each person to experience multiple related transitions at the same time (86). The nature of the transition to motherhood for this research corresponds to a conflictive matrescence. This transition has a multiple, simultaneous, and related pattern. In this process, women experience individual critical moments; these are considered turning points in the construction of their maternal identity, moments that contain many meanings for them and lead them to re-evaluate their experience as women and as mothers.

Each woman transitions to motherhood at a unique pace, and there is no common timeframe for all women to experience this process; understanding the timing allows us to grasp why there are differences in the transition to motherhood.

Transition conditions

They are recognized as those circumstances that influence a person's movement towards a transition. They can be facilitators or inhibitors and include meanings, beliefs, cultural attitudes, socioeconomic status, preparation, and knowledge (87). Understanding the facilitators and inhibitors of the transition to motherhood in women with obesity is a useful indicator for identifying the transitional care therapies that nursing can provide to facilitate progression towards a healthy transition to motherhood.

Facilitators of the transition to motherhood in women with obesity include acceptance of pregnancy, self-concept and perception of their body and the gestation process (88), the presence of the baby's father or partner (89), family support (90), positive interactions, genuine and respectful relationships with care providers (91), and being in a compassionate care environment free from prejudice and discrimination (92).

Barriers to the transition to motherhood in women with obesity include aspects such as negative interactions with care providers (93), obstetric violence and fatphobia (94), value judgments based on the appearance and size of their bodies (95), socioeconomic conditions (96), previous experiences of pregnancies with maternal obesity, parity (97), and the environment where maternal care is provided, especially if they are restrictive, dominant spaces focused based on an obesity-centric, weight-centric, or feto-centric perspective (98).

Patterns of responses to the transition to motherhood in women with obesity.

Patterns of response to this transition are identified as visible actions that allow us to recognize if a woman with obesity has made a healthy transition to motherhood. It is divided into process indicators and outcome indicators.

Process indicators include: feeling connected to her child, feeling identified as a mother, developing self-confidence, and assuming her maternal role (85). The outcome indicators include the mastery and development of individual skills for assuming their new role (81).

Transition to healthy motherhood

Transition is a process where people change their behavior, acquire a certain degree of self-awareness, and master new knowledge and skills to adapt positively to the new condition or role (81). A transition to motherhood is successful when the mother has the mastery and knowledge to perform her maternal role with confidence and security (84). A transition to motherhood is unhealthy, ineffective, or conflictive when a woman has difficulty performing her new role (81), such as feeling overwhelmed with caring for her baby (84), not knowing where to begin; she re-evaluates herself as a good or bad mother when she lacks self-confidence and is confused about her maternal roles (85). Subsequently, the theoretical and conceptual elements derived from the situation-specific theory of conflictive matrescence is developed.

Table 1 Theoretical and conceptual elements derived from the specific situation theory of conflictive matrescence.

NATURE OF THE TRANSITION			CONDITIONS OF THE TRANSITION These conditions are defined by personal, community, and social situations that facilitate or hinder the transition process.			RESPONSE PATTERNS TO THE TRANSITION TO MOTHERHOOD Response patterns assess indicators of progress and outcome in the transition process		
Types	Patterns	Properties	Personal	Personal	Personal	Feeling a connection		Development of an inclusive identity
Development Transition	Multiple, sequential or simultaneous	The transition period	<ul style="list-style-type: none"> - Acceptance of the pregnancy. - Knowledge and preparation - The maternal commitment. - Maternal resilience. - Maternal emancipation 	<ul style="list-style-type: none"> Unwanted or unplanned pregnancy Demographic and psychosocial factors Age, education level, income, parity, ethnicity, race. Psychological Factors: self-esteem, anxiety, stress, body image. Socio-cognitive factors: attitudes, beliefs. Cultural factors: misperceptions 	Establish a secure attachment with the NB		Feeling identified as a mother, developing self-confidence and achieving maternal adaptation. The outcome indicators include the mastery and development of individual skills for assuming their new role.	
		The critical points						Family members
Situational type transition	The transition pattern is multiple, simultaneous, and related; this transition occurs concomitantly with other transitions.	There are critical points, characterized by a period of uncertainty marked by fluctuation, continuous change, and disruption of the Reality.	The support of the partner. Family support.	<ul style="list-style-type: none"> -Lack of family support. -Absence of the baby's father. 	Develop skills and abilities for the care of her newborn.		<ul style="list-style-type: none"> -Feels competent to be a mother. -Develops skills and mastery in care. 	
		The meanings						Community and Social
		One of the characteristics of a transition is the creation of new meanings.	Positive interactions with healthcare providers Social support networks.	<ul style="list-style-type: none"> -Prejudices about female bodies that become mothers being obese. -Stereotypes -Fatphobia. -Obstetric violence 	She assumes her maternal role and acts accordingly.			
			Facilitators of the transition to motherhood in women with obesity.	Inhibitors of the transition to motherhood in women with obesity	Indicators of progress in the transition to motherhood in women with obesity.	Outcome Indicators of the transition to motherhood in women with obesity.		

Source: Author's elaboration based on the integration of the findings

Assumptions and propositions to understand the experience of the transition to motherhood in women with obesity

–All transitions are characterized by flow and movement over time. The transition pattern is multiple, simultaneous, and related, because more than one transition can occur at the same time, simultaneously and interrelated; for example: a woman can go from one trimester to another during pregnancy, transition from childbirth to postpartum, go from being a woman to becoming a mother and assume the maternal role during breastfeeding; in this order of ideas, as the transition progresses, women's expectations may change.

- The nature of the transition process to motherhood in women with obesity is seen as a complex, often confusing and critical process that cannot be predicted; where women face multiple challenges to become mothers; for these reasons, nursing care should help this process occur in a positive way; for example: when there is a conflict in the woman between the desire to become a mother and the maternal risk; this internal conflict requires support from nursing professionals through transitional care to help the new mother clarify her role, so that she can feel situated.

–The patterns of transition to motherhood in many women, including women with obesity, are sequential, dynamic, and require adjustments to achieve equilibrium, given that most transition experiences involved turning points or critical events. The transition pattern in women with obesity is disordered and confusing; it is marked by critical points that are recognized as situations that produce more stress in the transition process, such as the separation of the mother-child dyad, as a consequence of perinatal complications of maternal obesity.

–Knowing and understanding the critical points or events of the transition process to motherhood in women with obesity is of utmost importance so that nurses can put their therapy into practice and thus be able to support and accompany women in their transition process to motherhood.

–Nursing therapeutics is defined as the transitional care that nursing professionals provide to women with obesity during their reproductive continuum (matrescence, pregnancy, childbirth and postpartum) and is not limited solely to supporting critical events and points during this transition process.

–The partner or the baby's father support, as well as family support, as conditions of the transition process to motherhood in women with obesity, facilitates response patterns, so that a healthy transition to motherhood occurs; for example: having the presence of a loving partner, who positively reinforces the self-concept and self-image of the pregnant woman with obesity, makes it easier for the mother to cope with the stigma of weight and fatphobia during her transition process to motherhood.

–The context can make the transition to motherhood more difficult through social stigma and gender inequality. As systematic patterns of fatphobia are reinforced, women entering obstetric services will be affected by this type of symbolic violence, which perpetuates the inequality faced by women in a world that does not recognize the diversity of female bodies.

–The lack of professionals' preparation inhibits the transition process to motherhood; this is evidenced in the interactions occurring during obstetric care, a situation that is an invitation to reflect on what we do in nursing practice when providing care to women who are obese during their transition to motherhood.

–Response patterns (of a healthy or successful transition to motherhood) can be evidenced through indicators of progress such as: the mother's connection with her child, the

mother's self-confidence, the development of skills and abilities for the care of her newborn and the assumption of her maternal role, effective breastfeeding, maintaining a fluid and calm relationship with her environment, free from prejudice and discrimination.

NEW CONCEPTS DERIVED FROM THEORETICAL DERIVATION

Conflictive Matrescence: It represents the nature of the transition to motherhood in women with obesity. This process describes the physical, psychological or emotional and social/relational changes that a woman with obesity has to make to respond to the demands of this transition process. The manifestations of conflicted matrescence are related to women's feelings of ambivalence towards the risk and desire to become mothers, the change in expectations, and the resistance processes carried out by women with obesity in the face of weight stigma and fatphobia.

The concept “*Conflictive Motherhood*” is used in this SST to refer to the difficulties or conflicts that women with obesity may experience during their transition to motherhood. In addition to the emergence of this central concept, this situation-specific theory incorporates other sub-concepts resulting from theoretical integration.

Obstetric Fatphobia: The concept used in this SST to refer specifically to the set of stereotypes, prejudices, stigmas and discriminations surrounding obese female bodies, situated in the reproductive continuum of women (matrescence, gestation, childbirth and postpartum). This sub-concept is present in the spaces where obstetric care takes place, highlighting the social problems experienced by women with obesity who decide to become mothers.

Implications for the nursing discipline

The theorizing process is constant and dynamic; after the development of the theory, this SST must proceed with validation. In this process there may be advances or reflections on its development, so that it reaches maturity and becomes a reference to explain a phenomenon of interest to nursing practice. The processes of analyzing concepts and building empirical indicators help to recognize them in the real world; the development of instruments related to the theory of the specific situation becomes an important challenge to give more solidity to its construction.

The academy, especially graduate disciplinary training programs, is encouraged to use the integrative approach proposed by IM and Meleis, as a solid and consistent strategy for developing theories that respond to specific situations in nursing practice within the context of maternal-perinatal care.

Maternal-perinatal nursing education in Colombia must consolidate its own situation-specific theories, given that this area of nursing is broad and there is a diversity of phenomena of investigative and disciplinary interest that can benefit from this type of theory, offering an explanatory framework for practice, generating interventions based on the theoretical and empirical evidence derived from it.

Addressing the diversity of female bodies in the reproductive continuum of women, as well as approaching diverse motherhoods and the processes of transition to motherhood in specific population groups and specific sociopolitical contexts, becomes a challenge for the curricular transformation of maternal and perinatal care.

Studies favoring the development of empirical indicators that allow the evaluation of the nature, conditions and patterns of response to the transition to motherhood in women who are obese are recommended; it is necessary to validate nursing therapy based on the domains or areas affected in the process of conflictive matrescence (physical, psychic/emotional and social/relational dimension). Likewise, SST has to be validated in practice to give solidity to its theoretical approaches and propositions.

Transitional care in conflictive matrescence is configured as a new line of research within the framework of the theory of transitions, in a specific population (women who present obesity during their transition to motherhood) in a specific context (The Colombian context – obstetric and maternal-perinatal services).

CONCLUSIONS

This transition process was represented in 4 concepts derived from Meleis's Middle Range theory of transitions: nature of the transition (conflictive matrescence), conditions of the transition (facilitators and inhibitors), response patterns (process and outcome indicators), and transitional care during matrescence (related to nursing therapeutics), in addition to the linking of emerging concepts related or integrated to this specific transition, which are ***Conflictive Matrescence*** and ***obstetric fatphobia***.

The “Conflictive Matrescence” theory is a situation-specific theory of great importance to nursing practice because it describes the nature, conditions, and response patterns of the transition to motherhood in women with obesity. This population is not only vulnerable because they are pregnant and postpartum women, but also because their reproductive continuum is affected by weight stigma and fatphobia that they experience during their transition to motherhood. Understanding how this matrescence occurs allows nursing professionals to provide transitional care that promotes a healthy transition to motherhood for women with obesity, free from prejudice and obstetric fatphobia.

When nursing care focuses on the transition process to motherhood for women with obesity, they can benefit from nursing therapies that facilitate this transition, allowing this process to occur successfully or healthily. This perspective provides conceptual, theoretical, and empirical elements to respond to the care needs of this group of women and to the interaction they have with maternal and perinatal services where they receive their health care.

Limitations. Since this is a theoretical proposal based on evidence and the experiences of women with obesity and nursing professionals, it will require changes in the future, given that theoretical knowledge is constantly evolving and it is expected that this proposal will continue to be validated in practice.

Acknowledgments. To the University of Antioquia, especially to the professors of the Doctorate in Nursing, to the women who participated in this study, and to the colleagues who gave me all the support in the construction of this situation-specific theory, who invited me to reflect on nursing care in the transition to motherhood, in women who present obesity.

Conflict of interest: The author declares having no conflicts of interest.

REFERENCES

1. Hwang WY, Choi SY, An HJ. Concept analysis of transition to motherhood: a methodological study. *Korean J Women Health Nurs*. 2022 Mar 31;28(1):8-17. doi: 10.4069/kjwhn.2022.01.04. Epub 2022 Mar 23. PMID: 36312044; PMCID: PMC9334210
2. Lozano A, Betancourt WR, Turcios LJ, Cueva JE, Ocampo DM, Portillo CV et al. Sobrepeso y obesidad en el embarazo: complicaciones y manejo. *Arch Med [serie en Internet]*. 2016 [access: 8 oct 2020];12(3):1-7. Available from: <https://www.archivosdemedicina.com/medicina-de-familia/sobrepeso-y-obesidad-en-el-embarazo-complicaciones-y-manejo.pdf>
3. Herring SJ, Oken E. Ganancia de peso durante el embarazo: su importancia para el estado de salud materno-infantil. *Ann Nestlé (Ed española) [serie en Internet]*. 2010 [access: 22 ene 2021];68(1):17-28. DOI: <https://doi.org/10.1159/000320346>
4. Shah TJ, Walsh SW. Obese women may be at increased risk for cardiovascular diseases because of systemic vascular inflammation. *J Soc Gynecol Investig*. 2006;13(2):291A-291^a
5. Gudnadóttir TA, Bateman BT, Hernández-Díaz S, Luque-Fernández MA, Valdimarsdóttir U, Zoega H. Body mass index, smoking, and hypertensive disorders during pregnancy: a population-based case-control study. *PLoS One [serie en Internet]*. 2016 [access: 3 jul 2020];11(3): e0152187. DOI: <https://doi.org/10.1371/journal.pone.0152187>
6. Guzmán-Juárez W, Ávila-Esparza M, Contreras-Solís RE, Levario-Carrillo M. Factores asociados con hipertensión gestacional y preeclampsia. *Ginecol Obstet Mex [serie en Internet]*. 2012 [access: 23 jul 2020];80(7):461-466. Available from: <https://www.medigraphic.com/pdfs/ginobsmex/gom-2012/gom127d.pdf>
7. Lamminpää R, Vehviläinen-Julkunen K, Gissler M, Selander T, Heinonen S. Pregnancy outcomes of overweight and obese women aged 35 years or older: a registry-based study in Finland. *Obes Res Clin Pract [serie en Internet]*. 2016 [access: 23 jul 2020];10(2):133-142. DOI: <https://doi.org/10.1016/j.orcp.2015.05.008>
8. Moreno S, Tufiño E, Chávez V, Rodríguez M, Guerrero F, Levario M. Composición corporal en mujeres con diabetes mellitus gestacional. *Ginecol Obstet Mex [serie en Internet]*. 2009 [access: 30 jul 2020];77(6):270-276. Available from: <https://www.medigraphic.com/pdfs/ginobsmex/gom-2009/gom096c.pdf>
9. Sánchez-Larios S, Sánchez-Larios A, Hernández-Martínez M, Solorio-Meza E, Torres-Hernández R, Manuel Guillén-Contreras JM. Diabetes gestacional: comportamiento de los factores de riesgo en población mexicana. *Rev Med Inst Mex Seguro Soc [serie en Internet]*. 2008 [access: 30 jul 2020];46(6):659-662. Available from: <https://www.medigraphic.com/pdfs/imss/im-2008/im086m.pdf>
10. Crane SS, Wojtowycz MA, Dye TD, Aubry RH, Artal R. Association between pre-pregnancy obesity and the risk of cesarean delivery. *Obstet Gynecol [serie en Internet]*. 1997 [access: 12 Aug 2020];89(2):213-216. DOI: [https://doi.org/10.1016/S0029-7844\(96\)00449-8](https://doi.org/10.1016/S0029-7844(96)00449-8)
11. Hamon C, Fanello S, Catala L, Parot E. Conséquences de l'obésité maternelle sur le déroulement du travail et l'accouchement. *J Gynécol Obstet Biol Reprod [serie en Internet]*. 2005 [access: 12 Aug 2020];34(2):109-114. DOI: [https://doi.org/10.1016/S0368-2315\(05\)82702-4](https://doi.org/10.1016/S0368-2315(05)82702-4)
12. Leal-Mateos M, Giacomini L, Pacheco-Vargas LD. Índice de masa corporal pregestacional y ganancia de peso materno y su relación con el peso del recién nacido. *Acta Méd Costarric [serie en Internet]*. 2008 [access: 12 Aug 2020];50(3):160-167. Available from: <https://www.scielo.sa.cr/pdf/amc/v50n3/3786.pdf>

13. Chin JR, Swamy GK, Østbye T, Bastian LA. Contraceptive use by obese women one year postpartum. *Contraception* [serie en Internet]. 2009 [access: 22 Jan 2021];80(5):463-468. DOI: <https://doi.org/10.1016/j.contraception.2009.03.017>
14. Meleis AI, Trangenstein PA. Facilitating transitions: redefinition of the nursing mission. *Nurs Outlook* [serie en Internet]. 1994 ;42(6):255-259. DOI: [https://doi.org/10.1016/0029-6554\(94\)90045-0](https://doi.org/10.1016/0029-6554(94)90045-0)
15. Furness PJ, McSeveny K, Arden MA, Garland C, Dearden AM, Soltani H. Servicios de apoyo a la obesidad materna: un estudio cualitativo de las perspectivas de mujeres y parteras. *BMC Embarazo Parto* 2011;11 (1):69.
16. Knight-Agarwal CR, Williams L, Davis D, Davey R, Shepherd R, Downing A, et al. Las perspectivas de las mujeres obesas que reciben atención prenatal: un estudio cualitativo de las experiencias de las mujeres. *Mujeres y nacimiento* 2016;29 (2):189–195.
17. Meleis AI, Sawyer LM, Im EO, Hilfnger Messias DK, Schumacher K. Experimentar la transición. *Transiciones: una teoría emergente de rango medio. Ciencias de enfermería avanzada*. 2000;23(1):12–28.
18. Meleis AI, Trangenstein PA. Facilitating transitions: redefinition of the nursing mission. *Nurs Outlook* [serie en Internet]. 1994 ;42(6):255-259. DOI: [https://doi.org/10.1016/0029-6554\(94\)90045-0](https://doi.org/10.1016/0029-6554(94)90045-0)
19. Gramage, L., et al. "Obesidad en la edad reproductiva y embarazo." *Revisión bibliográfica. Matronas hoy* 3.1 (2015): 32-9.
20. Sánchez-Larios S, Sánchez-Larios A, Hernández-Martínez M, Solorio-Meza E, Torres-Hernández R, Manuel Guillén-Contreras JM. Diabetes gestacional: comportamiento de los factores de riesgo en población mexicana. *Rev Med Inst Mex Seguro Soc* [serie en Internet]. 2008 [access: 30 jul 2020];46(6):659-662. Available from: <https://www.medigraphic.com/pdfs/imss/im-2008/im086m.pdf>
21. Lawler D, Begley C, Lalor J. (Re)constructing myself: the process of transition to motherhood for women with a disability. *J Adv Nurs*. 2015;71(7):1672-1683. <https://doi.org/10.1111/jan.12635>
22. Wycoff et al. “Just Trying to Make it Through”: Understanding Transitions into Motherhood Among Young Black Women Amidst Trauma, Racism, and Structural Oppression. *Journal of Black Psychology* 2024, Vol. 0(0) 1–33. sagepub.com/journals-permissions DOI: 10.1177/00957984231223000
23. Santos RS, Ribeiro VM. Transition of blind women to motherhood from the perspective of Transitions Theory. *Rev Bras Enferm* [serie en Internet]. 2020 [access: 28 abr 2021];73(Suppl 4): e20190234. DOI: <http://dx.doi.org/10.1590/0034-7167-2019-0234>
24. Korukcu O, Deliktaş A, Kukulcu K. Transition to motherhood in women with an infant with special care needs. *Int Nurs Rev* [serie en Internet]. 2017 [access: 28 abr 2021];64(4):593-601. DOI: <http://dx.doi.org/10.1111/inr.12383>
25. Kohn-Willbridge C, Pike A, de Viser RO, “Look after me too”: A qualitative exploration of the transition into adoptive motherhood. *Adopt Foster* [serie en Internet]. 2021 [access: 29 abr 2021];45(3):300-315. DOI: <https://doi.org/10.1177/03085759211050043>
26. Silva et al. Balancing motherhood and drug addiction: The transition to parenthood of addicted mothers. *Journal of Health Psychology* 18(3) 359–367
27. Maehara, et al. Experiencias de transición a la maternidad entre mujeres embarazadas después de tecnología de reproducción asistida: un protocolo de revisión sistemática de evidencia cualitativa. *Síntesis de evidencia del JBI* 18(1): p 74-80, January de 2020. | DOI: 10.11124/JBISRIR-D-19-00071

28. Taborelli E, Easter A, Keefe R, Schmidt U, Treasure J, Micali N. Transition to motherhood in women with eating disorders: a qualitative study. *Psychol Psychother [serie en Internet]*. 2016 [access: 29 abr 2021];89(3):308-323. DOI: <https://doi.org/10.1111/papt.12076>
29. Berman et al. Laboring to Mother in the Context of Past Trauma: The Transition to Motherhood. *Qualitative Health Research* 2014, Vol. 24(9) 1253–1264
30. Carmona S, Martínez-García M, Paternina-Die M, Barba-Müller E, Wierenga LM, Alemán-Gómez Y, et al. El embarazo y la adolescencia conllevan adaptaciones neuroanatómicas similares: un análisis comparativo de los cambios morfométricos cerebrales. *Mapa cerebral Hum.* 2019. 40: 2143–52. 10.1002/hbm.24513
31. Fawcett J. Middle-range theories and situation-specific theories: similarities and differences. In: Im EO, Meleis A (ed.). *Situation specific theories: development, utilization and evaluation in nursing*. New York: Springer Publishing Company; 2021. pp. 39-48
32. Im EO, Meleis A. Situation-specific theories: philosophical roots, properties, and approach. In: Im EO, Meleis A (ed.). *Situation specific theories: development, utilization and evaluation in nursing*. New York: Springer Publishing Company; 2021.
33. Im EO, Meleis A. Situation-specific theories: philosophical roots, properties, and approach. In: Im EO, Meleis A (ed.). *Situation specific theories: development, utilization and evaluation in nursing*. New York: Springer Publishing Company; 2021
34. Figueroa Pedraza D. Obesidad y Pobreza: marco conceptual para su análisis en Latinoamérica. *Saúde Soc. São Paulo*, v.18, n.1, p.103-117, 2009. <https://www.scielo.br/j/sausoc/a/yXkvxTGjYS4QrhqW57TWGzP/>
35. Ministerio de Salud y Protección Social – MSPS. Dirección de Epidemiología y Demografía. Encuesta nacional de la situación nutricional-ENSIN 2015. <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/GCFI/documento-metodologico-ensin-2015.pdf>
36. Meisel JD, Ramírez AM, Esguerra V, et al. Utilizar un modelo de dinámica de sistemas para estudiar la transición de la obesidad por nivel socioeconómico en Colombia a nivel de país, región y departamento. 2020; 10: e036534. doi:10.1136/ bmjopen-2019-036534
37. Ministerio de Salud y Protección Social – MSPS. Dirección de Epidemiología y Demografía. Encuesta nacional de la situación nutricional. Encuesta Nacional de Situación Nutricional. <https://www.icbf.gov.co/bienestar/nutricion/encuesta-nacional-situacion-nutricional>
38. Congreso de la República de Colombia. Ley 1355 de octubre 14 de 2009.
39. Congreso de la República de Colombia. Ley 2120 del 30 de julio de 2021: Congreso de la República, Bogotá, D.C., 2021
40. Congreso de la República de Colombia. Ley de Impuestos Saludables.
41. Camacho Prieto, K. A., Torres Miranda, N. S., Guzmán Canabal, C. A., & Ordosgoitia Betin, M. E. (2023). Relación entre la obesidad materna y los resultados perinatales: revisión sistemática y metaanálisis. *RECIMUNDO*, 7(1), 689-696. [https://doi.org/10.26820/recimundo/7.\(1\).January.2023.689-696](https://doi.org/10.26820/recimundo/7.(1).January.2023.689-696)
42. UNICEF Colombia. Carga de enfermedad y económica del sobrepeso y la obesidad en mujeres gestantes, niñas, niños y adolescentes en Colombia. Available from: <https://www.unicef.org/colombia/media/12716/file/Estudio%20Obesidad%20en%20Colombia%20F%20Alzak.pdf>
43. Im EO. Desarrollo de teorías situacionales específicas: un enfoque integrador. *Ciencias de enfermería avanzada*. 2005; 28:137–51

44. Eichler, M. La relación entre sexista, no sexista, mujerinvestigación centrada y feminista. *Estudios de Comunicación*, 3, 37-74.
45. Ellermeir, W. y Olsen, V. Feminismos y modelos de investigación cualitativa. en NK Denzin y YS Lincoln (Eds.), *manual de investigación cualitativa* (158-174). Thousand Oaks, CA: Sabio.
46. Meleis, AI. Transitions theory. In: Smith MC, Parker ME (Eds.). *Nursing theories and nursing practice*. Philadelphia: F.A. Davis; 2015. pp. 361-80
47. Korukcu O, Deliktaş A, Kuku K. Transition to motherhood in women with an infant with special care needs. *Int Nurs Rev* [serie en Internet]. 2017 [access: 28 abr 2021];64(4):593-601. DOI: <http://dx.doi.org/10.1111/inr.12383>
48. Pearson A. Balancing the evidence: Incorporating the synthesis of qualitative data into systematic reviews. En: *JBI Reports*. 2004. Vol. 2
49. Merrill E, Grassley J. Historias de mujeres sobre sus experiencias como pacientes con obesidad *J Adv. Enfermeras*. 2008;64(2):139-46.
50. Foucault, M. (2002). *Vigilar y castigar: Nacimiento de la prisión*. Siglo XXI Editores: Buenos Aires.
51. Relph S, Ong M, Vieira MC, Pasupathy D, Sandall J. Perceptions of risk and influences of choice in pregnant women with obesity. An evidence synthesis of qualitative research. *PLoS One*. 2020 Jan 3;15(1):e0227325. doi: 10.1371/journal.pone.0227325. PMID: 31899773; PMCID: PMC6941828
52. McCloud MB, Barosso J. Experiences of Pregnant Women with Obesity. *Nurs Womens Health*. 2021 Jun;25(3):179-186. doi: 10.1016/j.nwh.2021.03.004. Epub 2021 Apr 23. PMID: 33895114.
53. Bjørsmo EH, Sandsæter HL, Horn J. Knowledge, experiences and attitudes of midwives in maternity care in encounters with pregnant women with obesity - are adverse childhood experiences understood and explored as a contributing factor? *Midwifery*. 2022 Nov; 114:103461. doi: 10.1016/j.midw.2022.103461. Epub 2022 Aug 13. PMID: 35995006.
54. Kerrigan et al. Obesity and normal birth: A qualitative study of clinician's management of obese pregnant women during labour *BMC Pregnancy and Childbirth* (2015) 15:256 DOI 10.1186/s12884-015-0673-2
55. Claesson, IM., Larsson, L., Steen, L. et al. "You just need to leave the room when you breastfeed" Breastfeeding experiences among obese women in Sweden – A qualitative study. *BMC Pregnancy Childbirth* 18, 39 (2018). <https://doi.org/10.1186/s12884-017-1656->
56. Singleton, Gillian, and Christine Furber. "The experiences of midwives when caring for obese women in labour, a qualitative study." *Midwifery* 30.1 (2014): 103-111.
57. Christenson A, Johansson E, Reynisdottir S, Torgerson J, Hemmingsson E. Shame and avoidance as barriers in midwives' communication about body weight with pregnant women: A qualitative interview study. *Midwifery*. 2018 Aug; 63:1-7. doi: 10.1016/j.midw.2018.04.020. Epub 2018 Apr 26. PMID: 29751291.
58. Parker G. Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care. *Women's Studies Journal*, Volume 31 Number 1, July 2017: 22-33. ISSN 1173-6615 2017 Women's Studies Association of New Zealand Hosted at www.wsanz.org.nz/
59. Vergara Bedoya M, Valencia Jiménez N, Barrientos García, K. narrativas de mujeres gestantes con obesidad: entre la alegría, el riesgo y el maltrato. Córdoba, Colombia. *Comunidad y Salud*. Año 2024; 22(2) Jul-Dic. <https://www.servicio.bc.uc.edu.ve/fcs/cysv22n2/art05.pdf>

60. Saw, W. Aung y L. Sweet, ¿Cuáles son las experiencias de las mujeres con obesidad que reciben atención prenatal de maternidad? Una revisión de alcance de la evidencia cualitativa, *Women Birth*, <https://doi.org/10.1016/j.wombi.2020.09.014>
61. Relph S, Ong M, Vieira MC, Pasupathy D, Sandall J. Perceptions of risk and influences of choice in pregnant women with obesity. An evidence synthesis of qualitative research. *PLoS One*. 2020 Jan 3;15(1):e0227325. doi: 10.1371/journal.pone.0227325. PMID: 31899773; PMCID: PMC6941828
62. Mehrabi, F., Ahmaripour, N., Jalali-Farahani, S. et al. Barriers to weight management in pregnant mothers with obesity: a qualitative study on mothers with low socioeconomic background. *BMC Pregnancy Childbirth* 21, 779 (2021). <https://doi.org/10.1186/s12884-021-04243-0>
63. Fair FJ, Watson H, Marvin-Dowle K, Spencer R, Soltani H. "Everything is revolved around me being heavy ... it's always, always spoken about." Qualitative experiences of weight management during pregnancy in women with a BMI of 40kg/m² or above. *PLoS One*. 2022 Jun 24;17(6):e0270470. doi: 10.1371/journal.pone.0270470. PMID: 35749542; PMCID: PMC9231696. 4
64. Parker G. Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care. *Women's Studies Journal*, Volume 31 Number 1, July 2017: 22-33. ISSN 1173-6615 2017 Women's Studies Association of New Zealand Hosted at www.wsanz.org.nz/
65. DeJoy SB, Bittner K, Mandel D. A Qualitative Study of the Maternity Care Experiences of Women with Obesity: "More than Just a Number on the Scale". *J Midwifery Womens Health*. 2016 Mar-Apr;61(2):217-23. doi: 10.1111/jmwh.12375. Epub 2016 Feb 2. PMID: 26840998
66. Padmanabhan, U., Summerbell, C.D. & Heslehurst, N. A qualitative study exploring pregnant women's weight-related attitudes and beliefs in UK: the BLOOM study. *BMC Pregnancy Childbirth* 15, 99 (2015). <https://doi.org/10.1186/s12884-015-0522-3>
67. Christenson A, Johansson E, Reynisdottir S, Torgerson J, Hemmingsson E. Shame and avoidance as barriers in midwives' communication about body weight with pregnant women: A qualitative interview study. *Midwifery*. 2018 Aug; 63:1-7. doi: 10.1016/j.midw.2018.04.020. Epub 2018 Apr 26. PMID: 29751291.
68. Carels, C. B. Wott, K. M. Young, A. Gumble, A. Koball, and M. W. Oehlhof, "Implicit, Explicit, and Internalized Weight Bias and Psychosocial Maladjustment Among Treatment-Seeking Adults," *Eating Behaviors* 11, no. 3 (2010): 180-185
69. Parker G. Shamed into health? Fat pregnant women's views on obesity management strategies in maternity care. *Women's Studies Journal*, Volume 31 Number 1, July 2017: 22-33. ISSN 1173-6615 2017 Women's Studies Association of New Zealand Hosted at www.wsanz.org.nz/
70. Walker Sandra B, Dolene M. Rossi, Teresa M Sander, Women's successful transition to motherhood during the early postnatal period: A qualitative systematic review of postnatal and midwifery home care literature., *Midwifery*, Volume 79, 2019, <https://doi.org/10.1016/j.midw.2019.102552>
71. Mehrabi, F., Ahmaripour, N., Jalali-Farahani, S. et al. Barriers to weight management in pregnant mothers with obesity: a qualitative study on mothers with low socioeconomic background. *BMC Pregnancy Childbirth* 21, 779 (2021). <https://doi.org/10.1186/s12884-021-04243-0>
72. Puhl and K. D. Brownell, "Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults," *Obesity* 14, no. 10 (2006): 1802-1815

73. Chang YS, Glaria AA, Davie P, Beake S, Bick D. Breastfeeding experiences and support for women who are overweight or obese: A mixed-methods systematic review. *Matern Child Nutr.* 2020 Jan;16(1):e12865. doi: 10.1111/mcn.12865. Epub 2019 Aug 6. PMID: 31240826; PMCID: PMC7038894.
74. Christenson A, Johansson E, Reynisdottir S, Torgerson J, Hemmingsson E. Shame and avoidance as barriers in midwives' communication about body weight with pregnant women: A qualitative interview study. *Midwifery.* 2018 Aug; 63:1-7. doi: 10.1016/j.midw.2018.04.020. Epub 2018 Apr 26. PMID: 29751291.
75. Fair FJ, Watson H, Marvin-Dowle K, Spencer R, Soltani H. "Everything is revolved around me being heavy ... it's always, always spoken about." Qualitative experiences of weight management during pregnancy in women with a BMI of 40kg/m² or above. *PLoS One.* 2022 Jun 24;17(6):e0270470. doi: 10.1371/journal.pone.0270470. PMID: 35749542; PMCID: PMC9231696. 4
76. Garner CD, McKenzie SA, Devine CM, Thornburg LL, Rasmussen KM. Obese women experience multiple challenges with breastfeeding that are either unique or exacerbated by their obesity: discoveries from a longitudinal, qualitative study. *Matern Child Nutr.* 2017 Jul;13(3):e12344. doi: 10.1111/mcn.12344. Epub 2016 Jul 25. PMID: 27452978; PMCID: PMC6866182
77. Keely A, Cunningham-Burley S, Elliott L, Sandall J, Whittaker A. "If she wants to eat...and eat and eat...fine! It's gonna feed the baby": Pregnant women and partners' perceptions and experiences of pregnancy with a BMI >40kg/m². *Midwifery.* 2017 Jun; 49:87-94. doi: 10.1016/j.midw.2016.09.016. Epub 2016 Sep 28. PMID: 27756643
78. Claesson, IM., Larsson, L., Steen, L. et al. "You just need to leave the room when you breastfeed" Breastfeeding experiences among obese women in Sweden – A qualitative study. *BMC Pregnancy Childbirth* 18, 39 (2018). <https://doi.org/10.1186/s12884-017-1656-2>
79. Garner CD, McKenzie SA, Devine CM, Thornburg LL, Rasmussen KM. Obese women experience multiple challenges with breastfeeding that are either unique or exacerbated by their obesity: discoveries from a longitudinal, qualitative study. *Matern Child Nutr.* 2017 Jul;13(3):e12344. doi: 10.1111/mcn.12344. Epub 2016 Jul 25. PMID: 27452978; PMCID: PMC6866182
80. Padmanabhan, U., Summerbell, C.D. & Heslehurst, N. A qualitative study exploring pregnant women's weight-related attitudes and beliefs in UK: the BLOOM study. *BMC Pregnancy Childbirth* 15, 99 (2015). <https://doi.org/10.1186/s12884-015-0522-3>
81. Lavender T, Smith DM. Seeing it through their eyes: a qualitative study of the pregnancy experiences of women with a body mass index of 30 or more. *Health Expect.* 2016 Apr;19(2):222-33. doi: 10.1111/hex.12339. Epub 2015 Jan 20. PMID: 25601510; PMCID: PMC5055269.
82. McCloud MB, Barosso J. Experiences of Pregnant Women With Obesity. *Nurs Womens Health.* 2021 Jun;25(3):179-186. doi: 10.1016/j.nwh.2021.03.004. Epub 2021 Apr 23. PMID: 33895114.
83. McCloud MB, Barosso J. Experiences of Pregnant Women With Obesity. *Nurs Womens Health.* 2021 Jun;25(3):179-186. doi: 10.1016/j.nwh.2021.03.004. Epub 2021 Apr 23. PMID: 33895114.
84. Keely A, Cunningham-Burley S, Elliott L, Sandall J, Whittaker A. "If she wants to eat...and eat and eat...fine! It's gonna feed the baby": Pregnant women and partners' perceptions and experiences of pregnancy with a BMI >40kg/m². *Midwifery.* 2017 Jun; 49:87-94. doi: 10.1016/j.midw.2016.09.016. Epub 2016 Sep 28. PMID: 27756643