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What is it like to live with obesity in Peninsular Malaysia? A qualitative study

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Summary

Understanding the experience of people living with obesity is crucial for delivering holistic care relevant to the socio-cultural context. Although half of the Malaysian adults have excessive weight, the lived experience of people with obesity in the Malaysian context is not well studied. Using the principles of hermeneutic phenomenology, this study explores the lived experience of adults with obesity in Malaysia and their perspective on the environmental influences on obesity. Participants were adults from Peninsular Malaysia living with obesity recruited from social media, clinics and snowball sampling. Twenty-five teleconference interviews in Malay were audio-recorded and transcribed verbatim. Data were analysed inductively using a reflexive thematic analysis approach, and quotes were translated into English. We identified five themes: (1) Malaysian life is centred around food; (2) social norms shape people living with obesity's perceptions of themselves and obesity; (3) people living with obesity are physically restricted by their body; (4) people living with obesity have repeated thoughts about efforts to lose weight; and (5) stigmatization of people living with obesity leads to negative emotions. Socio-cultural influences were highly impactful on participants' lifeworld, and these influences need to be considered in clinical practice and policy for obesity management in Malaysia. Clinical management should focus on assisting patients in navigating the unsupportive food and social environment instead of overfocusing on the individual's responsibility for weight reduction.

KEYWORDS
lived experience, Malaysia, obesity, phenomenology, qualitative

What is already known about this subject

- Asian people are at higher risk of metabolic and cardiovascular complications of obesity due to higher body fat percentage per body weight.
- Understanding the experience of living with obesity is crucial for delivering holistic care relevant to people's socio-cultural context.
- Little is known about the lived experience of people with obesity and the influence of environmental and cultural factors on patients' lives in Malaysia.

What this study adds?

- Navigating their lives within a socio-cultural environment that highly values food posed a vast and continuous challenge for adults with obesity in Malaysia.
- Both internalized weight stigma and discomfort with the body do not assist with motivation for behaviour change.
- Clinical management should focus on assisting patients in navigating the unsupportive food and social environment instead of overfocusing on the individual's responsibility for weight reduction.

1 | INTRODUCTION

Worldwide obesity prevalence has increased dramatically over 40 years[1,2] with a marked increase in low-middle income countries and Asian nations.[1] Malaysia, a multiracial, predominantly Muslim country in Southeast Asia, has the highest obesity prevalence in the region[3] with prevalence rising to 19.7% in 2019 from 15.1% in 2011.[4] Currently, half of Malaysia's adults have excessive weight, with a slightly higher prevalence (54.7%) in women.[4] The increasing obesity prevalence is worrying as, compared with non-Asian people, Asian people have a higher body fat percentage for each body mass index (BMI) category, which increases their risk of developing metabolic and cardiovascular complications at lower body weights.[5,6]

Studies from around the world have explored the experience of living with obesity in various social contexts.[7–9] Documented experiences include stigmatization and discrimination,[7,8,10] having repeated unsuccessful weight loss attempts,[7] feeling trapped by food and emotional eating,[8,10] emotional distress,[11] and being blamed and judged by others.[8] However, there are few qualitative studies exploring the experience of living with obesity in Asian countries, including Malaysia.[12] An earlier qualitative study in Sarawak, Malaysia, reported that participants were frustrated with their body size and had low self-esteem.[13] Interestingly, a qualitative study among homemakers in rural Malaysia found a different perception of obesity, where the majority of participants viewed obesity as a symbol of happiness.[14] Other qualitative studies from Malaysia only focus on body perceptions and barriers to weight loss,[15,16] and they lack a holistic exploration of the experience of living with obesity within the Malaysian socio-cultural and environmental context.

These infrequent studies are problematic as Asian populations have substantial socio-cultural differences from their western counterparts, including values and norms related to individualism–collectivism,[17,18] respect and etiquette.[18] For example, not refusing food and not wasting food is among the communal eating culture that may influence an individual's lifestyle and behaviour.[19] As perceptions and lived experience are shaped by an individual's social context, the experience of living with obesity in Malaysia should be explored. This study aims to understand the lived experience of adults with obesity in Peninsular Malaysia and their perspectives on environmental influences on obesity.

2 | MATERIALS AND METHODS

2.1 | Research design

The research design was informed by the principles of hermeneutic phenomenology[20,21] to explore the common meanings of a phenomenon (living with obesity) from the perspective of people experiencing the phenomenon (adults in Peninsular Malaysia).[20] People's meanings and interpretation of the experience are shaped by their lifeworld[21] and must be interpreted through their background.[22] In line with the principles of hermeneutic phenomenology, the researcher's past experiences and knowledge will guide the interpretations of the participants' experiences.[22]

The development of the interview guide was also informed by the socio-ecological model.[23] This model suggests a bidirectional relationship between individuals and their embedded environment, where individuals' behaviours are affected by and affect their social environments.[23] Individual behaviours are influenced by five levels of environmental factors: intrapersonal, interpersonal, institutional, community and policy.[23] The reporting of the study was guided by the Standards for Reporting Qualitative Research (SRQR) guideline.[24]

2.2 | Recruitment

This study obtained ethical approval from Monash University Human Research Ethics Committee (Project ID: 22953) and USM Human Research Ethics Committee (USM/JEPeM/20070376). We included adults (18 years old and over) with obesity living in Peninsular Malaysia, conversant in Malay (the official Malaysian language) or English, with a self-reported BMI of at least 27.5 kg/m^2 in line with the Malaysian guidelines for obesity.[25] We used purposive sampling to capture a variety of people with obesity to provide rich perspectives of the lived experience, ranging from individuals in the community inspired by weight loss-based Facebook groups to those who had access to healthcare for obesity management.

We recruited participants from four sources across various healthcare settings to enhance the richness of the data: weight loss-based Facebook groups in Malaysia (public), government health clinics (primary care), dietetic and bariatric clinics at a public university hospital (primary care and tertiary care), and snowball sampling.[26] We sought approval from the Facebook group administrators to upload a

post every 2–4 weeks and make it public so that it could be shared with other Facebook users. Recruitment at public health clinics and the university hospital was done through flyers posted at registration counters and waiting areas. Facebook group members and patients interested in participating left their contact details in an online Qualtrics link provided in the recruitment materials. The first author then contacted the participants through email or phone messages and arranged an interview. Online written consent was gained before the interview.

2.3 | Data collection

In-depth interviews were conducted using a semi-structured guide (Appendix S1) with questions focused on participants' perceptions and experiences living with obesity. Three images were used to initiate the exploration of participants' experiences and perceptions.[27] The first image was various emoticons to initiate a conversation about the participant's feelings about obesity. The second and third images were pictures of food and physical activities respectively, to explore their perspectives of food, dietary intake and physical activities. The interview guide was piloted in three interviews (data were not included in the analysis) and refined based on the interviewer's experience and feedback from the pilot interviewees. We collected demographic information about participants using an online survey, in either Malay language or English, which asked participants their age, gender, ethnicity, marital status, education level, employment status, self-reported weight and height, and geographic location.

The first author (N.A.Y.) conducted 25 interviews via teleconference in a private room to preserve confidentiality. N.A.Y. is a native Malay speaker and medical doctor, undertaking this research as part of her doctoral research. Participants were given the option of using the Malay language or English, and all chose Malay. The interviews lasted between 40 and 80 min and were audio-recorded.

Data collection was conducted from September 2020 until January 2021. At that time, the COVID-19 pandemic had hit Malaysia, but it was at an early stage, and factors related to the pandemic did not feature strongly in the interviews. Thus, the pandemic was not addressed further in the analysis.

2.4 | Data analysis

Audio recordings in the Malay language were transcribed verbatim by N.A.Y. Data analysis was done in NVivo software version 12. Coding was completed in English. Coding and analysis were guided by inductive reflexive thematic analysis by Braun and Clarke.[28] The first and third authors (native speakers of Malay and fluent in English) analysed the first three transcripts independently. We started with familiarization with the data, then generated the codes based on the meanings expressed in the data. Next, both authors discussed the developing codes from the three transcripts. Acknowledging researcher subjectivity in qualitative research, we did not apply agreeability measures or get to a consensus. Instead, we discussed the meaning of each code and its relevance to our research questions and resolved any conflicting interpretations of the data. The remaining transcripts were analysed by N.A.Y. The codes evolved as the analysis progressed with reflexive interpretations of the data. Following analysis of the codes, we developed the themes based on the pattern of shared meaning united by a central concept for each theme. The themes underwent several revisions to ensure a correct representation of the concept, including checking against the codes and data and vice versa. We deemed the data from 25 interviews were rich enough to address our research questions,[29] therefore, we decided to stop data collection at this point.

We conducted analysis meetings every 2–4 weeks to discuss the coding structure, meaning behind surprising quotes and the developing themes. N.A.Y. prepared a participants' summary in English to facilitate the discussion with other authors who were monolingual English speakers. For the discussions, the quotes in Malay were translated into English by a professional translator with continuous reflective conversations between N.A.Y. and the translator to maintain the accuracy of the quotes. Ongoing translation refinement was done during and after each meeting. Relevant quotes for each theme were translated by the professional translator.

2.5 | Trustworthiness and reflexivity

We applied the Lincoln and Guba approach[30] to enhance trustworthiness in this study, as illustrated in Table 1.

3 | RESULTS

We interviewed 25 participants: 23 women and two men, from nine states across Peninsular Malaysia. Participants were predominantly Malays (96%), had tertiary education (88%) and government employees (60%). The majority were recruited from Facebook (60%), with some uptake from snowball (28%) and the dietetic and bariatric clinic (12%). Participant demographics are presented in Table 2. We identified five themes: (1) Malaysian life is centred around food; (2) social norms shape people living with obesity's perceptions of themselves and obesity; (3) people living with obesity are physically restricted by their body; (4) people living with obesity have repeated thoughts about efforts to lose weight; and (5) stigmatization of people living with obesity leads to negative emotions.

3.1 | Theme 1: Malaysian life is centred around food

Several participants highlighted that the food culture in Malaysia contributes to obesity and is a barrier to weight loss. People in Malaysia enjoy eating, and they eat for the pleasure of good taste. Participants described cafe hopping (a common Malaysian practice of going from

TABLE 1 Techniques to enhance trustworthiness based on Guba and Lincoln criteria

Criteria	Techniques
Credibility	1. *Prolonged engagement*: we gathered and reviewed participants' sociodemographic profiles before the interview to learn about their socio-cultural context. Interviews were started with an informal conversation where N.A.Y. introduced herself to establish rapport. To minimize information distortion, participants were informed that there was no right or wrong answer, and they could answer the questions based on their experience. 2. *Investigator triangulation*: the first three transcripts were coded and analysed by two researchers separately. Then, both researchers discussed the findings and resolved any disagreement. 3. *Member checking*: six of 25 transcripts were emailed to the respective participants for review.
Transferability	1. *Purposeful sampling*: to provide rich data, we purposely selected participants from three different sources across three health care settings—Facebook group (community), health clinic, and dietetic clinic (primary care) and bariatric clinic (tertiary care). 2. *Thick description*: we described the experience within the participant's socio-cultural context.
Dependability	*Audit trail*: the research process and product were recorded and reviewed by the first author's supervisors (E.S., G.R., R.M.). We also had regular meetings between the team to discuss the process, data, and any issues.
Confirmability	*Investigator triangulation*—as described above for Credibility. *Confirmability audit*—as described above for Dependability. *Reflexivity* —The first author (N.A.Y.) is a female medical lecturer with a Master of Medicine degree in Family Medicine who is currently enrolled in a Doctor of Philosophy focused on the topic area. She is also a family medicine specialist in a university hospital in Malaysia and has five years of postgraduate experience in clinical practice and medical research. She has been involved in the clinical management of patients with obesity at the university hospital where she works. However, none of the study participants had been the patient of the first author. Although this study was her first qualitative study, the author had attended training in qualitative research before and during the study. Furthermore, throughout the research process, she was constantly guided by research team members who were experienced in qualitative and primary care research. The second (G.R.), fourth (C.B.), and last authors (E.S.) are English-speaking primary care researchers at an Australian public university, with vast experience in qualitative and primary care research. (E.S.) and (G.R.) are also family doctors in Australia and (E.S.) has expertise in obesity management in the Australian context. The authors (G.R., R.M., E.S.) are the supervisors of the first author. The third author (R.M.) research speciality is in qualitative inquiry. She works in the same university hospital with the first author as a medical lecturer and clinician. The first and third authors are Malaysians and native Malay speakers who understand the social context of people with obesity in Malaysia.

cafe to cafe with friends or family), looking for tasty food. The participants were surrounded by people who value food, and they found it difficult to get away from it.

> Malaysian food is undeniably delicious…if we have people around us who like to eat, enjoy the food…it is difficult for me to get out of this environment…I think the biggest challenge is food.—P7

Furthermore, food was a main part of any celebration in Malaysia, from a big celebration like Eid to a small one at the workplace or with family members. People were expected to take the food served to them, and refusing the food was considered impolite. Therefore, some participants took the offered food to avoid offending their friends or family. P2 explained her challenges dealing with food during a gathering, 'If we go to a ceremony… if we take less [food], there must be people saying bad words [like] 'you take so little'. And we also want to be polite to people'.—P2

Another aspect of food culture mentioned by P12 was the 'mentality of the Malaysian community' that people should enjoy food when they have the chance. She was surrounded by family members who thought, 'it's okay to eat, when would you get another chance to eat like this again'. Even among those with a medical illness, healthy eating was not addressed, as they still enjoyed food without restriction. Participants highlighted the availability, affordability, and feasibility of food as contributors to obesity. Both traditional and western food were sold everywhere at an affordable price, making it easy for the participants to satisfy their desire for their preferred food. P1 who liked fast food said, 'the advertisements on TV showed how delicious the food was' and he was 'attracted to that kind of food'. Moreover, the food was 'affordable' and more feasible to him as 'it's fast' and he did not 'need to bother himself with cooking'. Besides, some participants said healthy food such as broccoli was expensive and not easily available, which was a drawback to healthy eating and weight loss.

3.2 | Theme 2: social norms shape people living with obesity's perceptions of themselves and obesity

The beliefs and habits of participants' significant others influenced how they felt about themselves and their body and how they carried themselves in society. These perceptions and values were developed within their family culture and upbringing and were further enhanced in the circle of friends, workplace environment, and general Malaysian community. P3 said she did not feel concerned about her body and dietary habit since no one in her social circle seemed to care about body size or eating habits. So, she was not bothered living with a big body in that social circle. 'I don't feel anything [with the increasing body size]. Because we are among peers who…do not discriminate, [whether] you are fat [or] thin…and no one advises to take care of our health. I think I just go on, just eat'. —P3. In contrast, living around friends who seemed health-conscious and exercised regularly triggered

TABLE 2 List of participants ($n = 25$)

Num	ID	Location (state)	Age (years)	Gender	Ethnicity	Marital status	Highest education level	Employment status	Self-reported weight (kg)	Self-reported height (m)	Calculated BMI (kg/m^2)
1	P1	Selangor	39	Male	Malay	Single	Tertiary education	Private employee	118	1.79	36.8
2	P2	Selangor	36	Female	Malay	Married	Tertiary education	Homemaker	68	1.52	29.4
3	P6	Kuala Lumpur	31	Female	Malay	Single	Tertiary education	Government/semi-government employee	142	1.62	54.1
4	P3	Kuala Lumpur	44	Female	Malay	Single	Tertiary education	Government/semi-government employee	96	1.7	33.2
5	P11	Putrajaya	39	Female	Malay	Widow, widower, divorcee	Tertiary education	Government/semi-government employee	82	1.57	33.3
6	P9	Kuala Lumpur	26	Female	Malay	Single	Tertiary education	Private employee	127	1.6	49.6
7	P16	Selangor	47	Female	Malay	Single	Tertiary education	Private employee	100	1.57	40.6
8	P12	Selangor	41	Female	Malay	Married	Tertiary education	Homemaker	85	1.59	33.6
9	P10	Melaka	36	Female	Malay	Married	Tertiary education	Government/semi-government employee	91	1.58	36.5
10	P15	Perak	30	Female	Malay	Single	Tertiary education	Unemployed/looking for work	100.5	1.51	44.1
11	P7	Kuala Lumpur	31	Female	Malay	Married	Tertiary education	Government/semi-government employee	70	1.58	28.0
12	P21	Putrajaya	42	Female	Malay	Single	Secondary education	Unemployed/looking for work	155	1.56	63.7
13	P22	Kelantan	42	Female	Malay	Married	Prefer not to answer	Government/semi-government employee	80	1.55	33.3
14	P18	Johor	39	Female	Malay	Married	Tertiary education	Government/semi-government employee	82	1.62	31.2
15	P25	Kedah	45	Female	Malay	Married	Secondary education	Homemaker	67	1.53	28.6
16	P28	Kelantan	38	Female	Malay	Single	Tertiary education	Government/semi-government employee	150	1.6	58.6
17	P29	Kelantan	29	Female	Malay	Single	Tertiary education	Prefer not to answer	102	1.59	40.3
18	P30	Pulau Pinang	38	Female	Malay	Married	Tertiary education	Government/semi-government employee	88.8	1.48	40.5
19	P31	Kedah	43	Female	Malay	Married	Tertiary education	Government/semi-government employee	97	1.72	32.8
20	P32	Kuala Lumpur	35	Male	Malay	Married	Tertiary education	Private employee	96	1.7	33.2
21	P38	Kelantan	48	Female	Malay	Married	Tertiary education	Government/semi-government employee	90	1.72	30.4

(Continues)

TABLE 2 (Continued)

Num	ID	Location (state)	Age (years)	Gender	Ethnicity	Marital status	Highest education level	Employment status	Self-reported weight (kg)	Self-reported height (m)	Calculated BMI (kg/m^2)
22	P37	Kelantan	44	Female	Malay	Married	Tertiary education	Government/semi-government employee	79.9	1.5	35.5
23	P39	Kelantan	39	Female	Malay	Married	Tertiary education	Government/semi-government employee	85	1.52	36.8
24	P36	Selangor	38	Female	Malay	Single	Tertiary education	Government/semi-government employee	116	1.68	41.1
25	P33	Kedah	42	Female	Indian	Married	Tertiary education	Government/semi-government employee	110	1.54	46.4

motivation to change the behaviour as mentioned by P31, 'Among my friends at work, we have a so-called fitness group…when one person has done the exercise, we will put it in the group [chat]…it's like, we help each other…tell the group our workout for that day. It gives motivations, you know'.—P31

Moreover, some participants mentioned others did not always accept their big body. People commented on their body appearance and size, which they felt was typical behaviour in society. Participants felt that society viewed beauty as having a slender body and a big body, like theirs, would never be considered beautiful. This value was internalized by the participants, leading to self-stigmatization and unfavourable perceptions towards their body size. P31 said, 'I'm ashamed, [because] I'm fat… [sigh] I want to be small like them, they look beautiful…[But] I look like a giant'—P31. Meanwhile, P39 said, people with a big body 'do not look pretty' and were 'unattractive no matter how they dressed up or how expensive their clothes were.

3.3 | Theme 3: people living with obesity are physically restricted by their body

Living with a big body made the participants feel restricted due to physical symptoms related to high body weight or the high body weight itself. Because of the limitations, participants could not enjoy the activities they love, thus making them frustrated with their body. For example, jungle trekking is a common exercise activity in Malaysia where people hike a small hill in a group. However, P29's felt guilty for being a burden to others and had restrained her interest in that activity.

> I used to go hiking. And I was always the one who was far behind. Everybody had to wait….'Aargh, I don't want to hike anymore'…I feel like…I am a burden. I am slow and slowing down others.—P29

Physical symptoms related to obesity limited participants' everyday movement and activities. Most of our participants were Muslims, and prayer is one of the pillars of Islamic teaching. Participants mentioned that performing their prayers was 'not easy' because the 'knees were painful' (P31). Everyday activities like driving would cause difficulty for the participant as her 'tummy would hit the car steering', making it 'uncomfortable to drive' (P33). Sitting down on the floor is common in Asian culture. However, this simple activity was something the participants could not do as they 'would not be able to rise straight from the sitting positing as slim people do' (P38) because of the knee pain.

Their body also limited their clothes choices and restricted them from dressing up. When celebrating a big event like Eid, people want to wear their best clothes. Yet, our participants found it difficult to find nice clothes and they felt judged by others if they were too fashionable, as mentioned by P9, 'For us being big sized, we cannot have too much going on [the dresses]. It has to be moderately fashioned. If we want to dress up, we can't do as much [as we want]…[I feel that] people will judge us'.—P9

3.4 | Theme 4: people living with obesity have repeated thoughts about efforts to lose weight

Every participant brought up weight loss even when discussing other issues. They felt that they needed to lose weight because of health concerns, beauty image, and improving self-esteem. However, participants reported varied feelings of readiness to change. Some were still considering changing their behaviour, while others were strongly determined and took action to control their diet and exercise regularly. Even so, those who had acted were struggling with their efforts. We could draw two subthemes within this theme: *conflicting thoughts about changing behaviour* and *struggle with weight loss efforts*.

3.4.1 | Subtheme 4.1: conflicting thoughts about changing behaviour

Despite expressing their intentions to lose weight, some participants were not yet motivated to change due to conflicting feelings about their body and the worthiness of the behaviour change. Sometimes they felt secure, comfortable, and unthreatened when surrounded by their significant others, such as family members or friends. They developed this secure feeling as they were 'too comfortable' (P30), 'had been big for so long' (P36) since childhood, and people accepted them as they were with their big body. They felt comfortable with their lives and having a big size did not seem 'too bad' (P28).

P36 mentioned obesity gave her 'two sides' that she did not expect. At a certain point, having a big body was advantageous for her. She said, 'If we are big, we will be easily recognised by others, we don't have to introduce ourselves…This becomes an opportunity when I'm working, [and] when I was in the university'. Yet, she felt very uncomfortable about her body at other times, especially when she developed physical symptoms related to obesity or had negative feelings about her body image.

> When I put on my hijab, I look sweet, pretty. [Without the hijab] the neck is non-existence, the chin falls to the bottom of the neck, with a flabby stomach. Ah, at this time, I start to think, this is what I see when I look at myself. If someone else were to look at me, whatever they would think."—P36

Each individual described both comfortable and uncomfortable feelings with their big body that depended on the situation. When they felt comfortable with their body, they would not see obesity as a threat and tended to forget their reasons to lose weight. Yet, when the uncomfortable feeling came, those reasons reappeared. However, the uncomfortable feelings did not move their weight-loss intention into action.

Some participants were contemplating the worthiness of weight loss efforts. On one side, they thought of benefits they might get from losing weight. On the other side, they pondered what they loved and had to let go in order to lose weight. Those things included their love for food and the enjoyment of eating. They were also reasoning about the hardship they might face during the attempts and whether the benefits were worth those hardships. The anticipated distress became a hurdle for participants to take action, as mentioned by P28, 'I do have a strong urge to slim down my body…But…I love to dine out with my friends…When I don't go out with my friends, I feel like I have lost that enjoyment…there's no more pleasure'.

To some participants, weight loss was not a priority when they had more pressing life issues to handle. Their attention, time, and energy were focused on those issues, and they could not bring their mind to think about reducing weight. P2, who used to be physically active, started gaining weight after losing her job. She wanted to get back her old slimmer and more energetic self but did not feel motivated to diet or exercise as her priority was finding a new job. 'When I was fired…I'm not interested in that [fitness program and running event], I'm more interested in looking for another job'.—P2

3.4.2 | Subtheme 4.2: struggle with weight loss efforts

Almost all participants had tried to lose weight, and some were on weight loss attempts during the interview. Yet, they found it difficult to maintain their motivation and struggled with the ongoing effort. One of the biggest challenges was to break their strong connection with food. Despite acknowledging that their eating habit promoted weight gain, many participants struggled to overcome the longing for food and adopt a healthier dietary practice.

P9 mentioned that the beginning of the diet process was tough and emotional. She tried to lose weight by cutting down her meal portion which put her in constant hunger. Being in the state of 'feeling hungry' and 'tried to control the hunger', it was difficult to control her emotions, and she 'easily got irritated and angry even though on a small issue'. Later, she started blaming herself and feeling frustrated when facing difficulties with the weight loss process. 'I…keep thinking, what should I eat for dinner tonight. I can't eat this, I can't eat that. So, I feel like I restrict myself because…I want to lose weight'.—P9

All participants mentioned that they had tried to lose weight with goals related to the number of kilograms lost or achieving a certain weight. Their target weight drove their weight loss efforts, and they became motivated or demotivated by the outcome. However, their weight-centric target added to their struggles and frustration. P6 said, 'I would lose 5kg to 10kg…But once I reached the flat curve, plateau, at that moment my psyche breaks'.

Furthermore, many participants could not sustain the lost weight. Once they had lost some weight or achieved their desired weight, they felt complacent with the achievement and less susceptible. They could not maintain the new dietary changes and the physical activity patterns and one day they would notice their weight escalated again. They went through the same cycle of developing the motivation, struggling with emotions when facing hurdles, possibly achieving the desired weight and finally regaining the weight. '[I had tried] so many [types of diet]…it had quite an impact…When I saw the results, I started to deviate…[and] suddenly my weight escalated'. —P6

Adding to the difficulty, when people with obesity modified their lifestyle to lose weight, their efforts were mocked by others. The participants expressed their need for support from their significant others in their weight loss attempts and that the lack of support was a barrier to weight loss. 'There are co-workers, relatives [who mock]…When they see me eating a little, people will say, 'you don't have to be skinny, [your weight] will increase again''.—P7

3.5 | Theme 5: stigmatization of people living with obesity leads to negative emotions

Participants experienced various negative emotions in relation to stigmatization such as low self-esteem, frustration with their body, and anger towards society. The participants described the emotions either coming from their own mind or they noticed that they were triggered by the outer world. They tried numerous coping strategies to deal with the unpleasant feelings and keep going with their lives.

Some participants mentioned stigmatized attitudes in society. They felt that society perceived people with obesity as lazy, not moving enough, and eating a lot, making them feel judged and stigmatized. P15 said, '[Obesity means] big people, and they eat a lot. Even though I don't eat much…like on the TV, dramas, movies and all'. The stigmatization and discrimination triggered frustration and anger towards society in some participants. 'I'm quite angry too. Why do people choose [who to associate with] based on the appearance, not on the person's talent?'—P28.

Participants described various coping mechanisms when navigating their lives through challenging encounters. Some described coping with negative feelings by turning away and avoiding the stressful situation as P1 did. 'When I'm frustrated, I'll go out with friends…who don't talk about physical appearance…I want to find someone I am comfortable with…If I hear people talking [about my physical appearance], I become reclusive'—P1. Some participants would try to fit in by proving their talent and ability to others. Some would rationalize the situation and try to comfort their feelings by accepting their bodies and thinking positively.

> 'We need to see how a plump person dresses up in social media…from the point of make-up, to mask the size of our body…Even though I'm plump, I'm not lazy as people made me out to be…I can be attractive…look attractive despite being plump'.—P15

> 'This one [the emoticon] is like, she knows she has a problem…she is obese…I need to do something but, I'm still happy with my body…She is a bit anxious because she knows the risks of obesity…I shouldn't be angry because it is myself [my body], right. So, even though I'm frustrated, I still have to make myself happy. Because I'm still trying, right, it does not mean, 'oh when you are obese, [then] you're going to be fat forever'.—P6

Negative emotions also came from self-blame and self-stigmatization in the participants. In dealing with these emotions, some participants tried hiding their body through their clothes and makeup. All our Muslim female participants wore hijab during the interviews, which is a common practice in Malaysia. Some participants felt more confident when in hijabs or wearing an oversized shirt that could hide their big body. 'When I put on my hijab, I look sweet, pretty [giggles]'.—P36

4 | DISCUSSION

Participants reflected on their challenging experiences of living with obesity in Peninsular Malaysia with their experience shaped by their outer world that was sometimes supportive, but usually not. Perceptions, beliefs, and behaviours of people around them shaped their personal meaning and experience of living with obesity. Navigating their lives within a socio-cultural environment that highly values food posed a continuous challenge for the participants. Furthermore, pervasive weight stigma in society was internalized by people with obesity, which added to their struggles.

Consistent with current literature on obesity complexity,[31] our participants mentioned various environmental factors that influence obesity. One of the key factors highlighted was food as a central focus within the Malaysian socio-cultural context. This finding is not surprising since Malaysia is famous for its multicultural culinary heritage.[32] The value of food goes beyond satisfying one's hunger. Food practice and consumption is part of the Malaysian identity[32] and tourism attraction.[33] This is emphasized in a Malaysian study showing that food plays a role in forging happy memories in family and social connections.[34]

The centrality of food in the Malaysian culture may pose a risk to health since many traditional foods have high energy density[35] and energy-dense traditional and fast food is readily available, while choices for healthy food are limited as they are more expensive and less widely available. Therefore, living in an environment surrounded by food and people who value food is challenging for people with obesity. Previous Malaysian studies highlighted that individual dietary habits contribute to obesity.[16,36] However, current clinical obesity management fails to consider the food environment that surrounds the patient.

The voiced perspectives of others influenced our participants' views and actions towards obesity, a finding which is consistent with collectivism in Asian culture. Different from the western culture, Asian populations have more sense of togetherness and emphasis on social relationships, especially among people in their social network.[37] This collective culture is reflected in our findings involving the social norms at the workplace. For example, communal gatherings where people bring food to the office ('potluck') is common in some workplaces in Malaysia. Despite trying to control their diet, our participants felt compelled to eat the food their friends brought to the office because they did not want to offend their friends.

Consistent with the literature, people with obesity in our study have tried multiple times to lose weight.[7,16] Several studies mentioned

self-awareness of obesity was a strong motivator to lose weight.[16,38] Our data support an earlier study in Malaysia where health concern and beauty consciousness were the driving factors to weight loss.[15] However, our data show having self-awareness of health and body image is not enough to motivate weight loss efforts or ensure weight maintenance. All our participants were aware of obesity health implications and wanted to lose weight. Yet, awareness of health implications did not necessarily translate into intention and action. In addition, when people were made to feel uncomfortable or ashamed about their body size, this did not seem to lead to behaviour change.

Our findings clearly show that the complex nature of obesity goes beyond 'eat less and move more'. Therefore, besides individualized diet advice, patients should be supported to navigate through unsupportive food cultures mindfully and healthily. Nutrition education should be practical to the patient's context, considering personal meaning and connection to food. Public health messages should increase awareness of the complexity of obesity, thus reducing attribution to individual self-control and stigmatization. A focus on weight alone can overshadow other essential indices of health and well-being and increase the objectification of obesity.[39]

4.1 | Strengths and limitations

To the best of our knowledge, this is the first study in Malaysia that explores people's experience living with obesity through a hermeneutic phenomenological lens. This approach allows in-depth exploration of their experience 'being' in the world, which may not surface using a descriptive approach. Food environment and socio-cultural beliefs influenced our participants' lived experience with obesity, which has rarely been highlighted in previous literature. Furthermore, the first author's positionality is another strength for understanding and reflecting on the findings from the insider perspective.

Limitations include that the participants were mainly recruited from social media, so we may have missed those who do not use social media or have limited internet access. Second, most of our participants were women and Malay ethnics, thus the findings must be interpreted within this context. We purposively recruited participants from a diverse range of settings, but our sample did not include different ethnicities or economic backgrounds, which is a limitation of the study. Further research could include a broader range of socio-demographics, including people of low socioeconomic status, from rural areas, more male participants, and other ethnicities in Malaysia to get a more holistic understanding of this phenomenon.

5 | CONCLUSION

The experience of living with obesity in Malaysia is challenging, and our study brings new knowledge from this Asian context. Socio-cultural circumstances influence the lifeworld of people living with obesity. Thus, further research could focus on what these experiences mean in the context of clinical management. Furthermore, clinical management should also focus on assisting patients in navigating the unsupportive food and social environment instead of over-focusing on the individual's responsibility for weight reduction.

AUTHOR CONTRIBUTIONS

Nor Akma Yunus is the lead author and led data collection and analysis and wrote the first draft of the manuscript. All authors were involved in study design, data interpretation, manuscript writing, and final approval.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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