Patients’ experience of accessing healthcare for obesity in Peninsular Malaysia: a qualitative descriptive study

Nor Akma Yunus 1,2, Grant Russell 3, Rosediani Muhamad, Elizabeth Ann Sturgiss 1

ABSTRACT
Objective To explore patients’ experiences accessing healthcare for obesity and their perceived behaviour changes following the care.

Design Using a descriptive qualitative research approach informed by Levesque’s framework of access to healthcare, we conducted phone interviews in the Malaysian language, which were audio-recorded and transcribed verbatim. Data were analysed inductively using a reflexive thematic analysis approach.

Setting Primary care clinics in five states in Peninsular Malaysia.

Participants Adult patients with obesity receiving face-to-face care for obesity from healthcare providers in Peninsular Malaysia.

Results We interviewed 22 participants aged 24–62, with the majority being female (77%), Malay (95%), married (73%) and with tertiary education (82%). Most participants attended obesity management services at public primary care clinics. We identified five themes: (1) moving from the need to seeking obesity care is a non-linear process for patients, (2) providers’ words can inspire patients to change, (3) patients’ needs and preferences are not adequately addressed in current obesity care, (4) over-focusing on weight by patients and healthcare providers can lead to self-blame and loss of hope for patients and (5) obesity healthcare can have consequences beyond weight loss.

Conclusion Patients lack the self-regulatory skills to continue their lifestyle changes and struggle with self-blame and hopelessness. Over-focusing on weight by patients and obesity healthcare increase patients’ self-stigmatisation. While provider-initiated weight discussions and engaging and personalised consultation provide the initial step towards weight management, obesity healthcare could be enhanced by behavioural support and patient education on the complexity of obesity. Further considerations could be given to shifting from a weight-centric to a more holistic health-centred approach in obesity healthcare.

INTRODUCTION
Obesity is defined as a disease of excessive accumulation of fat to the extent that it poses a health risk. 1 Worldwide obesity prevalence is increasing, 2 with Malaysia having the highest prevalence among Southeast Asian nations. 3

In 2019, half of the Malaysian adults had excessive weight, 4 which is concerning as health risks in the Asian population are conferred at a lower body mass index (BMI) compared with non-Asian populations. 5,6 Hence, obesity classifications in the Asian population based on BMI have lower cut-off points compared with the general population. 5 The Malaysian obesity management guidelines classify obesity as class 1 (BMI 27.5–34.9), class 2 (BMI 35.0–39.9) and class 3 (BMI ≥40.0). 7

Obesity is a well-known risk factor for metabolic diseases and cancers. 8,9 In addition, some patients with obesity can be emotionally burdened by their internal struggle with food and the judgmental attitudes of family and friends, 10 contributing to poor mental health. 11 Despite the health concern, international studies show people with obesity...
(PwO) receive insufficient support from healthcare services. \textsuperscript{12,13} ‘Eat less and move more’ advice implies that weight management is the patients’ responsibility and portrays a blaming discourse on PwO,\textsuperscript{12} which negatively affects patients’ engagement with obesity management.\textsuperscript{12}

Obesity healthcare in Malaysia is delivered in the public and private sectors. One of the key weight management services is nutrition counselling by nutritionists or dietitians in government health clinics.\textsuperscript{14,15} Some primary care clinics and tertiary hospitals run obesity management services either as clinical consultations or medically supervised weight reduction programmes.\textsuperscript{16-18} Each service’s availability, structure and methods vary based on the managing teams’ preference and feasibility of human resources. Some tertiary centres in Malaysia provide surgical management for obesity.\textsuperscript{19} However, this service is not widely available due to cost\textsuperscript{19,20} and was not often performed until recently.\textsuperscript{19}

Considering the gaps in obesity care worldwide, exploring patients’ experience with healthcare for obesity in Malaysia is essential to understand their perceptions of local obesity care services and the perceived effects of the care. Yet, experiences from patients’ perspectives are under-explored in Malaysia. Previous studies focus on PwO’s strategies to reduce weight\textsuperscript{16,18} but not on the interaction with healthcare. An earlier study on people’s perception of weight management was limited to services provided by community pharmacies, which were found to be underused by the patients in the survey.\textsuperscript{21} Therefore, this study aims to explore patients’ experience accessing healthcare for obesity in Malaysia and their perceived behaviour change following the care.

**METHODS**

**Study design**

This study applied a descriptive qualitative approach\textsuperscript{22,23} to understand and describe participants’ experience accessing healthcare for obesity within their sociocultural and clinical context.\textsuperscript{23} Reporting was guided by the Standards for Reporting Qualitative Research guideline.\textsuperscript{24}

This study was informed by Levesque’s framework of access to healthcare.\textsuperscript{25} Healthcare access conceptualised by this framework is not limited to the presence of services but extends to the adequacy and acceptability of the services, including patients’ engagement with the services.\textsuperscript{25} Patient–provider interactions in healthcare access happen across five dimensions of patients’ care journey: perceiving the needs for healthcare, healthcare seeking, reaching, utilisation and consequences.\textsuperscript{25} Although our target participants were patients who had reached obesity healthcare services, this framework was appropriate to guide the reflection of patients’ experiences (the demand side) before (perceiving the needs for care, seeking and reaching care), during (using care) and after (benefiting from the care) receiving obesity care. This framework informed our semistructured interview guide and understanding of patients’ experiences across the healthcare access dimensions.

**Patient and public involvement**

This study did not involve patients and the public in the design. However, the objective and findings were focused on patients’ perspectives.

**Participants**

Inclusion criteria included patients aged 18 years and over diagnosed with obesity (BMI $\geq$ 27.5 kg/m$^2$ based on the Malaysian obesity management guidelines\textsuperscript{7}) and received healthcare for obesity at least once in Peninsular Malaysia. Non-Malay-speaking or English-speaking individuals were excluded. Obesity healthcare in this study referred to a medically supervised face-to-face clinical care or weight management programme such as consultation, physical activities coaching, medication and/or surgery, delivered by a doctor, dietitian, nutritionist, physical therapist, occupational therapist, exercise physiologist and/or counsellor. Commercial, entirely online or application-based programmes were excluded.

We applied a convenience sampling method to recruit participants from a previous study\textsuperscript{26} and government health clinics. We selected clinics in five states in Peninsular Malaysia for variation in geographic location. A resource person (a staff member in each clinic) was identified and briefed on the inclusion criteria and the research process. Resource persons identified the potential participants and requested permission to submit their contact details to the principal investigator (PI). Participants were informed that their participation was voluntary, and their decision would not affect their care at the clinic. Next, the PI contacted the participants and checked for their eligibility, including their weight and BMI. Those who agreed to participate received a link to the Qualtrics website for explanatory statement and consent and were scheduled for interviews. Each participant was offered a 50-Malaysian ringgit gift voucher as an honorarium in recognition of their time as approved by the ethics committee.

**Data collection**

We gathered participants’ sociodemographic profiles on Qualtrics: age, gender, ethnicity, marital status, education level, employment status, name of the healthcare facilities and current follow-up status, which provided context to participants’ experiences. Verbal consent was obtained and recorded before the interview if participants could not provide consent on Qualtrics.

The PI conducted 22 interviews from July 2021 until January 2022 through phone calls in the Malaysian language. The initial semistructured interview guide was informed by the literature and Levesque’s framework.\textsuperscript{25} The interviews started with general questions before moving on to the details about participants’ experiences, from perceiving the care to benefiting from it. Three pilot interviews were conducted, and included in the...
data for their richness. Following the pilot interviews, the interview guide underwent minimal refinement of the sentences and the order of questions to improve the flow and clarity (online supplemental appendix 1). The interviews took place in a quiet and private space for 35–60 min and were audio-recorded. The recordings were transcribed verbatim by a professional transcriber.

**Data analysis**

Interview transcripts in the Malaysian language (Malay) were analysed thematically in NVivo (Qualitative Research Computer Analysis Package) software using reflexive thematic analysis. We applied inductive coding to look for data on participants’ experience from perceiving the need for obesity care until benefiting from the care. The codes were not predefined based on the domains in Levesque’s framework, as we were open to other elements or experiences mentioned by participants that might not be elaborated in the framework.

A professional translator translated the first three transcripts into English. Two investigators (NAY and EAS) coded the data independently, then discussed the developing codes and resolved any conflicting interpretations. Agreement measures were not applied, given researcher subjectivity in qualitative research. NAY analysed the remaining transcripts in Malay and developed the codes in English. The analysis followed the reflexive thematic analysis’s six phases: familiarisation, generating codes, constructing initial themes, developing and reviewing themes, refining and defining themes and reporting the themes. No new code was identified after the 19th interview. Data from the interviews were rich and covered various sociodemographic characteristics, therefore considered adequate to answer our research questions. The codes, draft themes and relevant quotes were discussed with the research team and revised accordingly. Related quotes from the remaining transcripts were translated into English by a professional translator, with ongoing discussions between NAY and the translator for translation refinement.

**Techniques to enhance trustworthiness**

We applied Lincoln and Guba’s techniques to enhance the trustworthiness. To enhance credibility, we established rapport first and had a prolonged engagement with the participants. We tried to minimise information distortion by ensuring the participants that their experiences would not be judged as right or wrong. The respective participants reviewed six transcripts for member checking, and two researchers analysed the three transcripts separately for investigator triangulation. The PI recorded the research process, data analysis and issues and discussed them with research team members (PI’s PhD supervisors) for the audit trail.

**Reflexivity**

The principal investigator (NAY) is a family doctor and medical lecturer at a public university in Malaysia and is currently enrolled in a Doctor of Philosophy. She has been involved in obesity management in Malaysia and is familiar with patients’ experiences with obesity care. Throughout data collection, NAY constantly reflected on her prior knowledge and experience, which guided her understanding and interpretation of patients’ experiences in this study. However, none of the study participants was NAY’s previous patient.

EAS, GR and RM are NAY’s PhD supervisors and are experienced in primary care and qualitative research. EAS and GR are primary care researchers and general practitioners in Australia. EAS is experienced in obesity management in the Australian context. RM is a family doctor and medical lecturer at a public university in Malaysia with a specialty in qualitative inquiry. NAY and RM are Malaysian and native Malay speakers who understand the social context of PoW in Malaysia.

**RESULTS**

**Demographic and obesity service characteristics**

We interviewed 22 participants—the demographics are described in table 1. Participants’ BMI ranged between 27.9 and 58.6 kg/m².

Most participants attended government-funded health services at primary care clinics (72%) or specialist clinics at public hospitals (5%) or both (18%). Only one participant received care at a private hospital. Nine participants, all health staff, joined a 3-month weight loss programme and 13 participants attended clinical services at primary care clinics or specialist clinics. None had undergone bariatric surgery except one participant waiting for the operation. Twelve participants had ongoing follow-ups, while 10 had stopped treatment. Table 2 describes the types of services attended by participants.

Because our research was conducted during the COVID-19 pandemic, the pandemic’s impact on participants’ obesity healthcare was apparent. Participants reported interrupted care, including delayed appointments. Some services were converted to online, which elicited varied reactions from participants. Furthermore, the prolonged staying-at-home period during the movement restriction order caused some participants to gain weight.

**Themes**

Five themes with an overarching theme were identified describing participants’ experiences throughout their obesity healthcare journey. Reflecting on Levesque’s framework, the themes were centred around the perceived need for and engagement with obesity care, as well as the consequences of their obesity care. However, healthcare-seeking and reaching domains were less prominent. There was no obvious pattern of shared experience between the different types of providers or obesity management services.

**Overarching theme: culture and social norms shape patients’ obesity healthcare experiences**

Asian culture and social norms influenced participants’ health-seeking behaviour and interactions with...
Theme 1: moving from perceiving the need to seeking obesity care is a non-linear process for patients

All participants acknowledged their excessive weight and said they needed to reduce it as some had already developed physical symptoms and health complications of obesity. Other reasons were beauty concerns and awareness of obesity health complications. Despite having the awareness and perceived need for weight reduction, only a few participants instigated obesity healthcare from healthcare providers. “When I had a stroke, I was referred to a doctor. He assessed everything [and] the doctor said, if I want to get better fast, I have to lose weight… So, this [obesity management] is his suggestion.”—P03, obesity class 3. Some had tried self-care to lose weight. However, most who intended to lose weight did not take any action until they developed a complication or were advised by providers during consultation for other medical illnesses.

Despite attending obesity healthcare, some participants did not perceive a strong need for weight reduction. For them, being coerced into changing behaviour did not assist obesity management. Some participants did not voluntarily attend obesity healthcare but were instructed by their workplace supervisors to participate in a weight loss programme run by their organisation. These participants expressed their agreement about needing to reduce weight and that the obesity programme was justified. Yet, they only attended the programmes on command and did not perceive much benefit from the care.

“My superior will choose whom she thinks suitable to join [the weight loss program]…I wasn’t too keen, [I was] coaxed…the more I am in the program, the worse I got…I felt bounded [by the program].”—P18, obesity class 3.

Meanwhile, some participants who perceived the need for weight management were unaware of the services and where to access them, particularly at public health facilities. Many participants searched the internet for information on self-weight management. A participant who worked in the health sector mentioned that he “did not even know where he should go [to get the treatment], let alone…laypersons”—P10, obesity class 1. Another participant highlighted that obesity management services in

healthcare providers, which could be seen throughout their healthcare journey. Because of the indirect and implicit nature of Asian communication, some participants were reluctant to ask questions despite not fully understanding the advice given by providers. They seldom voiced their opinion and openly discussed their disagreements with providers. One of the participants was reluctant to continue the group exercise conducted at the clinic because it took up his time from work, and he could not feel any difference with the exercise. However, he felt uncomfortable voicing his concerns due to his respect for the referring doctor. Other participants were concerned about giving a bad impression to their providers if they asked for more information but failed to comply with it. “I don’t actually like cycling, [but] I just follow [the order]…I may go just for the sake of the doctor…I have to answer to the doctor…it does not look good, especially when the doctor is nice.”—P20, obesity class 3.

Furthermore, hierarchical relationships in the Asian culture shaped participants’ views of providers as more knowledgeable and having more authority over health issues and management. Therefore, some participants were inclined to follow their providers’ advice without arguing or seeking clarification. “The doctor suggested reducing 12 kilos [in two months]…that is a huge target… it is impossible for me to achieve that…I don’t dare to tell the doctor [of my concern about the impossible target]…I don’t know, I guess he already has his formula [for the target], maybe other patients are all like me [using the same formula], so I just go on with it.”—P09, obesity class 3.

### Table 1 Participants’ demographic characteristics

<table>
<thead>
<tr>
<th>Demographic characteristic</th>
<th>n (%)</th>
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<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>30–39</td>
<td>8 (36.4)</td>
</tr>
<tr>
<td>40–49</td>
<td>10 (45.4)</td>
</tr>
<tr>
<td>50–59</td>
<td>0 (0)</td>
</tr>
<tr>
<td>≥60</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td><strong>Obesity class</strong></td>
<td></td>
</tr>
<tr>
<td>Class 1 (BMI 27.5–34.9 kg/m²)</td>
<td>6 (27.3)</td>
</tr>
<tr>
<td>Class 2 (BMI 35.0–39.9 kg/m²)</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Class 3 (BMI ≥40.0 kg/m²)</td>
<td>13 (59.1)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17 (77.3)</td>
</tr>
<tr>
<td>Male</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Malay</td>
<td>21 (95.5)</td>
</tr>
<tr>
<td>Others</td>
<td>1 (4.5)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5 (22.7)</td>
</tr>
<tr>
<td>Married</td>
<td>16 (72.7)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1 (4.6)</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
</tr>
<tr>
<td>Secondary education</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>18 (81.8)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1 (4.6)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Government, semi-government employee</td>
<td>14 (63.6)</td>
</tr>
<tr>
<td>Private employee</td>
<td>3 (13.6)</td>
</tr>
<tr>
<td>Homemaker/unemployed</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Retiree</td>
<td>2 (9.1)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1 (4.6)</td>
</tr>
<tr>
<td><strong>BMI, body mass index</strong></td>
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</table>
government healthcare facilities needed more promotion as participants were unaware of the services until their providers referred them. “The ministry of health conducted this [obesity management services]…do people know? I only knew [about it] when I was referred to.”—P11, obesity class 3. In contrast, weight loss programmes, clinical consultations or exercise facilities at public health clinics were available to some participants, especially those working in the healthcare sector. However, the availability of those services did not trigger the participants to use and benefit from the services.

**Theme 2: providers’ words can inspire patients to change**

Provider-initiated weight discussions substantially influenced participants’ awareness and motivation to manage their weight. Many participants started their obesity care at the healthcare facilities after providers brought up weight issues during their medical follow-ups at primary care clinics. This discussion, particularly if tailored to participants’ health conditions, raised awareness of personal health threats of obesity and inspired some participants to start managing their weight. “I went for my diabetic treatment…He [the doctor] explained to me one by one the things I have to do…so, because of his words, I’m inspired to lose weight.”—P08, obesity class 3. None of our participants reported feeling offended when providers mentioned weight issues, and the majority valued the advice and accepted the referral offer.

Some providers discussed the management plan, including the weight target. However, not many participants stated that they had received explanations about obesity medication and surgery. Consistently, many participants showed limited knowledge and negative perceptions towards obesity medications and surgery.

Besides the initial weight discussion, providers’ good approaches and communication styles positively influenced participants’ perceptions of weight management. Participants were more attracted to an engaging and clear explanation. Non-engaging consultations with one-way communication and no continuity between providers at each visit would easily be forgotten. A participant said she could not remember anything from her dietary consultation because it was boring and had no continuity between providers at each visit. However, she could still recall the bariatric surgeon’s engaging and clear explanation. “During the second meeting, it was a different [provider]. So, it’s like [the information] does not relate to the first meeting, she [the second provider] talked about something else… I don’t really remember…to me, it was not interesting…maybe the way she talked to me, it was not earnest…[but] I was pulled in by the way [the doctor] explained.”

**Table 2** Types of services attended by participants and the descriptions

<table>
<thead>
<tr>
<th>Types of services</th>
<th>Descriptions</th>
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<tbody>
<tr>
<td>Clinical obesity services at primary health clinics</td>
<td>This type of service was conducted at public-funded primary care clinics in the form of clinical consultations by primary care doctors, dietitians, nutritionists and/or counsellors or guided exercise activities by physiotherapists. The consultations were usually individual between a provider and patient, except for the exercise activities, which were conducted in groups. The dietitian, nutritionist, physiotherapist and counsellor could be permanent staff at the clinic or visiting staff from other clinics in the same district. Patients might see a different provider at each visit. The cost of this service was minimum (MYR 1–5 for Malaysian citizens; the mean Malaysian household income is MYR5873), similar to other services provided at primary care clinics.</td>
</tr>
<tr>
<td>Clinical obesity services at specialist clinics</td>
<td>This type of service was conducted at specialist clinics run at hospitals. It was run either by the internal medicine or bariatric surgery department, with a multidisciplinary involvement of dietitians and physiotherapists. Patients might see a different provider at each visit. The service cost was slightly higher than primary care clinics (minimum MYR 5 for Malaysian citizens), with an additional cost for laboratory or radiological investigations. Participants had to cover the cost of obesity medications and surgery.</td>
</tr>
<tr>
<td>Weight loss programme</td>
<td>The programme was conducted at public primary care clinics or district health offices targeted at the clinic staff and/or the public. It was a group programme run by a medical officer, a dietitian and/or physiotherapist and a counsellor. The same providers were involved throughout the programme. However, the structure and content of each programme might differ between health facilities. This service’s cost was minimal (MYR 1–5 for Malaysian citizens), similar to other services provided at primary care clinics.</td>
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I could really listen, [I was] immediately determined to have it [bariatric surgery] done... he drew out his explanation on paper for me. His explanation was fascinating.—P01, obesity class 3.

Participants reported the positive effects of providers’ encouraging approach. They felt supported by providers’ positive reinforcement and motivating words which helped them sustain their efforts. “Some of [the doctors’] techniques were threat-like...[while] some are motivating... When [the doctor] said with his support, he opened up a way [and] I could see that this could really happen. So, I became [motivated] to do more.”—P20, obesity class 3. Conversely, an unpleasant consultation experience, such as threatening and blaming comments from health providers, made the participants feel dejected and unwelcome. “It doesn’t matter that person is fat or obese or diabetic or whatever, the doctor’s words can build their [the patients] trust in them. Let’s say the doctor says, ‘you will be fat until you die, look at these flabby things’, people [patients] will not come [to seek healthcare]...the communication is the most important.”—P11, obesity class 3. The unwelcoming experiences, therefore, led the participants to avoid further care.

Theme 3: patients’ needs and preferences are not adequately addressed in current obesity care

Participants stated various barriers to lifestyle changes towards weight loss, including emotional eating, juggling between exercise and family-related demands, feeling bored by eating the same diet, stressful life situations that reduce motivation and external food temptation. They lacked the skills to handle the barriers, making continuing their weight loss efforts difficult. However, discussions about the barriers were not part of their obesity care. “I definitely would be hungry again...[the provider] suggested taking fruits, like half an apple [or] drink plain water. The problem is those things will not get rid of my hunger. There is no specific [advice] on how to handle that hunger.”—P15, obesity class 3. Even when some participants mentioned their difficulties, their providers advised them to remain disciplined and motivated without directly addressing the barriers. As a result, they felt lost on how to move forward when facing the barriers and needed providers’ guidance to handle those barriers. “There was no [discussion] about [poor] motivation...they just motivate us about our dietary habit, that’s it...I mentioned it [poor motivation], but they said I shouldn’t be like that, this [weight loss attempt] needs high discipline.”—P14, obesity class 1.

Some participants described the obesity care they received as a standardised approach that was not personalised to their situations and preferences. The standardised advice they received did not help them to accommodate behaviour changes in their daily lives; thus, they would not follow it. For example, P20 mentioned that he preferred to control his diet by fasting as he did not want his friends to know he was on a diet. “I cannot follow some of the advice... I told [the provider] that I wanted to fast. He said he didn’t really encourage it... He was more focused on the quarter-quarter-half diet [a quarter plate of carbohydrates, a quarter plate of protein and a half plate of vegetables]... he seemed to think that I overdo [my diet], [like] I want to be quick.”—P20, obesity class 3. Voluntary fasting on Monday and Thursday is a common practice among Muslims in Malaysia. This participant felt that this voluntary fasting was a feasible attempt for him to lose weight. However, he said his health provider did not support his preference, as the obesity care he attended practised a different standardised diet approach. In contrast, a more flexible and practical approach that considered participants’ preferences meant that some participants could incorporate diet and exercise advice into their daily lives and were more appreciated by the participants.

Theme 4: over-focusing on weight by patients and healthcare providers can lead to self-blame and loss of hope for patients

Participants attended obesity healthcare with their own weight targets and expectations. Weight was the central focus not only for the participants but also in their obesity healthcare. Some participants were informed about the target weight reduction they should achieve in a given duration. In addition, some weight loss programmes, especially for healthcare staff, gave rewards to the participants with the biggest weight reduction or who achieved the target weight loss, making it look like a competition to participants, despite the rewards being small and not made public.

Obesity healthcare approach that only focused on weight negatively affected some participants. Many were motivated and even excited at the start of the weight loss programmes to compete to achieve the set weight and get the rewards. However, the excitement and motivation were not long-lasting. The majority became frustrated and demotivated when they did not achieve their expected weight reduction despite following the advice. “I tried to follow [the doctor’s] advice... but it [my weight] increased... I only tried it for 1 month... I feel like, frustrated... because there were no results.”—P01, obesity class 3. Behaviour changes in diet and exercise were seen as the means to achieve their desired weight. When they lost hope of getting the reward or achieving their weight target, they saw no point in continuing their diet and exercise; hence they stopped their efforts. “[My weight] dropped 3 kilos... but it was not enough. You needed to lose some percentage of your weight to get the prize... They organised the programme again... my friends [and I] decided not to join because we didn’t reach the target [weight].”—P14, obesity class 1.

Meanwhile, many participants could not sustain their efforts beyond several weeks because they could no longer control their desire for delicious food or the external influence of family and friends. The failure to sustain the effort and lose weight led to frustration and self-blame over their poor willpower. “I do feel regret... I cannot commit... [I] shouldn’t have don’t that, [I] should have tried... but you know, sometimes [I] am motivated, sometimes not.”—P05, obesity class 1. Some were embarrassed about their failure to lose weight despite attending care,
which increased their stress and self-blame. “I joined this [programme], I have the knowledge, [so] I must be able to do it... It’s embarrassing [and] stressful too...[when] you entered this programme but you’re not getting thinner.”—P05, obesity class 1.

Many participants had tried to lose weight many times, and some experienced cycles of weight loss and regain. Repeated disappointment and self-blame over their perceived poor willpower and failed attempts led to indifference and loss of hope about losing weight, especially when success was only determined by the amount of weight lost. Some even mentioned being afraid to try again for fear of more failure. “It’s me who cannot apply the advice...that’s why I failed...maybe I am the problem...I feel afraid to join [weight reduction program]...I’m afraid it will be like that again...in the beginning, it [the weight] reduces, then it regains and maintain like that”—P17, obesity class 1.

In addition, failing to lose weight made some participants perceive that their health providers had also lost hope in them. “I think they [health providers] were frustrated to talk to me, [to] tell me to change my habits.”—P01, obesity class 3.

Theme 5: obesity healthcare can have consequences beyond weight loss
Participants’ perceptions of the effects of obesity healthcare varied. Some perceived they benefited from the care, while others did not. A participant, P16, said obesity healthcare had changed her perceptions about food and weight loss. She used to be stressed about sticking to a strict diet and weight loss target. However, after attending obesity healthcare and reading further, she realised that weight loss would be a long journey, and she should not target reducing weight in a short time. Her current focus was on diet and exercise that was sustainable. “If I want to reduce [weight] within 6 months, it is impossible...Now, since I got the treatment at [clinic], I do not set the target in 1 year [but] I set longer than that...so that I will have the time for myself, not too stressful to cut, cut, cut the food...my target is not to reduce weight, but to discipline myself with my meal. It [the effect] on weight is minimal, but more about changes in my behaviours and mindset.”—P16, obesity class 3. This participant’s views were unique compared with others, possibly due to her weight loss programme structure. Her programme was dedicated to patients in the higher obesity category and had only two participants, with personal coaching by a medical officer and dietetic counselling. Furthermore, because of her frustration with repeated failed attempts, she read about weight management, which contributed to her mindset change.

Attending care for obesity changed some participants’ views of themselves. A participant, P08, had struggled with anxiety and depression for years and sometimes had negative feelings about herself. With advice and support from her providers, she felt more positive about herself and focused on getting healthier physically and mentally. Instead of feeling indifferent about her body due to perceived dislike by others for her large size, she accepted that obesity was a health threat to her and was ready to take control of her own body. She became more motivated to practise a healthy diet and exercise with guidance and support from her providers. “Mentally, I feel more positive...I have to get up [and] my starting point is now...they [providers] said, don’t be negative, we’ll work for it [losing weight]...those words make me motivated to see the dietitian, to continue the follow-up [for weight management].”—P08, obesity class 3.

Other participants stated gaining more knowledge on diet, exercise and weight management, and this knowledge was applied in their daily lives and extended to their family members. A participant, P20, said he was more conscious about the sugar content in food and started looking for lower-sugar food during grocery shopping. Similarly, another participant shared her knowledge of exercise with her family members and included them in her exercise routine.

Meanwhile, those who measured success by kilogram loss felt that obesity healthcare did not benefit them as they did not achieve their target weight. “If [the obesity program] was not really effective for me, [I] did not lose weight.”—P13, obesity class 2. Despite that, the majority blamed their poor efforts and inability to follow the advice from providers. They mentioned that obesity healthcare did not affect their perceptions of obesity and their eating and exercise behaviours. They continued their usual lifestyles but, at the same time, still thought about their weight. “Because I was not earnest... I just went for the sake of joining... I think there’s no effect on me... [my lifestyle] is the same.”—P19, obesity class 2. Many felt they needed strong willpower to succeed in their weight loss journey, which they still had not found.

DISCUSSION

We identified five themes plus an overarching theme from our participants’ experiences throughout their obesity healthcare journey. The overarching theme of ‘Asian culture and social norms’ shaped all the other themes, from perceiving their need for healthcare until benefiting (or not) from the care. As people living with obesity, our participants were able to perceive their own need for weight loss. However, moving from perceiving that need to seeking care was a non-linear process. When they received obesity healthcare, at times, their healthcare providers’ words inspired them to start managing their weight. However, often participants’ needs and preferences were not adequately addressed by the care that is currently provided. Moreover, when participants and healthcare providers are overly focused on weight loss, it can lead to self-blame and loss of hope for the participants. The consequences of obesity healthcare extended beyond weight loss for the participants, such as the positive value of oneself, although some felt indifferent.

A patient’s perceived need for healthcare is an essential starting point for seeking care.25 However, having the intention and motivation was insufficient to initiate or maintain our participants’ weight management, which
might be hindered by many barriers. Consistent with the literature, PwO took several years from the time they started struggling with obesity to seeking healthcare, despite acknowledging that obesity is a chronic disease.31 The delay in seeking healthcare for obesity might be due to perceiving oneself as healthy and not needing care,32 attributing obesity to personal responsibility,31 and lacking confidence in the effectiveness of healthcare to treat obesity.33

Participants blamed their lack of willpower for their inability to maintain behaviour change, despite having a poor understanding of body weight mechanisms and poor self-regulatory skills to overcome those mechanisms. Obesity involves complex mechanisms and physiological adaptations that fight against weight reduction, making weight loss efforts more challenging.34 The awareness of these mechanisms and their implications on the weight loss process reduces self-stigmatisation and attribution of obesity to personal causes.35 Yet, it was not covered in participants’ obesity healthcare. Therefore, instead of focusing only on diet and exercise education, obesity healthcare can educate patients on obesity metabolisms and individual responses to interventions. This education could be accompanied by behavioural support such as identifying barriers, problem-solving, stimulus control and relapse prevention36 to facilitate patients’ behaviour change.

Our findings support the negative impact of the weight-centric approach on patients’ mental health and self-perceptions,36 particularly when there is poor provider communication. The weight-centric approach is criticised for contributing to weight stigma among patients, healthcare providers and the public, lowering patients’ health and well-being.37 38 Therefore, newer obesity guidelines emphasise improving patient-centred health outcomes rather than focusing only on weight changes.39 40 A weight acceptance approach, Health at Every Size, shows promising evidence of psychological and physical benefits.41 42 Still, the long-term effectiveness and applicability in more diverse populations, including Asian groups, need further study.42 As there is no one-size-fits-all solution, it remains a challenge for researchers, clinicians and policymakers to find a clinical and public health approach to obesity management that balances addressing obesity health implications while avoiding exacerbating weight stigma.

Despite conflicting views on patient–provider weight discussion in the literature,45–48 within the Malaysian sociocultural context, provider-initiated weight discussion was appreciated by our participants and was a significant starting point toward weight management. However, the therapeutic alliance in obesity management lacks continuity of providers when participants see a different provider at each visit. Besides, some consultations do not discuss the collaborative goal or limit the goal to weight loss. Participants have limited self-regulatory strategies to comply with or continue doing the agreed tasks (adjusting their diet and doing regular exercise), thus needing more support from health providers. Like other studies,46 47 our participants need personalised advice to assist them incorporate diet and exercise changes into their lifestyles, compassionate listening, positive reinforcement and partnership with their providers in weight management. Some of the needs were not well met by current obesity healthcare, affecting participants’ engagement and ability to benefit from the care. In addition, based on our findings and others,26 35 48 threats and making patients feel bad about themselves do not help motivate them to change. Instead, it increases patients’ self-stigmatisation and poor mental health implications. Providers’ narratives significantly impact patients’ perceptions about obesity and themselves, which could eventually be translated into behaviour change towards healthier lives.

Asian people have their own culture that shapes their way of life. As culture influences how people perceive information and interact with each other,49 public awareness and clinical consultations in obesity healthcare should consider the cultural differences in health-seeking behaviour and information interpretation. Given the implicit nature of Asian communication, healthcare providers can encourage their patients to express their concerns, for example, about the diet they have been prescribed, and address these concerns in a non-judgmental way.

The study participants came from a broad geographic location in Peninsular Malaysia which is a strength in capturing diverse variations and adding to the richness of the data. This study is guided by a qualitative descriptive approach and Levesque’s framework of access to healthcare which added to the robust methodology. The hono- rarium that was provided to participants was approved by ethics and deemed not to cause undue inducement, as the amount was not large compared with the average household income in Malaysia. The limitation includes phone interviews which restrict the observation of non-verbal cues and participants’ behaviour in their natural environment.

CONCLUSION
Patients with obesity require providers’ support in moving their intention towards taking action and maintaining their weight loss efforts. Current obesity healthcare provides the initial step for weight management through provider-initiated weight discussions and engaging and personalised consultation. Yet, over-focusing on weight without patient education on obesity complexities and support for behavioural change worsens patients’ struggles and self-stigmatisation.

Twitter Nor Akma Yunus @norakmayunus, Grant Russell @grantrussell17 and Elizabeth Ann Sturgiss @LizSturgiss

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**ORCID iDs**

Nor Akma Yusun http://orcid.org/0000-0002-3291-6406

Grant Russell http://orcid.org/0000-0003-3773-2355

Elizabeth Ann Sturgiss http://orcid.org/0000-0003-4428-4060

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